

Schedule of Benefits

Employer: State Of Maine
 MSA: 307297
 Issue Date: June 2, 2015
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 Schedule: 1A
 Booklet Base: 1

For: Aetna Choice POSII (In State Plan)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$500	\$2,500
Family Deductible*	\$1,000	\$5,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible**, **coinsurance** and **in network medical copayments**

Plan Maximum Out of Pocket Limit excludes **precertification** penalties of \$500 per type of covered expenses.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$5,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$10,000.

Prescription Drug Maximum Out-of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Maximum</i>	\$4,600 Individual	Does not apply
Out-of-Pocket Limit does not apply to out of network.	\$9,200 Family	

<i>Lifetime Maximum Benefit per person</i>	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
<i>Preventive Care Benefits</i>		
<i>Routine Physical Exams</i>		
<i>Office Visits</i>	100% per visit No copay or Calendar Year deductible applies.	Not Covered
<i>Covered Persons birth through age 21: Maximum Age & 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 physician or Member Services by logging onto the custom website aetnastateofmaine.com, or calling the number on the back of your ID card</i>	Not Covered.
<i>Covered Persons ages 22 and above Maximum Visits per 12 months</i>	1 visit	Not Covered.

Preventive Care Immunizations

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

100% per visit

Not Covered

No **copay** or Calendar Year **deductible** applies.

Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

*For details, contact your **physician** or Member Services by logging onto the custom website aetnastateofmaine.com, or calling the number on the back of your ID card.*

Screening & Counseling Services

Screening & Counseling Services

100% per visit

Not Covered

Office Visits

Obesity and/or Healthy Diet

No **copay** or Calendar Year **deductible** applies.

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

Sexually Transmitted Infections

Genetic Risk for Breast and Ovarian Cancer

Obesity and/or Healthy Diet

Maximum Visits per 12 months
(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) This can be with a registered dietician or physician**

Not Covered

Nutritional Counseling
(Non- diagnosis specific)

2 visits *This can be with a registered dietician or physician**

Not Covered

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Misuse of Alcohol and/or Drugs</i>		
Maximum Visits per 12 months	5 visits*	Not Covered
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Use of Tobacco Products</i>		
Maximum Visits per 12 months	8 visits*	Not Covered
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit. Refer to the Pharmacy section for further information		

<i>Well Woman Preventive Care</i>		
<i>Well Woman Preventive Visits</i>		
<i>Office Visits</i>	100% per visit	100% per visit No Calendar Year deductible applies.
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	No Calendar Year deductible applies.	

<i>Hearing Care</i>		
<i>Hearing Exam</i>	\$25 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible
	No Calendar Year deductible applies.	
Hearing Supply Maximum per 36 month period for children to age 19	100% after Calendar Year deductible up to \$1,400 per ear	60% after Calendar Year deductible up to \$1,400 per ear

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Cancer Screenings</i>		
<i>Routine Cancer Screening Outpatient</i>	100% per visit	100% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

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"> 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. <p><i>For details, contact your physician or Member Services by logging onto the custom website aetnastateofmaine.com, 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"> 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. <p><i>For details, contact your physician or Member Services by logging onto the custom website aetnastateofmaine.com, or calling the number on the back of your ID card.</i></p>
<i>Prostate Specific Antigen Test</i>	<p>100% per test</p> <p>No Calendar Year deductible applies.</p>	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Routine Digital Rectal Exam</i>	<p>100% per test</p> <p>No Calendar Year deductible applies.</p>	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Lung Cancer Screening Age 55 and above</i>	<p>100% per test</p> <p>No Calendar Year deductible applies.</p>	Not Covered
<i>Lung Cancer Screening Maximum (see benefits booklet for eligibility criteria)</i>	One screening every 12 months*	Not Covered
<i>*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.</i>		

Prenatal Care

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Prenatal Care

Office Visits

100% per visit

60% per visit after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies.

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.

Lactation Support and Counseling Services

Comprehensive Lactation Support and Counseling Services

Lactation Counseling Services

Facility or Office Visits

100% per visit

60% per visit after Calendar Year
deductible

No **copay** or **deductible** applies.

Lactation Counseling Services

6* visits per 12 months

Not Applicable

Maximum Visits either in a group or
individual setting

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

Breast Pumps & Supplies

100% per item

60% per item after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies

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

Family Planning Services

Family Planning Services

Female Contraceptive Counseling
Services -Office Visits.

100% per visit.

60% per visit after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies.

Contraceptive Counseling Services -
Maximum Visits either in a group or
individual setting

2* visits per 12 months

2* visits per 12 months

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

Family Planning - Other

Voluntary Termination of Pregnancy

Preferred Providers Office Visit

100% per visit

Not applicable

No **copay** or Calendar Year
deductible applies.

Voluntary Sterilization for Males		
Preferred Providers Office Visit	100% per visit No copay or Calendar Year deductible applies.	Not applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Family Planning - Other</i> Voluntary Termination of Pregnancy		
All Other Providers Office Visit	\$20 per visit copay No Calendar Year deductible applies.	60% per visit after Calendar Year deductible
Voluntary Sterilization for Males		
All Other Providers Office Visit	\$20 per visit copay No Calendar Year deductible applies.	60% per visit after Calendar Year deductible

<i>Family Planning - Other</i> Voluntary Termination of Pregnancy		
Preferred Providers Outpatient	90% per visit after Calendar Year deductible.	Not applicable
Voluntary Sterilization for Males		
Preferred Provider Outpatient	90% per visit after Calendar Year deductible.	Not applicable

<i>Family Planning - Other</i> Voluntary Termination of Pregnancy		
All Other Providers Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
Voluntary Sterilization for Males		
All Other Providers Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.

<i>Family Planning - Female Voluntary Sterilization</i>		
<i>Inpatient</i>	100% per visit No copay or Calendar Year deductible applies.	60% per visit after Calendar Year deductible
<i>Outpatient</i>	100% per visit No copay or Calendar Year deductible applies.	60% per visit after Calendar Year deductible

Family Planning Services - Female Contraceptives

Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item. No copay or deductible applies.	60% per item after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible
Maximum Benefit per Calendar Year	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist		
Preferred Providers	100% per visit No copay or Calendar Year deductible applies	Not applicable
All Other Providers	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible

Alternatives to Physicians' Office Visits

E-Visit Online or Telephonic Consultation by a PCP

<i>Preferred Providers</i>	100% per visit No copay or Calendar Year deductible applies	Not Covered
<i>All Other Providers</i>	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies.	Not Covered

<i>Specialist Office Visits</i>	\$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible
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Alternative to Specialist Office Visit

<i>E-visits Online Internet Consultation by a Specialist</i>	\$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	Not Covered
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Physician Office Visits-Surgery

<i>Physician Preferred Providers</i>	100% per visit No Calendar Year deductible	Not applicable
<i>All other Providers</i>	\$20 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible
<i>Specialist</i>	\$25 visit copay then the plan pays 100% No 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 deductible applies. For details, contact your physician , log onto the <i>custom website</i> aetnastateofmaine.com , or call the number on the back of your ID card.	60% per visit after Calendar Year deductible
Individual Screening and Counseling Services for Tobacco Use	100% per visit No copay or deductible applies.	60% 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 copay or deductible applies.	60% 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
*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	\$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible

PLAN FEATURES**NETWORK****OUT-OF-NETWORK****Physician Services for Inpatient Facility and Hospital Visits****Preferred Providers**90% per visit after Calendar Year **deductible**

Not applicable

All Other Providers80% per visit after Calendar Year **deductible**60% per visit after Calendar Year **deductible****Administration of Anesthesia (may be billed separately)**90% per procedure after Calendar Year **deductible**60% per procedure after Calendar Year **deductible**

Allergy Testing and Treatment	100% per visit after applicable copay No Calendar Year deductible applies	60% per visit after Calendar Year deductible
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Allergy Injections	100% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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Immunizations (when not part of the physical exam)	90% per visit after Calendar Year deductible.	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Emergency Medical Services		
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Hospital Emergency Facility and Physician	\$300 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$300 copay per visit then the plan pays 100% No Calendar Year deductible applies. See Important Note Below
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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	\$300 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$300 copay per visit then the plan pays 100% No Calendar Year deductible applies.
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Important Notice:
A separate **hospital** emergency room **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **copay** is waived.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Urgent Care Services</i>		
<i>Urgent Medical Care</i> <i>(at a non-hospital free standing facility)</i>	\$25 copay per visit then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible

<i>Urgent Medical Care</i> <i>(from other than a non-hospital free standing facility)</i>	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.
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<i>Non-Urgent Use of Urgent Care Provider</i> <i>(at an Emergency Room or a non-hospital free standing facility)</i>	\$25 copay per visit then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible
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Important Notice:

A separate **urgent care copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay** cannot be applied to any other **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **copays** cannot be applied to the **urgent care copay**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Diagnostic and Preoperative Testing</i>		

<i>Complex Imaging Services</i>		
<i>Complex Imaging</i> <i>(MRI, Cat Scan, Pet Scan)</i>	\$50 per visit copay then the plan pays 100% No Calendar Year deductible applies	\$50 per test deductible then the plan pays 100% No Calendar Year deductible applies

<i>Diagnostic Laboratory Testing</i>		
<i>Diagnostic Laboratory Testing</i>	90% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible

<i>Diagnostic X-Rays (except Complex Imaging Services)</i>		
<i>Diagnostic X-Rays</i> <i>(including ultrasounds)</i> Allows 2 diagnostic Mammograms per Calendar Year	90% per procedure after Calendar Year deductible 100% per test No Calendar Year Deductible applies	60% per procedure after Calendar Year deductible 100% per test No Calendar Year Deductible applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Preferred Providers Performed in a Physician's Office</i>	90% per visit/surgical procedure after Calendar Year deductible	Not applicable
<i>Performed at an Ambulatory Surgery Center or Facility other than a Hospital Outpatient Facility</i>	95% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible
<i>All Other Providers</i>	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birthing Center</i>	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.

<i>Hospital Facility Expenses</i> Room and Board (excluding Maternity)		
<i>Preferred Providers</i>	90% per admission after Calendar Year deductible	Not applicable
<i>All Other Providers</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Preferred Providers</i> (Other than Room and Board)	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>All Other Providers</i> (Other than Room and Board)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Hospital Facility Expenses</i> Room and Board - Maternity		
	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board		
	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	100 days	100 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	100% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Hospice Outpatient Visits	100% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses Expenses for Comprehensive Infertility services will not be used to satisfy the plan Maximum Out-of-Pocket Limit .	80% per visit after Calendar Year deductible	Not Covered
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Maximum per lifetime	\$20,000	Not Covered
The Comprehensive Infertility services maximum per lifetime amount shown above will not be used to satisfy the plan Maximum Out-of-Pocket Limit .		

<i>Advanced Reproductive Technology (ART) Expenses</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan Maximum Out-of-Pocket Limit .		

Maximum per lifetime	\$20,000	Not Covered
The Advanced Reproductive Technology (ART) Expenses Maximum per lifetime amount shown above will not be used to satisfy the plan Maximum Out-of-Pocket Limit .		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		

<i>MENTAL DISORDERS</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% after Calendar Year deductible	60% after Calendar Year deductible

<i>Outpatient Treatment Of Mental Disorders</i>		
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<i>Outpatient Services</i>	\$25 per visit copay then the plan pays 100%	60% per visit after the Calendar Year deductible
	No Calendar Year deductible applies	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	90% 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	60% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

<i>Outpatient Treatment of Substance Abuse</i>		
<i>Outpatient Treatment</i>	\$25 per visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Non Surgical</i>		
<i>Outpatient Obesity Treatment (non surgical)</i>	100% per visit	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>		
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services) at Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center</i>	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>All Other Providers</i>	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Outpatient Morbid Obesity Surgery at (Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center)</i>	100% per service after Calendar Year deductible	60% per services after Calendar Year deductible
<i>All Other Providers</i>	90% per service after Calendar Year deductible	60% per services after Calendar Year deductible

Maximum Travel and Lodging Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	\$10,000 per lifetime	\$10,000 per lifetime
This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna		

PLAN FEATURES	NETWORK (Institute of Excellence(IOE) Facility	NETWORK (Non-Institute of Excellence (IOE) Facility	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i>			
<i>Transplant Facility Expenses Preferred Providers</i>	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	Not applicable
<i>Transplant Physician Services Preferred Providers</i> (including office visits)	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.	Not applicable

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-Institutes of Excellence (IOE) Facility	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i>			
<i>Transplant Facility Expenses All Other Providers</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Transplant Physician Services All Other Providers</i> (including office visits)	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
<i>Acupuncture</i>	\$25 per visit copay then the plan pays 80% No Calendar Year deductible applies	60% per visit after Calendar Year deductible
<i>Ground, Air or Water Ambulance</i>	100% after Calendar Year deductible	100% after Calendar Year deductible
<i>Diabetic Equipment, Supplies and Education</i>	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.
<i>Durable Medical and Surgical Equipment</i>	100% per item after the Calendar Year deductible	60% per item after the Calendar Year deductible
<i>Clinical Trial Therapies</i> (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.
<i>Routine Patient Costs</i>	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.
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	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.
<i>Prosthetic Devices</i>	100% per item after Calendar Year deductible	60% per item after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
<i>Chemotherapy</i>	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.

<i>Infusion Therapy</i>	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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<i>Radiation Therapy</i>	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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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Speech Therapy only</i>	\$25 per visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical and Occupational Therapy only</i>	\$25 per visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Autism Spectrum Disorder</i>		
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	\$25 per visit copay then the plan pays 100% No Calendar Year deductible applies. (Does not cover maintenance visits).	60% per visit after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$10	\$10
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$15	Not Applicable
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply (retail)	\$30	\$30
For more than a 30 day supply but less than a 91 day supply (mail order)	\$45	Not Applicable
<i>Non-Preferred Generic Prescription Drugs</i>		
For each 30 day supply (retail)	\$10	\$10
For more than a 30 day supply but less than a 91 day supply (mail order)	\$15	Not Applicable
<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$45	\$45
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$70	Not Applicable
<i>Infertility/ Erectile Dysfunction Prescription Drugs</i>		
For each 30 day supply (retail)	\$50	\$50
For more than a 30 day supply but less than a 91 day supply (mail order)	\$75	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name**

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

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 (OTC)

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for certain 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives	100% per supply	Not covered.
For each 30 day supply filled at a retail pharmacy	No copay or deductible applies.	
FDA-Approved Female Generic Emergency Over-the-Counter	100% per supply	Not covered.

Contraceptives	No copay or deductible applies.
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Important Note:

This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the *custom website* aetnastateofmaine.com or calling the toll-free number on the back of the ID card.

Preventive Care Drugs and Supplements

Preventive care drugs and supplements filled at a pharmacy with a prescription :	100% per item. No copay or deductible applies.	Not Covered.
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Coverage will be subject to any gender, 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 *custom website* aetnastateofmaine.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.

Coinsurance

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

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

Individual Prescription Drug Maximum Out-of-Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Prescription Drug Maximum Out-of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug Maximum Out-of-Pocket Limit does not apply to out of network.	\$4,600 Individual \$9,200 Family	Does not apply

Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent's share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Prescription Drug Maximum Out-of-Pocket Limit- does not apply to out of network

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** payment percentage limit and the family prescription **drug** payment percentage limit. These include:

Expenses applied toward a deductible or copay amount.

Expenses above the **recognized charge**.

Non-**covered expenses**.

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.

Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers** or **out-of-network** providers will also count toward the following year's **network providers** or **out-of-network** providers **deductibles**.

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. You have separate **Maximum Out-of-Pocket Limit** for in-network and out-of-network benefits. **Maximum Out-of-Pocket Limit** amounts paid by you for in-network and out-of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one limit.

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**;
 - Expenses incurred for outpatient **prescription drugs**;
 - Non-covered expenses;
- 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 \$500 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.

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
 - the 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information

The custom website aetnastateofmaine.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.