HDHP SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. MEDICAL CARE BENEFITS

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Calendar Year Deductible *(taken before benefits are payable unless waived).* *Note: There is no limit to the amount that an individual may apply towards the family deductible. However, note that the entire family deductible amount must be met before any benefits are payable for any individual in the family (except for Wellness benefits as specifically stated herein.*	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family
Deductible Carry-Over	N/A	
Out-of-Pocket Maximum per Calendar Year(Medical co-pays, co-insurance and deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit • Vitamins and Supplements • Durable Over-head lifts • Organ and Tissue Transplants that are not provided by an Institute of Excellence *Note: There is no limit to the amount that an individual may apply towards the family Out-of-Pocket Maximum. However, note that the entire family Out-of-Pocket maximum amount must be met before any Out-of-Network benefits are payable at 100% (except for Wellness benefits as specifically stated herein)*	$2,500 per person $5,000 per family	$7,500 per person $15,000 per family
Calendar Year Benefit Maximum for all Benefits	Unlimited	
Benefits will be subject to a $250 penalty per occurrence (in addition to Deductible) for not pre-authorizing Inpatient Mental/Nervous and Substance Use Disorder Services per instructions.	TO PRE-AUTHORIZE, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD	
Pre-certification per instructions is required under your Plan. Benefits are subject to a penalty of a $250 reduction in benefits per occurrence ***(after Deductible)*** when pre-certification procedures are not followed. Please refer to the Pre-Certification Program section for additional information	TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
Deductible and In-Network and Out-of-Network Out of Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.		

II. PRESCRIPTION DRUGS:

BENEFITS and PROVISIONS	
Your Prescription Drug Benefit is administered by Express Scripts. For prescription drug questions please call 1-800-451-6245 or visit www.express-scripts.com.	
Prescription Drug Card Benefit (up to 34-day supply per prescription through participating pharmacies)	**Discount Drug Card Only** (drugs to be purchased from pharmacy at reduced cost) 100% After Deductible
Mail-Order Drug Benefit *(up to 91-day supply per prescription through mail order)*	
***Generics** are lower cost medications that are clinically equivalent to the more expensive brand counterparts.*	
***Preferred Brand Drugs** are drugs that are clinically equivalent to non-preferred brand drugs, but are usually less expensive.*	
***Non-Preferred Brand Drugs** are drugs that usually cost more than other clinically equivalent drugs or drugs that have been deemed by the Express Scripts Pharmacy and Therapeutics Committee to not be as clinically appropriate as Preferred Brand Drugs (i.e., they have more side effects, potential for interactions, etc.). There is a generic and/or preferred drug available that does the same thing as the non-preferred drug.*	
Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations	

Contraception and contraceptive counseling - This Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered at no cost to you as the plan participant. Brand and Non-Formulary contraceptives will remain covered, but you will be responsible for the standard co-pay. For additional information about your contraceptive benefits, including the applicable co-pay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at www.express-scripts.com.

III. PREVENTIVE CARE SERVICES

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Preventive Care Services- *(must be billed with a routine diagnosis)* This plan includes coverage for physical exams, immunizations, tests, x-rays, pap smears and analysis, PSA test, and bone density tests (for women age 60 and older, every 5 Calendar Years). *This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* (This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI's, PET or other similar tests)	100% Deductible Waived	70%
	Note: coverage for Mammograms and Comprehensive ultrasound screening of an entire breast or breasts if mammogram demonstrates heterogeneous or dense breast tissue will not apply to the overall Calendar Year Maximum.	
Comprehensive Ultrasound Screening of an entire breast or breasts *if mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician.*	100% Deductible Waived	70%
Routine Mammogram for Covered Females *limited to the following:* i) *one baseline mammogram, age 35 through 39* ii) *one mammogram every 12 months, ages 40 and over* *Age limits will not apply for women with family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors (Must be billed with family history diagnosis).*	100% Deductible waived *In-Network charges do not apply toward the Calendar Year Benefit Maximum.*	
Routine Colonoscopy Screening *for Covered Persons age 50 and over once every 3 Calendar Years. Colonoscopies for men or women under 50 with documentation of family history of colon disease are covered. (Must be billed with family history diagnosis)*	100% Deductible waived	
Family Planning - Permanent Procedures for Women *Includes:* *Sterilization.*	100% Deductible Waived	70%
Family Planning – Temporary Procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	100% Deductible Waived	70%
Breast Pumps and Supplies (Includes breast pumps and supplies purchased through a retail supplier). *Limited to a maximum payment of $450 (includes pump and supplies) per person per pregnancy.*	100% Deductible waived	

IV. PHYSICIAN SERVICES

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Outpatient Surgery *including all related charges on the same day as surgery.*	100%	70%
Chiropractic and Naprapath Care (*not including Massage Therapy, see below)* *Limited to a maximum of 13 visits per person per Calendar Year*	100%	70%
Massage Therapy *(including Rolfing, Reflexology and Craniosacral Therapy) when it is prescribed by a Physician. Limited to a maximum of 13 visits per person per Calendar Year*	100%	70%
Diagnosis and treatment of temporomandibular joint dysfunction ("TMJ")	100%	70%
Chelation Therapy *Limited to a $3,000 maximum payment per person per Calendar Year.*	100%	70%
Biofeedback Therapy *Limited to a $3,000 maximum payment per person per Calendar Year.*	100%	70%
Urgent Care Services	100%	70%
Physician Services *including Home and Office visits (Exam charge only)*	100%	70%
Other Physician Services *(except as indicated under the Outpatient Laboratory/Radiology/Pathology benefit listed below).*	100%	70%
If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician *(due to Medically Necessary services not being available In-Network).*	N/A	Paid same as In Network.
Non-Network Physician Services Received at a Network Hospital *If services are performed by a 1) non-network anesthesiologist or 2) a non-network specialist, such as a radiologist or pathologist, limited to interpreting tests, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician.*	N/A	Paid same as In-Network

V. OUTPATIENT LABORATORY/RADIOLOGY/PATHOLOGY INCLUDING ADMINISTRATION/MRI, PET AND CT SCANS

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Outpatient Services		
All Outpatient/Independent Laboratory/Office Routine Radiology and Pathology Administration and Interpretation Services *(does not include MRI, PET or CT scans)*	100% Deductible Waived	
All Outpatient/Independent Laboratory/Office Diagnostic Radiology and Pathology Administration and Interpretation Services *(does not include MRI, PET or CT scans)*	100%	
Outpatient/Independent Laboratory/Office Imaging Services (MRI, PET, and CT scans)	100%	70%

VI. FACILITY SERVICES

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Inpatient Hospital Services ▪ *Room and board (The Plan will allow the semi-private room rate or if in a private room the benefit will be the semi-private rate plus 10%).* ▪ *Necessary services and supplies including an intensive care unit and a cardiac care unit*	100%	70% *Note: Payment of Inpatient charges exceeding $50,000 will be limited to Medicare DRG Reimbursement*
Outpatient Hospital Services *(other than for surgical procedures or diagnostic radiology and pathology charges).*	100%	70% *Note: Payment of Inpatient charges exceeding $50,000 will be limited to Medicare APC Reimbursement*
Outpatient Hospital Surgery/Ambulatory Surgical Facility *including all related charges on the same day as surgery.*	100%	*Coverage of Charges exceeding $15,000 will be limited to the Medicare ASC Reimbursement, subject to the applicable out-of-network co-insurance (70%) and deductible*
Emergency Room Services *(includes all services done during the visit) Co-pay waived if admitted.*	100%	Paid Same as In-Network
Urgent Care Services- *facility fees*	100%	70%
Renal Dialysis (All dialysis providers are out-of-network. This Plan does not access or use the Aetna network for dialysis providers.) *Note: For charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses.*	100% after the In-Network deductible	

VII. MENTAL HEALTH SERVICES

BENEFITS and PROVISIONS	In-Network	Out-of-Network
BEHAVIOR HEALTH ENHANCED BENEFIT (Mental/Nervous/Substance Use Disorders)		
Treatment Through Allied Care Solutions *Allied Care Solutions (ACS) is your single source for Support, Resources and Information. This program is designed to help you manage life's daily challenges. We can refer you to professional counselors and services that can help you and your eligible family members resolve a broad range of personal concerns, such as marriage and relationships, stress and anxiety, depression, substance abuse, anger management, family problems, grief and loss, legal and financial services and dependent care. Allied Care Solutions is a no-cost confidential program that is available to you and your family 24 hours a day, 365 days a year. At some point in our lives, each of us faces a problem or situation that is difficult to resolve. Your Company understands how work and personal challenges can affect your well-being and encourages you to call Allied Care Solutions at 1-800-440-1440 or visit http://www.alliedbenefit.com/acs.aspx (user name is your Company name).* **Contact Allied Care Solutions (ACS) at 1-800-440-1440.** **By calling Allied Care Solutions, you may be eligible to receive certain services payable at no cost to you with no claims submission required.**		
BEHAVIOR HEALTH ENHANCED BENEFIT (Mental/Nervous/Substance Use Disorders)		
Treatment for Mental/Nervous and Substance Use Disorders not provided through Allied Care Solutions referenced above. **Note that Inpatient mental/nervous and substance use disorder services must be pre-authorized through Allied Care Solutions in order to avoid $250 penalty per occurrence.**	Paid same as any other service according to type of service, provider and place of service.	

VIII. OTHER COVERED SERVICES

BENEFITS and PROVISIONS	In-Network	Out-of-Network
Professional Ambulance Service *by ground or air transportation from the city or town in which the Employee or covered Dependent becomes disabled, to the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.*	100%	70%
	City of Aurora Ambulance paid at 100%	
Pre-Admission Testing	100%	
Vitamins and Supplements *Must be prescribed by a licensed practitioner. Maximum payment of $1,000 per person per Calendar Year. Charges do not apply to and are not affected by the Out-of-Pocket Maximum. Note certain vitamins and/or supplements will be paid under the Preventive Care benefits as required by the Patient Protection and Affordable Care Act.*	100%	
Durable Overhead Lift *For purchase of an overhead lift with tracking system to assist with mobility within a home for a covered participant who has a medical necessity pre-approved by the Utilization Review Administrator. Charges do not apply to and are not affected by the Out-of-Pocket Maximum. Limited to a maximum payment of $12,000 per family per Lifetime.*	100%	
Extended Care/Skilled Nursing Facility – *Includes:* ▪ *Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area;* ▪ *physical, occupational or speech therapy* ▪ *drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patient* *Limited to 120 days per Calendar Year*	100%	70%
Services and supplies required for the treatment of Diabetes, *including Diabetes Self-Management Education Programs.*	100%	70%
Hearing Exams *(other than as covered under any federal regulations, see preventive care benefit).* Limited to a maximum of $100 per person per Calendar Year.	100%	
Hearing Aid *Limited to a maximum payment of $2,000 per ear with a $4,000 maximum payment per person per Calendar Year.*	100%	
Home Health Care *Limited to 120 days per Calendar Year*	100%	70%
Infertility Diagnosis and Treatment *includes prescription drugs not covered under the Prescription Drug Card Benefit.*	100%	
Infertility Reproduction Technology *including but not limited to artificial insemination, In-vitro fertilization and G.I.F.T. procedures. Limited to a maximum payment of $12,000 per family per Lifetime.*	100%	70%

VIII. OTHER COVERED SERVICES

BENEFITS and PROVISIONS	In-Network	
ORGAN AND TISSUE TRANSPLANTS **For cornea or skin transplants:** The Covered Person, who is the transplant recipient, must receive two opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition. **For all other Organ and Tissue Transplants:** The Plan has contracted with a separate network, distinct from the Preferred Provider Organization applicable for other Plan medical coverage. For specific details on all elements of this coverage, refer to the following pages for The Aetna's IOE/Transplant language. **For all Organ and Tissue Transplants:** *In no event will benefits be paid for experimental or investigational services; or, for treatment not deemed clinically acceptable by (a) the National Institute of Health; or (b) the FDA; or (c) a similar national medical organization of the United States*	100%	70%
Other Covered Services/Items *(see following pages)*	100% Unless included under a previous category	70% Unless included under a previous category
Covered Services/Items not available In-Network	Paid at In-Network Level	
Covered Services for Employees residing outside the PPO Service Area.	Paid at In-Network Level	

OTHER COVERED SERVICES/ITEMS

Please see previous pages for detailed information regarding the coverage of services/items in and out of network.

Allergy testing, shots and treatment

Ambulatory Surgical Center

Anesthesia *and* **Its Administration** *(Inpatient/Outpatient)*

Acupuncture *no more than one treatment per day, provided the services are performed by an individual licensed to perform acupuncture (If required by State law) and the services are within the scope of the license.*

Artificial Limbs, Eyes, *and* **Larynx**

AUTISM SPECTRUM DISORDERS. Such diagnosis entails one or more tests, evaluations, or assessments to diagnose whether an individual has an autism spectrum disorder. Such tests, evaluations, or assessments must be prescribed, performed, or ordered by a physician licensed to practice medicine in all its branches, or a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

For those diagnosed with this disorder, the following treatments are covered:

1. Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist
2. Psychological care, meaning direct or consultative services provided by a licensed psychologist;
3. **For Dependent Children only**: Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior; and
4. **For Dependent Children only:** Therapeutic care, including behavioral, speech, occupational and physical therapies addressing the following areas:

    a. Self care and feeding
    b. Pragmatic, receptive and expressive language
    c. Cognitive functioning
    d. Applied behavioral analysis, intervention, and modification
    e. Motor planning
    f. Sensory processing

All covered services must be prescribed by a physician. However, some of the services may be delivered by certified or licensed professionals who are not physicians (including but not limited to speech therapists, physical therapists, and occupational therapists).

Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Diagnosis of autism spectrum disorders means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (a) a physician licensed to practice medicine in all its branches or (b) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

Birthing Center *including services rendered by a Certified Registered Nurse Midwife*

Braces, Casts, Crutches, Dressings, Pacemakers, Splints *and* **Trusses**

Medically Necessary **Cardiac Rehabilitation Therapy**

Chemotherapy

OTHER COVERED SERVICES/ITEMS
Electro-Shock therapy treatment
First Pair Of Glasses *or* **Contact Lenses**, *but not both, needed after cataract surgery*
Covered Medically Necessary Prescription Drugs *if not available through the Prescription Drug Card or Mail Order Programs*
Dental Treatment *limited to*: *(A) surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, provided that the Injury occurred on or after the Covered Participant's Eligibility Date under the Plan; and* *(B) excision of exotoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts and the reduction of dislocations; and* *(C) treatment of injury to sound natural teeth while covered under the plan. Treatment must be rendered within six months from the date of the injury.* *(D) Removal of bony impacted wisdom teeth.*
Durable Medical Equipment *for the rental of a wheelchair, hospital bed, iron lung or other Durable Medical Equipment required for temporary therapeutic use up to rental or purchase price or maximum.*
Hospice Care *when the Covered Person has a life expectancy of six months or less as certified by a Physician.*
Mastectomy Bras *limited to two per Covered Person per Calendar Year.*
Orthotics *or custom molded inserts that can only be utilized by the patient, of a nature which is therapeutic and durable in quality and which may not be used by any family members or of common use, when prescribed by a Physician for the chronic diagnosis of foot pain, limited to one pair every 24 consecutive months from date of last procedure.*
Ostomy Supplies
Outpatient Physical, Occupational Therapy, or Speech Therapy
Oxygen *and rental of equipment for administration of oxygen.*
Purchasing of **Prosthetic Appliances** *used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth*
Radium *and* **Radioisotope Treatment**
Medically Necessary **Respiratory Therapy**
Routine Newborn Nursery Care *(including circumcision) during the initial Hospital confinement.*
Processing and administration of **Unreplaced Blood** *and its components*
Second Surgical Opinion
Men's Voluntary Sterilization *for Covered Employee, Covered Retiree or their spouses.*
Wigs *for hair loss resulting from the treatment of cancer*

See "Aetna/IOE Transplant Language", "Exclusions" & "General Provisions" for Additional Coverage Details, Exclusions and Limitations