Schedule of Benefits

Employer: **PDS Tech, Inc.**

ASA: MSA-809341

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For: Aetna Select Medical Plan

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

EPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,000	Not applicable
Family Deductible*	$2,000	Not applicable

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

Plan Payment Limit excludes plan **deductible, copayments, and precertification** penalties.

Individual Payment Limit:

- For **network** expenses: $3,000

Family Payment Limit:

- For **network** expenses: $6,000

Calendar Year **Maximum Benefit per Person**	$100,000	Not applicable
Lifetime Maximum Benefit per person	$1,000,000	Not applicable

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, co payments, 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
Routine Physical Exams Adults only. Includes coverage for immunizations	$40 exam **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Maximum exams per 24 consecutive month period		
Adult age 18 to 65	1 exam	Not Covered
Maximum exams per 12 consecutive month period		
Adult age 65 and over	1 exam	Not Covered
Well Child Exams Includes coverage for immunizations	$40 exam **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Maximum exams per 36 consecutive month period		
Under age 3		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	3 exams	Not Covered
25th-36th months of life	3 exams	Not Covered
Maximum exams per 12 consecutive month period		
For age 3 to 18	1 exam	Not Covered
Routine Gynecological Exam	$50 exam **copay** then the plan pays 100% No **deductible** applies.	Not Covered

Maximum exams per Calendar Year	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screening		
Routine Mammography	100% No **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Prostate Specific Antigen Test For covered males age 40 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Digital Rectal Exam For covered males age 40 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Pap Smears	100% No **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered

Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 10 consecutive year period	1 test	Not Covered
Family Planning Services	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations (including refraction)	$50 exam **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Maximum Benefit per 24 consecutive month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$40 visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Specialist Office Visits	$50 visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered

Walk-In Clinics Non-Emergency Visit	$40 visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Physician Office Visits-Surgery		
Primary Care Physician	$40 visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Specialist Physician	$50 visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	70% per visit after Calendar Year **deductible**	Not Covered
Administration of Anesthesia	70% after Calendar Year **deductible**	Not Covered
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Immunizations when not part of the physical exam	70% No **deductible** applies.	Not Covered
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	$150 **copay** per visit then the plan pays 100% No **deductible** applies	Paid same as Network benefits

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

Important Notice:
A separate **hospital** emergency room **copay** or **deductible** 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 deductible is waived.

Covered expenses that are applied to the emergency room **copay** or **deductible** cannot be applied to any other **copay** or **deductible** under your plan. Likewise, covered expenses that are applied to any of your plan's other **copays** or **deductibles** cannot be applied to the emergency room **copay** or **deductible**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$75 **copay** per visit then the plan pays 100% No **deductible** applies	Paid same as Network benefits
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)*	Not Covered	Not Covered

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

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

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	$40 per visit **copay** then the plan pays 100% No **deductible** applies	Not Covered

Diagnostic Laboratory Testing		
	$40 per visit **copay** then the plan pays 100% No **deductible** applies	Not Covered

Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	$40 per visit **copay** then the plan pays 100% No **deductible** applies	Not Covered

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.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	70% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	70% per admission after Calendar Year **deductible**	Not Covered
Skilled Nursing Inpatient Facility	Calendar Year **deductible** then the plan pays 70%	Not Covered
Maximum Days per Calendar Year	120 days	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit after the Calendar Year **deductible**	Not Covered
Maximum Visits per Calendar Year	120 visits	Not Covered

Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	70% per admission after Calendar Year **deductible**	Not Covered
Hospice Care – Other Expenses during a stay	70% per admission after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	30 days	Not Covered
Hospice Outpatient Visits	70% per visit after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	$5,000	Not Covered

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.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	70% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	70% per admission after Calendar Year **deductible**	Not Covered
Physician Services	70% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	70% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	70% after Calendar Year **deductible**	Not Covered

Maximum Days per Calendar Year	120 days	Not Covered

Outpatient Treatment Of Mental Disorders		
Mental Disorders	$50 per visit **copay** then the plan pays 100% No **deductible** applies	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	70% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	70% per admission after Calendar Year **deductible**	Not Covered
Physician Services	70% per admission after Calendar Year **deductible**	Not Covered

Inpatient Residential Treatment Facility Expenses	70% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	70% after Calendar Year **deductible**	Not Covered

Outpatient Treatment of Substance Abuse		
Outpatient Services	$50 per visit **copay** then the plan pays 100% No **deductible** applies	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Facility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered
Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	Not Covered
Diabetic Equipment, Supplies and Education	70% No **deductible** applies.	Not Covered
Durable Medical and Surgical Equipment	70% per item after the Calendar Year **deductible**	Not Covered
Maximum Benefit per Calendar Year	$10,000	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	70% per visit after the Calendar Year **deductible**	Not Covered
Infusion Therapy	70% per visit after the Calendar Year **deductible**	Not Covered
Radiation Therapy	70% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational, and Speech Therapy combined	$50 per visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$50 per visit **copay** then the plan pays 100% No **deductible** applies.	Not Covered

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply	$20	Not Covered
For more than a 30 day supply but less than a 91 day supply	$40	Not Covered

Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$40	Not Covered
For more than a 30 day supply but less than a 91 day supply	$80	Not Covered

Non-Preferred Generic Prescription Drugs		
For each 30 day supply	$20	Not Covered
For more than a 30 day supply but less than a 91 day supply	$40	Not Covered

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$70	Not Covered
For more than a 30 day supply but less than a 91 day supply	$140	Not Covered

Coinsurance

	NETWORK	**OUT-OF-NETWORK**
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Not Covered

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

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

Network Calendar Year Deductible
This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Network Family Deductible Limit
When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Copayments and Benefit Deductible Provisions

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

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment Limit
The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Payment Limit** applies to network benefits.

This plan has an Individual **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family **Payment Limit** amount in the Summary of Benefits, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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

Expenses That Do Not Apply to Your Payment Limit
Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*); 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**.

Maximum Benefit Provisions

Calendar Year **Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to the medical and **prescription drug** expense coverage described in the Booklet.

Lifetime Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to the medical and **prescription drug** expense coverage described in this Booklet.

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.