# Schedule of Benefits

**Employer:** **University of Rochester**

**ASA:** 700143
**Control:** 878253

**Issue Date:** April 9, 2015
**Effective Date:** January 1, 2015
**Schedule:** 15B
**Booklet Base:** 15

For: YOUR HSA –Eligible Plan

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 TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| **Calendar Year Deductible*** | | | |
| ***Individual Deductible**** | $1,300 | $1,800 | $2,500 |
| ***Family Deductible**** | $2,600 | $3,600 | $5,000 |
| *Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid. | | | |

**Plan Maximum Out of Pocket Limit** includes plan **deductible** and **copayments**.

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

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| **Maximum Out-of-Pocket Limit** | | | |
| ***Employees Earning less than $46,300*** | | | |
| ***Individual Limit*** | $2,500 | $3,500 | $4,750 |
| ***Family Limit*** | $5,000 | $7,000 | $9,500 |
| ***Employees Earning $46,300 or more*** | | | |
| ***Individual Limit*** | $3,000 | $4,000 | $4,750 |
| ***Family Limit*** | $6,000 | $8,000 | $9,500 |

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| ***Lifetime Maximum Benefit Per Person*** | Unlimited | 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 TIER 1/Accountable Health Partners** | **NETWORK TIER 2/Aetna National** | **OUT-OF-NETWORK** |
|---|---|---|---|
| ***Preventive Care Benefits*** | | | |
| ***Routine Physical Exams Office Visits*** | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| *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.<br><br>*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.<br><br>*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.* | Not Covered |
| *Covered Persons ages 22 but less than 65*: Maximum Visits per Calendar Year | 1 visit | 1 visit | Not Covered |
| *Covered Persons age 65 and over*: Maximum Visits per Calendar Year | 1 visit | 1 visit | Not Covered |

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| ***Preventive Care Immunizations*** *Performed in a facility or* ***physician's*** *office* | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| ***Screening & Counseling Services***<br><br>***Office Visits***<br>***Obesity and/or Healthy Diet***<br><br>***Misuse of Alcohol and/or Drugs & Use of Tobacco Products***<br><br>***Sexually Transmitted Infections***<br><br>***Genetic Risk for Breast and Ovarian Cancer*** | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| *Obesity and/or Healthy Diet*<br>Maximum Visits per Calendar Year<br>*(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)****** | Not Covered |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | | |
| *Misuse of Alcohol and/or Drugs*<br>Maximum Visits per Calendar Year | 5 visits* | 5 visits* | Not Covered |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | | |
| *Use of Tobacco Products*<br>Maximum Visits per Calendar Year<br>*Use of Tobacco Products*<br>Maximum Visits per Calendar Year | 8 visits* | 8 visits* | Not Covered |
| ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*** | | | |

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| *Sexually Transmitted Infections Benefit Maximums*<br>Maximum Visits per Calendar Year | 2 visits* | 2 visits* | Not Covered |

***Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.***

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| ***Well Woman Preventive Visits***<br>***Visits***<br><br>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| ***Well Woman Preventive Visits*** Maximum Visits per Calendar Year | 2 visits | 2 visits | Not Covered |
| ***Hearing Exam*** | 90% per exam after Calendar Year **deductible.** | 90% per exam after Tier 1 Calendar Year **deductible.** | 60% per exam after Calendar Year **deductible** |
| Maximum Exams per Calendar Year | 1 exam | 1 exam | 1 exam |
| **Hearing Aids for dependent children to age 19** | 100% per aid after Calendar Year **deductible** | 100% per aid after Tier 1 Calendar Year **deductible** | 100% per aid after Calendar Year **deductible** |
| Hearing Supply Maximum per 36 month period | $600 | $600 | $600 |
| ***Routine Cancer Screenings***<br>***Outpatient*** | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |

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| Maximums | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• 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<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>*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; family history and frequency guidelines as set forth in the most current:<br>• 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<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>*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.* | Not Covered |
| *Lung Cancer Screening Maximum* | One screening every 12 months***** | One screening every 12 months***** | Not Covered |
| ***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<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or 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<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or 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 12 months | 6* visits per 12 months | Not Applicable |

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| **Breast Pumps & Supplies**<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per item<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per item<br><br>No **copay** or 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-Certificate for limitations on breast pumps and supplies. | | | |
| ***Family Planning Services***<br>Female Contraceptive Counseling Services - Office Visits. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or 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 | Not Applicable |
| *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.* | | | |
| Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits. | 100% per item<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per item<br><br>No **copay** or Calendar Year **deductible** applies | 60% per item after Calendar Year **deductible.** |
| ***Family Planning Services - Other***<br>Voluntary Sterilization for Males | | | |
| Outpatient | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible**. |
| Voluntary Termination of Pregnancy | | | |
| Outpatient | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible**. |
| ***Family Planning Services - Female Voluntary Sterilization*** | | | |
| ***Inpatient***<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per procedure<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per procedure<br><br>No **copay** or Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible.** |
| ***Outpatient***<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible.** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Vision Care*** | | | |
| ***Eye Examinations*** (including refraction) | 90% per exam after the Calendar Year **deductible** | 90% per exam after the Tier 1 Calendar Year **deductible** | 60% per exam after Calendar Year **deductible** |
| Maximum Benefit per Calendar Year | 1 exam | 1 exam | 1 exam |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Vision Care Supplies**** | 100% per item<br><br>No Calendar Year **deductible** applies. | 100% per item<br><br>No Calendar Year **deductible** applies. |
| ***Contact Lenses or Eyeglasses following cataract surgery (including aphakia)*** | 100% per item<br><br>No Calendar Year **deductible** applies. | 100% per item<br><br>No Calendar Year **deductible** applies. |

Vision Supply Maximum*- $60 per Calendar Year.

* Vision Supply Maximum for Dependent children up to the age of 19 - $60 per Calendar Year, plan pays 5% of the remaining balance.

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Physician Services*** | | | |
| ***Physician Office Visits*** (*non-surgical*) | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible** |
| ***Specialist Office Visits*** | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible** |
| ***Physician Office Visits-Surgery*** | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible** |

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| ***Walk-In Clinic Visit (Non-Emergency)*** | | | |
| ***Preventive Care Services**** | | | |
| Immunizations | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies.<br><br>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<br><br>No **copay** or Calendar Year **deductible** applies.<br><br>For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card. | Not Covered |
| Individual Screening and Counseling Services for Tobacco Use | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| 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<br><br>No **copay** or Calendar Year **deductible** applies. | 100% per visit<br><br>No **copay** or Calendar Year **deductible** applies. | Not Covered |
| 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**:<br>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*** | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible** |

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| ***Physician Services for Inpatient Facility and Hospital Visits*** | 90% per visit after Calendar Year **deductible**. | 80% per visit after Calendar Year **deductible**. | 60% per visit after Calendar Year **deductible**. |
| ***Administration of Anesthesia*** | 90% per procedure after Calendar Year **deductible**. | 80% per procedure after Calendar Year **deductible**. | 60% per procedure after Calendar Year **deductible**. |

| **PLAN FEATURES** | **NETWORK TIER 1/Accountable Health Partners** | **NETWORK TIER 2/Aetna National** | **OUT-OF-NETWORK** |
|---|---|---|---|
| ***Emergency Medical Services*** | | | |
| ***Hospital Emergency Facility and Physician*** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Tier 1 Calendar Year **deductible** | 90% per visit after the Tier 1 Calendar Year **deductible** |
| **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*** | Not Covered | Not Covered | Not Covered |
| ***Urgent Care Services*** | | | |
| ***Urgent Medical Care*** *(at a non-hospital free standing facility)* | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Tier 1 Calendar Year **deductible** | 60% per visit after the 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. | Refer to *Emergency Medical Services* and *Physician Services* above. |
| ***Non-Urgent Use of Urgent Care Provider*** *(at an Emergency Room or a non-hospital free standing facility)* | Not Covered | Not Covered | Not Covered |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** | | | |
| ***Complex Imaging Services*** | | | |
| ***Complex Imaging*** | 90% per test after the Calendar Year **deductible** | 80% per test after the Calendar Year **deductible** | 60% per test after the Calendar Year **deductible** |
| ***Diagnostic Laboratory Testing*** | | | |
| ***Diagnostic Laboratory Testing*** | 90% per procedure after the Calendar Year **deductible** | 80% per procedure after the Calendar Year **deductible** | 60% per procedure after the Calendar Year **deductible** |
| ***Diagnostic X-Rays*** | | | |
| ***Diagnostic X-Rays*** | 90% per procedure after the Calendar Year **deductible** | 80% per procedure after the Calendar Year **deductible** | 60% per procedure after the Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Outpatient Surgery*** | | | |
| ***Outpatient Hospital*** | 90% per visit/surgical procedure after Calendar Year **deductible** | 80% per visit/surgical procedure after Calendar Year **deductible** | 60% per visit/surgical procedure after Calendar Year **deductible** |
| ***Outpatient Surgical Center*** | 90% per visit/surgical procedure after Calendar Year **deductible** | 90% per visit/surgical procedure after the Tier 1 Calendar Year **deductible** | 60% per visit/surgical procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Inpatient Facility Expenses*** | | | |
| ***Birthing Center*** | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

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| ***Hospital Facility Expenses*** Room and Board (including maternity) | 90% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Skilled Nursing Inpatient Facility*** | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Maximum Days per Calendar Year | 120 days | 120 days | 120 days |

| **PLAN FEATURES** | **NETWORK TIER 1/Accountable Health Partners** | **NETWORK TIER 2/Aetna National** | **OUT-OF-NETWORK** |
|---|---|---|---|
| ***Specialty Benefits*** | | | |
| ***Home Health Care (Outpatient)*** | 90% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** |
| ***Hospice Benefits*** | | | |
| ***Hospice Care –Facility Expenses*** (Room & Board) | 90% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** |
| ***Hospice Care – Other Expenses during a stay*** | 90% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 90% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Infertility Treatment*** | | | |
| ***Basic Infertility Expenses*** Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only. | 90% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Comprehensive Infertility Expenses*** Expenses for Comprehensive Infertility services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**. | 90% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| Cervical Insemination Maximum Benefit | 24 courses of treatment per lifetime | 24 courses of treatment per lifetime | 24 courses of treatment per lifetime |
| Intrauterine Insemination Maximum Benefit | 12 courses of treatment per lifetime | 12 courses of treatment per lifetime | 12courses of treatment per lifetime |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Inpatient Treatment of Mental Disorders*** | | | |
| ***Hospital Facility Expenses*** | | | |
| Room and Board | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |

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|---|---|---|---|
| ***Inpatient Residential Treatment*** | | | |
| Facility Expenses | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 90% after Calendar Year **deductible** | 90% after Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Outpatient Treatment Of Mental Disorders*** | | | |
| ***Outpatient Services*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| **PLAN FEATURES** | **NETWORK TIER 1/Accountable Health Partners** | **NETWORK TIER 2/Aetna National** | **OUT-OF-NETWORK** |
|---|---|---|---|
| ***Inpatient Treatment of Substance Abuse*** | | | |
| ***Hospital Facility Expense*** | | | |
| Room and Board | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment*** | | | |
| Facility Expenses | 90% per admission after Calendar Year **deductible** | 90% per admission after the Tier 1 Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| Physician Services | 90% after Calendar Year **deductible** | 90% after the Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Outpatient Treatment of Substance Abuse*** | | | |
| ***Outpatient Treatment*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Obesity Treatment Non Surgical*** | | | |
| ***Outpatient Obesity Treatment (non surgical)*** | 90% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Obesity Treatment Surgical*** | | | |
| ***Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)*** | 90% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** |
| ***Outpatient Morbid Obesity Surgery*** | 90% per service after the Calendar Year **deductible** | 80% per service after the Calendar Year **deductible** | 60% per service after the Calendar Year **deductible** |
| Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) | Unlimited | Unlimited | Unlimited |

| PLAN FEATURES | NETWORK (IOE Facility) | NETWORK (Non IOE Facility) | OUT-OF-NETWORK |
|---|---|---|---|
| ***Transplant Services Facility and Non-Facility Expenses*** | | | |
| ***Transplant Facility Expenses*** | 90% 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) | 90% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Other Covered Health Expenses*** | | | |
| ***Acupuncture*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| Maximum Visits per Calendar Year | 10 visits | 10 visits | 10 visits |

| | | | |
|---|---|---|---|
| ***Ground, Air or Water Ambulance*** | 90% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Diabetic Equipment, Supplies and Education*** | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Durable Medical and Surgical Equipment*** | 90% per item after the Calendar Year **deductible** | 90% per item after the Tier 1 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. | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | 90% after Calendar Year **deductible** | 90% after Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Prosthetic Devices*** | 90% per item after the Calendar Year **deductible** | 90% per item after Tier 1 Calendar Year **deductible** | 60% per item after Calendar Year **deductible** |
| ***Breast Prosthetic and Post Mastectomy Bras*** | 100% after Calendar Year **deductible** | 100% after Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| **PLAN FEATURES** | **NETWORK TIER 1/Accountable Health Partners** | **NETWORK TIER 2/Aetna National** | **OUT-OF-NETWORK** |
| ***Outpatient Therapies*** | | | |
| ***Chemotherapy*** | 90% after Calendar Year **deductible** | 90% after Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***Infusion Therapy*** | 90% after Calendar Year **deductible** | 90% after Tier 1 Calendar Year **deductible** | 60% after Calendar Year **deductible** |
| ***RadiationTherapy*** | 90% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Autism Spectrum Disorder*** | | | |
| ***Autism – Physical Therapy, Occupational Therapy, Speech Therapy*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Autism – Behavorial Therapy*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| ***Autism – Applied Behavorial Analysis*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** | | | |
| ***Outpatient Physical, Occupational, and Speech Therapy combined*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |
| Combined Physical, Occupational and Speech Therapy Maximum visits per Plan Year for Developmental Delays and Pervasive Developmental Disorders/Autism | 45 visits | 45 visits | 45 visits |

| PLAN FEATURES | NETWORK TIER 1/Accountable Health Partners | NETWORK TIER 2/Aetna National | OUT-OF-NETWORK |
|---|---|---|---|
| ***Spinal Manipulation*** | | | |
| ***Spinal Manipulation*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Tier 1 Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** |

# Pharmacy Benefit

**Copays**

| PER PRESCRIPTION COPAY | AETNA NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Generic Prescription Drugs*** | | |
| For each initial 30 day supply filled at a retail **pharmacy** | $10 after Tier 1 Calendar Year **deductible** | Not Covered |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy** | $25 after Tier 1 Calendar Year **deductible** | Not Covered |
| ***Preferred Brand-Name Prescription Drugs*** | | |
| For each initial 30 day supply filled at a retail **pharmacy** | The greater of $25 or 20% of the **negotiated charge** not to exceed $50, after Tier 1 Calendar Year **deductible** | Not Covered |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy** | The greater of $62.50 or 20% of the **negotiated charge** not to exceed $125, after Tier 1 Calendar Year **deductible** | Not Covered |
| ***Non-Preferred Brand-Name Prescription Drugs*** | | |
| For each initial 30 day supply filled at a retail **pharmacy** | The greater of $45 or 35% of the **negotiated charge** not to exceed $90, after Tier 1 Calendar Year **deductible** | Not Covered |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy** | The greater of $112.50 or 35% of the **negotiated charge** not to exceed $225, after Tier 1 Calendar Year **deductible** | Not Covered |
| ***Diabetic prescription drugs, supplies and insulin*** | | |
| For each 30 day supply filled at a retail **pharmacy** | 10% of the **negotiated charge** after Tier 1 Calendar Year **deductible** | Not Covered |
| For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy** | 10% of the **negotiated charge** after Tier 1 Calendar Year **deductible** | Not Covered |

| UNIVERSITY OF ROCHESTER PHARMACY | PER PRESCRIPTION COPAY |
|---|---|
| ***Generic Prescription Drugs*** | |
| For each 30 day supply filled up to a 90 day supply | 7.5% of the **negotiated charge** after Tier 1 Calendar Year **deductible** |
| ***Preferred Brand Name Drugs*** | |
| For each 30 day supply filled up to a 90 day supply | The greater of $18.75 or 15% of the **negotiated charge** not to exceed $37.50, after Tier 1 Calendar Year **deductible** |
| ***Non-Preferred Brand Name Drugs*** | |
| For each 30 day supply filled up to a 90 day supply | The greater of $33.75 or 26.25% of the **negotiated charge** not to exceed $67.50, after Tier 1 Calendar Year **deductible** |
| ***Diabetic prescription drugs, supplies and insulin*** | |
| For each 30 day supply filled up to a 90 day supply | 7.5% of the **negotiated charge** not to exceed $11.25 / Not Covered |

**Copays are waived for oral chemotherapy and chemotherapy injectables under the Aetna Network and University of Rochester Pharmacies.**

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

**Copay and Deductible Waiver**

**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;
- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

This means that such contraceptive methods will be paid at 100%.

The per **prescription copay/deductible** and any **prescription drug** calendar year **deductible** continue to apply:

- For contraceptive methods that are:
  - **brand-name prescription drugs** and brand name devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

**Coinsurance**

| | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Prescription Drug Plan Coinsurance*** | 100% of the **negotiated charge** after Calendar Year **deductible** | Not Covered |

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.

**Precertification** and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

## 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*.

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

You and each of your covered dependents have separate calendar year **deductibles**. This Plan has individual and family calendar year **deductibles**.

For purposes of 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.

**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.

## Copayments and Benefit Deductible Provisions

**Copayment, Copay**
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

## 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 out-of-network **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;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; 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 $400 benefit reduction will be applied separately to each type of expense.

# 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.