

# Schedule of Benefits

**Employer:** Adobe Systems Incorporated  
**MSA:** 660819  
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**Schedule:** 2A  
**Booklet Base:** 2

For: Aetna Choice POS II HDHP - HealthSave HSA

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
<b>Calendar Year Deductible*</b>		
<b>Individual Deductible*</b>	\$1,350	\$2,700
<b>Family Deductible*</b>	\$2,700	\$5,400

\*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: \$2,700.
- For **out-of-network** expenses: \$5,400.

### Family Maximum Out of Pocket Limit:

- For **network** expenses: \$6,500.
- For **out-of-network** expenses: \$10,800.

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

<b>Lifetime Maximum Benefit per person</b>	Unlimited	Unlimited
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*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
<b>Preventive Care Benefits</b>		
<b>Routine Physical Exams</b>		
<b>Office Visits</b>	100% per visit  No Calendar Year deductible applies.	100% per visit after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits</i>	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.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	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.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card</i>
<i>*Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>*Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>*Includes Travel, Immunizations and related X-Ray and Lab</i>		

**Preventive Care Immunizations**

*Performed in a facility or **physician's** office*

100% per visit

100% per visit after Calendar Year **deductible**

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.

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*For details, contact your **physician** or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com), or calling the number on the back of your ID card.*

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**Screening & Counseling Services**

**Office Visits**

**Obesity and/or Healthy Diet**

100% per visit

100% per visits after Calendar Year **deductible**

**Misuse of Alcohol and/or Drugs & Use of Tobacco Products**

No Calendar Year **deductible** applies.

**Sexually Transmitted Infections**

**Genetic Risk for Breast and Ovarian Cancer**

*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)\*

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**\*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.**



Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>
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<i>Lung Cancer Screening Maximum Age 55 and Above</i>	One screening every 12 months*	One screening every 12 months*
<p><b>*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.</b></p>		

<b>Prenatal Care Office Visits</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<p><b>Important Note:</b> 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.</p>		

<b>Comprehensive Lactation Support and Counseling Services</b>		
<b>Lactation Counseling Services Facility or Office Visits</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per calendar year	6* visits per calendar year
<p><b>*Important Note:</b> Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i>.</p>		

<b>Breast Pumps &amp; Supplies</b>	100% per item  No Calendar Year <b>deductible</b> applies	70% per item after Calendar Year <b>deductible</b>
<b>Important Note:</b> Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.		

<b>Family Planning Services</b> Female Contraceptive Counseling Services -Office Visits	100% per visit.  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
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Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months
<b>*Important Note:</b> Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

<b>Family Planning Services - Female Contraceptives</b>		
Female Contraceptive Generic <b>Prescription Drugs</b> and Devices provided, administered, or removed, by a <b>Physician</b> during an Office Visits.	100% per item.  No Calendar Year <b>deductible</b> applies.	70% per item after Calendar Year <b>deductible</b>

<b>Family Planning - Other</b>		
Voluntary Termination of Pregnancy Outpatient	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Voluntary Sterilization for Males Outpatient	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b>Family Planning - Female Voluntary Sterilization</b>		
<b>Inpatient</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b>Outpatient</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Physician Services</b>		
<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b>Specialist Office Visits</b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b>Physician Office Visits-Surgery</b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</b>		
Immunizations	100% per visit  No Calendar Year deductible applies.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , 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 <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> 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 <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
<b>*Important Note:</b> Not all preventive care services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .		
<b>All Other Services</b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b><i>Administration of Anesthesia</i></b>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<b><i>Allergy Testing and Treatment</i></b>	90% per visit after Calendar Year deductible.	70% per visit after Calendar Year deductible.
<b><i>Allergy Injections</i></b>	90% per visit after Calendar Year deductible.	70% per visit after Calendar Year deductible.
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Emergency Medical Services</i></b>		
<b><i>Hospital Emergency Facility and Physician</i></b>	90% per visit after the Calendar Year deductible	Paid the same as the Network level of benefits.
		<b>See Important Note Below</b>
<b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b> , the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b> ), 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 <b>physician</b> 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.		
<b><i>Non-Emergency Care in a Hospital Emergency Room and Non-Emergency use of an ambulance (unless medically certified)</i></b>	50% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
<b><i>Urgent Care Services</i></b>		
<b><i>Urgent Medical Care (at a non-hospital free standing facility)</i></b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b><i>Urgent Medical Care (from other than a non-hospital free standing facility)</i></b>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Diagnostic and Preoperative Testing</i></b>		
<b><i>Complex Imaging Services</i></b>		
<b><i>Complex Imaging</i></b>	90% per test after Calendar Year deductible	70% per test after Calendar Year deductible
<b><i>Diagnostic Laboratory Testing</i></b>		
<b><i>Diagnostic Laboratory Testing</i></b>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<b><i>Diagnostic X-Rays (except Complex Imaging Services)</i></b>		
<b><i>Diagnostic X-Rays</i></b>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Surgery</i></b>		
<b><i>Outpatient Surgery</i></b>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Facility Expenses</i></b>		
<b><i>Birth Center</i></b>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
<b><i>Hospital Facility Expenses</i></b>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<b><i>Skilled Nursing Inpatient Facility</i></b>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Days per Calendar Year	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Specialty Benefits</b>		
<b>Home Health Care (Outpatient)</b>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	120 visits	120 visits
<b>Skilled Nursing Care (Outpatient)</b>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
<b>Private Duty Nursing (Outpatient)</b>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
<b>Hospice Benefits</b>		
<b>Hospice Care - Facility Expenses (Room &amp; Board)</b>	100% per admission after Calendar Year deductible	100% per admission after Calendar Year deductible
<b>Hospice Care - Other Expenses during a stay</b>	100% per admission after Calendar Year deductible	100% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days
<b>Hospice Outpatient Visits</b>	100% per visit after Calendar Year deductible	100% per visit after Calendar Year deductible
<b>PLAN FEATURES</b>		
<b>Infertility Treatment</b>		
<b>Basic Infertility Expenses</b> 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.
<b>Comprehensive Infertility Expenses</b>	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

<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	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
<b><i>Maximum Dollar Amount per lifetime for fertility drugs under your Pharmacy Benefit</i></b>	\$20,000	\$20,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b><i>Inpatient Treatment of Mental Disorders</i></b>		
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<b><i>MENTAL DISORDERS</i></b>		
<b><i>Hospital Facility Expenses</i></b>		
Room and Board	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Physician Services	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b><i>Outpatient Treatment Of Mental Disorders</i></b>		
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<b><i>Outpatient Services</i></b>	90% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b><i>Inpatient Treatment of Substance Abuse</i></b>		
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<b><i>Hospital Facility Expenses</i></b>		
Room and Board	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Physician Services	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b><i>Outpatient Treatment of Substance Abuse</i></b>		
<b><i>Outpatient Treatment</i></b>	90% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Obesity Treatment Non Surgical</i></b>		
<b><i>Outpatient Obesity Treatment (non surgical)</i></b>	90% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Obesity Treatment Surgical</i></b>		
<b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b>	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>

<b><i>Outpatient Morbid Obesity Surgery</i></b>	90% per service after Calendar Year <b>deductible</b>	70% per service after Calendar Year <b>deductible</b>
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited
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<b>PLAN FEATURES</b>	<b>NETWORK (IOE Facility)</b>	<b>NETWORK (Non-IOE Facility)</b>	<b>OUT-OF-NETWORK</b>
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>			
<b><i>Transplant Facility Expenses</i></b>	90% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services (including office visits)</i></b>	90% per service after Calendar Year <b>deductible</b>	70% per service after Calendar Year <b>deductible</b>	70% per service after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Other Covered Health Expenses</i></b>		
<b><i>Acupuncture</i></b>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Maximum visits per Calendar Year	45	45
<b><i>Ground, Air or Water Ambulance</i></b> For emergency and medically certified non-emergency use	90% per trip after Calendar Year deductible	90% per trip after Calendar Year deductible
<b><i>Ground, Air or Water Ambulance</i></b> For non-emergency use of non-certified ambulance	50% per trip after Calendar Year deductible	50% per trip after Calendar Year deductible
<b><i>Durable Medical and Surgical Equipment</i></b>	90% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible
<b><i>Clinical Trial Therapies</i></b> (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.
<b><i>Routine Patient Costs</i></b>	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.
<b><i>Jaw Joint Disorder Treatment</i></b> Includes surgical and non-surgical treatment and appliances if condition exists. Must be preauthorized.	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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.
<b><i>Prosthetic Devices and Orthotics</i></b>	90% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Therapies</i></b>		
<b><i>Chemotherapy</i></b>	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.
<b><i>Infusion Therapy</i></b>	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.
<b><i>Radiation Therapy</i></b>	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
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>		
<b><i>Outpatient Physical and Occupational Therapy and Autism Outpatient Physical and Autism Occupational Therapy Combined</i></b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Combined Physical and Occupational Therapy Maximum visits per Calendar Year	60 visits	60 visits
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<b><i>Speech Therapy</i></b>		
<b><i>Outpatient Speech Therapy combined with Autism Speech Therapy - Includes Treatment for Developmental Delays</i></b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

<b><i>Speech Therapy Calendar Year Limit combined with Autism Speech Therapy – No medical necessity</i></b>	60 visits	60 visits
<b><i>Additional visits based upon medical necessity</i></b>		

<b><i>Autism Applied Behavioral Analysis</i></b>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Spinal Manipulation</i></b>		
	90% per visit after Calendar Year deductible	70% 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
<b><i>Preferred Generic Prescription Drugs</i></b>		
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

<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
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

<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
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

<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>		
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**:

100% per item.

Not Covered.

No Calendar Year **deductible** applies.

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](http://www.aetna.com) or calling the number on the back of your ID card.

**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.

100% per supply

Not covered.

No Calendar Year **deductible** applies.

**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](http://www.aetna.com) or calling the number on the back of your ID card.

**Coinsurance**

	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drug Plan Coinsurance</b>	100% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>

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.