Schedule of Benefits

Employer: **Adobe Systems Incorporated**

MSA: 660819

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Schedule: 2B
Booklet Base: 2

For: Aetna Choice POS II HDHP - HealthSave Basic

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,600	$3,200
Family Deductible*	$3,200	$6,400

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid. Note: The Family deductible applies if you have dependents on your medical plan. If you cover any dependents, the entire family deductible must be satisfied before the plan starts paying for costs.

Plan Maximum Out of Pocket Limit includes the Calendar Year **deductible**. Once the **Maximum Out of Pocket Limit** is met, the Calendar Year **deductible** will no longer apply.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $3,200.
- For **out-of-network** expenses: $7,200

Family Maximum Out of Pocket Limit:

- For **network** expenses: $7,350
- For **out-of-network** expenses: $14,400

* If you cover dependents, the entire family maximum out of pocket limit must be satisfied prior to the plan covering 100% of the costs.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card*
***Covered Persons ages 22 but less than 65*: Maximum Visits per Calendar Year	1 visit	1 visit
***Covered Persons age 65 and over*: Maximum Visits per Calendar Year *****Includes Travel, Immunizations and related X7Ray and Lab	1 visit	1 visit

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No Calendar Year **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	100% per visit after Calendar Year **deductible** Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*
Screening & Counseling Services		
Office Visits ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No Calendar Year **deductible** applies.	100% per visits after Calendar Year **deductible**
Obesity and/or Healthy Diet Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits *	5 visits *
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*	8 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Sexually Transmitted Infections Benefit Maximums Maximum Visits per Calendar Year	2 visits*	2 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		
Well Woman Preventive Visits ***Office Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**
Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit
Hearing Exam	80% per exam after Calendar Year **deductible**	60% per exam after Calendar Year **deductible**
Hearing Hardware	80% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
Hearing Supply Maximum per 24 month period	1 hearing aid per ear	1 hearing aid per ear
Routine Cancer Screening ***Outpatient***	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**
Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and

	• the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*	• the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*
Lung Cancer Screening Maximum Age 55 and Above	One screening every 12 months*	One screening every 12 months*

Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

Prenatal Care		
Office Visits	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per calendar year	6* visits per calendar year

***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies	100% per item No Calendar Year **deductible** applies	60% per item after Calendar Year **deductible**

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits	100% per visit. No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months
***Important Note**: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Family Planning Services - Female Contraceptives		
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item. No Calendar Year **deductible** applies.	60% per item after Calendar Year **deductible**
Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males Outpatient	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Outpatient	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Specialist Office Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit No Calendar Year **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	100% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.		
All Other Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

Allergy Testing and Treatment	80% per visit after Calendar Year **deductible**.	60% per visit after Calendar Year **deductible**.
Allergy Injections	80% per visit after Calendar Year **deductible**.	60% per visit after Calendar Year **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	80% per visit after the Calendar Year **deductible**	Paid the same as the Network level of benefits. **See Important Note Below**

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room and Non-Emergency use of an ambulance (unless medically certified)	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year **deductible**	100% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year **deductible**	100% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	100% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Advanced Reproductive Technology (ART) Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Attempts	3 Attempts per Lifetime	3 Attempts per Lifetime
Maximum Dollar Amount per lifetime for fertility drugs under your Pharmacy Benefit	$20,000	$20,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60%per admission after Calendar Year **deductible**
Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery	80% per service after Calendar Year **deductible**	60% per service after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	80% per service after Calendar Year **deductible**	60% per service after Calendar Year **deductible**	60% per service after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum visits per Calendar Year	45	45
Ground, Air or Water Ambulance For emergency and medically certified non-emergency use	80% per trip after Calendar Year **deductible**	80% per trip after Calendar Year **deductible**

Ground, Air or Water Ambulance For non-emergency use of non-certified ambulance	50% per trip after Calendar Year **deductible**	50% per trip after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Jaw Joint Disorder Treatment Includes surgical and non-surgical treatment and appliances if condition exists. Must be preauthorized.	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices and Orthotics	80% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy and Autism Outpatient Physical and Autism Occupational Therapy Combined	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Combined Physical and Occupational Therapy Maximum visits per Calendar Year	60 visits	60 visits
Speech Therapy		
Outpatient Speech Therapy combined with Autism Speech Therapy - Includes Treatment for Developmental Delays	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Speech Therapy Calendar Year Limit combined with Autism Speech Therapy – No medical necessity ***Additional visits based upon medical necessity***	60 visits	60 visits
Autism Applied Behavioral Analysis	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	45 visits	45 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$45	$45
For more than a 30 day supply but less than a 91 day supply (mail order)	$90	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	$15
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$65	$65
For more than a 30 day supply but less than a 91 day supply (mail order)	$130	Not Applicable

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

Preventive Care Drugs and Supplements		
Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.	100% per item. No Calendar Year **deductible** applies.	Not Covered.

Important Note:
Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per supply No Calendar Year **deductible** applies.	Not covered.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	50% of the **recognized charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

For purposes of the Calendar Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you incur each Calendar Year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year

Family
This is the amount of **covered expenses** that you and your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this family Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from a **network provider** for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family
This is the amount of **covered expenses** that you and your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. After **covered expenses** reach this family Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from an **out-of-network provider** for the rest of the Calendar Year.

Deductible Waiver Provision for Preventive Prescription Drug Expenses
No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat the prevention of conditions relating to:

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis;

- Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

The preventive **prescription drug** list is available from your employer in printed form. Member Services can answer any questions you have about this preventive **prescription drug** list.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual and family **Maximum Out-of-Pocket Limit.**

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

The **Maximum Out-of-Pocket Limit** applies to **network provider** and **out-of-network provider** benefits.

You have a separate **Maximum Out-of-Pocket Limit** for **network provider and out-of-network provider** benefits. **Covered expenses** applied to the **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family
The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** expenses paid during the Calendar Year meets this family **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

Out-of Network Provider Maximum Out-of-Pocket Limit
Individual
Once the amount of eligible **out-of-network provider** expenses you have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit,** this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family
The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the Calendar Year meets this family **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A reduced payment of $400 will apply separately to the eligible expenses incurred for each type of in-patient service or supply as designated in the Understanding Precertification" section of your benefit Booklet.
- A reduced payment of $200 will apply separately to the eligible expenses incurred for each type of out-patient service or supply as designated in the Understanding Precertification" section of your benefit Booklet.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.