

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$7,000.
- For **out-of-network** expenses: \$18,000.

Calendar Year Maximum Benefit per Person	\$100,000	\$100,000
Lifetime Maximum Benefit per person	\$1,000,000	\$1,000,000

Coinsurance 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
Wellness Benefit		
Routine Physical Exams Adults only.	100% per exam	60% per exam after Calendar Year deductible
Includes coverage for immunizations.	No deductible applies.	
Maximum Exams per 24 consecutive month period		
Adults age 18 to 65	1 exam	1 exam
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% per exam No deductible applies.	60% per exam after Calendar Year deductible

Maximum Exams per 36 consecutive month period		
Under age 3		
first 12 months of life	7 exams	7 exams
13th-24th months of life	3 exams	3 exams
25th-36th months of life	3 exams	3 exams
Maximum Exams per 12 consecutive month period		
For age 3 to 18	1 exam	1 exam

<i>Routine Gynecological Exam</i>	100% per exam No deductible applies.	60% per exam after Calendar Year deductible
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Maximum exams per Calendar Year	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Cancer Screenings</i>		
<i>Routine Mammography</i>	100% per test No deductible applies.	60% per test after Calendar Year deductible

Maximum tests per Calendar Year	1 test	1 test
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<i>Prostate Specific Antigen Test</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum tests per Calendar Year	1 test	1 test
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<i>Routine Digital Rectal Exam</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum tests per Calendar Year	1 test	1 test
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<i>Routine Pap Smears</i>	100% per test No deductible applies.	60% per test after Calendar Year deductible
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Maximum tests per Calendar Year	1 test	1 test
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<i>Fecal Occult Blood Test</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
<i>Sigmoidoscopy</i> Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Colonoscopy</i> age 50 and over	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.
Maximum Tests per 10 consecutive year period	1 test	1 test
<i>Family Planning Services</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Care</i>		
<i>Eye Examinations</i> including refraction	100% per exam No deductible applies.	60% per exam after Calendar Year deductible
Maximum Benefit per 24 consecutive month period	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	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Specialist Office Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Physician Office Visits-Surgery	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Walk-in Clinics Non-Emergency Visit	80% per visit after Calendar Year deductible	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Administration of Anesthesia	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible
Allergy Testing and Treatment	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
Allergy Injections	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
Immunizations (when not part of the physical exam)	80% per visit No deductible applies.	60% per visit after Calendar Year deductible
Prenatal 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.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	80% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
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Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	80% after Calendar Year deductible	60% after Calendar Year deductible

Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		

Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible
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Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible

Diagnostic X-Rays (except Complex Imaging Services)		
Performed at a Hospital Outpatient Facility	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Hospital Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
<i>Home Health Care (Outpatient)</i>	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	120 visits	120 visits
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Hospice Benefits		
<i>Hospice Care - Facility Expenses (Room & Board)</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

Maximum Benefit per lifetime	30 days	30 days
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<i>Hospice Outpatient Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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Maximum Benefit per lifetime	\$5,000	\$5,000
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> 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.

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

<i>MENTAL DISORDERS</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	80% after Calendar Year deductible	60% after Calendar Year deductible

Maximum Days per Calendar Year	120 days	120 days
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<i>Outpatient Treatment Of Mental Disorders</i>		
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<i>Mental Disorders</i>	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Maximum Days per Calendar Year	120 days	120 days

<i>Outpatient Treatment of Substance Abuse</i>		
<i>Outpatient Treatment</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Ground, Air or Water Ambulance	80% after Calendar Year deductible	80% 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	80% per item after the Calendar Year deductible	60% per item after the Calendar Year deductible
Maximum Benefit per Calendar Year	\$10,000	\$10,000

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	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
Outpatient Therapies		
Chemotherapy	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Infusion Therapy	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Radiation Therapy	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply	\$10	\$10
For more than a 30 day supply but less than a 91 day supply	\$20	Not Applicable

Preferred Brand-Name Prescription Drugs		
For each 30 day supply	\$20	\$20
For more than a 30 day supply but less than a 91 day supply	\$40	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 30 day supply	\$10	\$10
For more than a 30 day supply but less than a 91 day supply	\$20	Not Applicable

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply	\$35	\$35
For more than a 30 day supply but less than a 91 day supply	\$70	Not Applicable

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	60% 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.

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.

Out-of-Network Calendar Year Deductible

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

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

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

Individual Deductible

The Individual **deductible** is the amount of **network** or **out of network covered expenses** you must incur in a Calendar Year before benefits are paid. For purposes of this Plan, an individual means a single covered person enrolled for self only coverage.

Family Deductible

The Family **deductible** is the amount of **network** or **out of network covered expenses** that you and your covered dependents must incur in a Calendar Year before benefits are paid during the Calendar Year for any family members. For purposes of this Plan, a family means a covered person enrolled with one or more dependents

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.

Out-of-Network Family Deductible Limit

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

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

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 pharmacy 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

This plan has an Individual and Family **Maximum Out-of-Pocket Limit**. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

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

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

There is also a Family **Maximum Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family **Maximum Out-of-Pocket 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.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Covered expenses that are subject to the Maximum Out-of-Pocket Limit include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- 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 **network care** and **out-of-network care** expenses combined.

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 **network** and **out-of-network** expenses combined.

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

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A \$400 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.