Schedule of Benefits

Employer: **University of Rochester**

ASA: 700143
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For: YOUR PPO 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*	$400	$800	$1,600
Family Deductible*	$1,000	$2,000	$4,800
*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.

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

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 No **copay** or Calendar Year **deductible** applies.	100% per visit 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. *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.*	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

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
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 **copay** or Calendar Year **deductible** applies.	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
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)******	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 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 Maximum Visits per Calendar Year *Use of Tobacco Products* 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.			

Sexually Transmitted Infections Benefit Maximums 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.

Well Woman Preventive Visits ***Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit 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	$30 exam **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 exam **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	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 ***Outpatient***	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered

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 • 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.*	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.*	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 No **copay** or Calendar Year **deductible** applies.	100% per visit 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 No **copay** or Calendar Year **deductible** applies.	100% per visit 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

Breast Pumps & Supplies	100% per item No **copay** or Calendar Year **deductible** applies.	100% per item 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			
Female Contraceptive Counseling Services - Office Visits.	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit 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 No **copay** or Calendar Year **deductible** applies.	100% per item No **copay** or Calendar Year **deductible** applies	60% per item after Calendar Year **deductible.**
Family Planning Services - Other			
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	100% per procedure No **copay** or Calendar Year **deductible** applies.	100% per procedure No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible.**
Outpatient	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit 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)	$30 exam **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 exam **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	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 No Calendar Year **deductible** applies.	100% per item No Calendar Year **deductible** applies.
Contact Lenses or Eyeglasses following cataract surgery (including aphakia)	100% per item No Calendar Year **deductible** applies.	100% per item 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*)	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Specialist Office Visits	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$60 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery			
Physician	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Specialist	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$60 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Walk-In Clinic Visit (Non-Emergency)			
Preventive Care Services*			
Immunizations	100% per visit No **copay** or 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 No **copay** or 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.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or Calendar Year **deductible** applies.	100% per visit 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 No **copay** or Calendar Year **deductible** applies.	100% per visit 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**:
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	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
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.

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**

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	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$15 per visit **copay** then the plan pays 100% No 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**
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	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$15 per visit **copay** then the plan pays 100% No 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**
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	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	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)	$30 per visit **copay** then the plan pays 100% in an office setting. Otherwise, 90% after the Calendar Year **deductible**	$30 per visit **copay** then the plan pays 100% in an office setting. Otherwise, 90% after the Tier 1 Calendar Year **deductible**	60% after Calendar Year **deductible**

Prosthetic Devices	90% per item after the Calendar Year **deductible**	90% per item after the 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	$30 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the Calendar Year **deductible**	$30 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the Tier 1 Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Infusion Therapy	$30 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the Calendar Year **deductible**	$30 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the Tier 1 Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
RadiationTherapy	$30 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the Calendar Year **deductible**	$60 per visit copay then the plan pays 100% in an office setting. Otherwise, 90% after the 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**
Autism Spectrum Disorder			
Autism – Physical Therapy, Occupational Therapy, Speech Therapy	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Autism – Behavorial Therapy	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$15 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Autism – Applied Behavorial Analysis	$30 visit **copay** then the plan pays 100% No **copay** or Calendar Year **deductible** applies.	$30 visit **copay** then the plan pays 100% 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
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Occupational, and Speech Therapy combined	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	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	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	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	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	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	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	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	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	Not Covered
Diabetic prescription drugs, supplies and insulin		
For each 30 day supply filled at a retail **pharmacy**	10% of the **negotiated charge** not to exceed $15	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** not to exceed $37.50	Not Covered

UNIVERSITY OF ROCHESTER PHARMACY	PER PRESCRIPTION COPAY	
Generic Prescription Drugs		
For each 30 day supply filled up to a 90 day supply	$7.50	
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	
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	
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**	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*.

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**.

Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. 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 Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents 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 and each of your covered dependents. 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 Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met 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.

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 **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

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

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents 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 Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents 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 Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

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

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.