Schedule of Benefits

Employer: **State Of Maine**

MSA: 307297

Issue Date: June 27, 2016
Effective Date: July 1, 2016
Schedule: 1A
Booklet Base: 1 rev2

For: Aetna Choice POSII (In State Plan)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$600	$3,000
Family Deductible*	$1,200	$6,000

*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
***Prescription Drug* Maximum Out-of-Pocket Limit does not apply to out of network.**	$4,600 Individual $9,200 Family	Does not apply
Lifetime Maximum Benefit per person	Unlimited	Unlimited

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

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams ***Office Visits***	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
Covered Persons birth 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 custom website* ***aetnastateofmaine.com****, or calling the number on the back of your ID card*	Not Covered.
Covered Persons ages 22 and above Maximum Visits per 12 months	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. 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.*	Not Covered

Screening & Counseling Services		
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.	Not Covered

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
Misuse of Alcohol and/or Drugs 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.*		

Use of Tobacco Products 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		

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

Hearing Care		
Hearing Exam	$30 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
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
Routine Cancer Screenings		
Routine Cancer Screening ***Outpatient***	100% per visit No Calendar Year **deductible** applies.	100% per visit after Calendar Year **deductible**

Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *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.*	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 custom website aetnastateofmaine.com, or calling the number on the back of your ID card.*
Prostate Specific Antigen Test	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Digital Rectal Exam	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Lung Cancer Screening *Age 55 and above*	100% per test No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Lung Cancer Screening Maximum	One screening every 12 months*	One screening every 12 months*

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

Prenatal Care		
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Prenatal Care ***Office Visits***	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.		

Lactation Support and Counseling Services		
Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **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	Not Applicable
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps & Supplies	100% per item No **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 for limitations on breast pumps and supplies.		

Family Planning Services		
Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	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
*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 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

Family Planning - Other 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.**

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit 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.	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**

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	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
All Other Providers	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Specialist Office Visits	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery		
Physician Preferred Providers	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
All other Providers	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Specialist	$30 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 *custom website* ***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 *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 **deductible** applies.	60% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services

***Important Note**:
Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

All Other Services	$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 Providers	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia (may be billed separately)	80% 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**
Allergy Injections	100% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible**
Immunizations (when not part of the physical exam)	90% per visit after Calendar Year **deductible.**	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
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

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.

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
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

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
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging (MRI, Cat Scan, Pet Scan)	$50 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$50 per visit deductible then the plan pays 100% No Calendar Year **deductible** applies.
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays (including ultrasounds) 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
Outpatient Surgery		
Performed in a Physician's Office		
Preferred Providers	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
All other Providers	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit/surgical procedure after Calendar Year **deductible**
Specialist	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit/surgical procedure after Calendar Year **deductible**
Performed at an Ambulatory Surgery Center or Facility other than a Hospital Outpatient Facility	95% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
Outpatient Hospital Preferred	90% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
All Other Providers	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	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 (excluding Maternity)		
Preferred Providers	90% per admission after Calendar Year **deductible**	Not applicable
All Other Providers	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Preferred Providers (Other than Room and Board)	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
All Other Providers (Other than Room and Board)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospital Facility Expenses 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**
Skilled Nursing Inpatient Facility	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	100 days	100 days

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**

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**.		
Advanced Reproductive Technology (ART) Expenses Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
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**
Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% after Calendar Year **deductible**	60% after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	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**

Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$30 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**
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	100% per visit	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services) at Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
All Other Providers	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery at (Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center)	100% per service after Calendar Year **deducible**	60% per services after Calendar Year **deductible**
All Other Providers	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) This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna	$10,000 per lifetime	$10,000 per lifetime

PLAN FEATURES	**NETWORK (Institute of Excellence(IOE) Facility**	**NETWORK (Non-Institute of Excellence (IOE) Facility**	**OUT-OF-NETWORK**
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses Preferred Providers	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	Not applicable
Transplant Physician Services Preferred Providers (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**
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses All Other Providers	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Transplant Physician Services All Other Providers (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		
Acupuncture	$30 per visit copay then the plan pays 80% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	100% 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.
Durable Medical and Surgical Equipment	100% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	100% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$30 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
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$30 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
Autism Spectrum Disorder		
	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
Spinal Manipulation		
	$30 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
Spinal Manipulation Maximum visits		
Maximum visits per Calendar Year	25 visits	25 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
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
Preferred Brand-Name Prescription Drugs		
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
Non-Preferred Generic Prescription Drugs		
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
Non-Preferred Brand-Name Prescription Drugs		
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
Infertility/ Erectile Dysfunction Prescription Drugs		
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 For each 30 day supply filled at a retail **pharmacy**	100% per supply No **copay** or **deductible** applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter	100% per supply	Not covered.

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

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**: 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.	100% per item. No **copay** or **deductible** applies.	Not Covered.

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

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.

<u>Excluded Covered Expenses</u>
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.