Schedule of Benefits

Employer: **PDS Tech, Inc.**

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For: Aetna Choice POS II Medical Plan

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

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,200	$2,000
Family Deductible*	$3,600	$6,000
Per Admission Copayment	$250 per admission	Not Applicable
Per Admission Deductible*	Not Applicable	$500 per admission

*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: $5,000.
- For **out-of-network** expenses: $10,000.

Family Payment Limit:

- For **network** expenses: $10,000.
- For **out-of-network** expenses: $20,000.

Calendar Year **Maximum Benefit per Person**	$100,000	$100,000

Lifetime Maximum Benefit per person	$1,000,000	$1,000,000

Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, copayments, 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. Includes coverage for immunizations.	$25 exam **copay** then the plan pays 100% No **deductible** applies.	50% per exam after Calendar Year **deductible**
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	$25 exam **copay** then the plan pays 100% No **deductible** applies.	50% 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

Routine Gynecological Exam	$35 exam **copay** then the plan pays 100% No **deductible** applies.	50% per exam after Calendar Year **deductible**
Maximum exams per Calendar Year	1 exam	1 exam

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screenings		
Routine Mammography	100% per test No **deductible** applies.	50% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
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.	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
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.	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
Routine Pap Smears	100% per test No **deductible** applies.	50% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Fecal Occult Blood Test	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

Sigmoidoscopy 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
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.	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
Colonoscopy 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
Family Planning Services	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**
Vision Care		
Eye Examinations including refraction	$35 exam **copay** then the plan pays 100% No **deductible** applies.	50% 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**	$25 visit **copay** then the plan pays 100% No **deductible** applies.	50% per visit after Calendar Year **deductible**

Specialist Office Visits	$35 visit **copay** then the plan pays 100% No **deductible** applies.	50% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery		
Physician	$25 visit **copay** then the plan pays 100% No **deductible** applies.	50% per visit after Calendar Year **deductible**
Specialist	$35 visit **copay** then the plan pays 100% No **deductible** applies.	50% per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	$35 visit **copay** then the plan pays 100% No **deductible** applies.	50% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Administration of Anesthesia	70% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Allergy Testing and 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.
Allergy Injections	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.
Immunizations (when not part of the physical exam)	70% per visit No **deductible** applies.	50% 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	$150 **copay** per visit then the plan pays 70% No **deductible** applies	$150 **deductible** per visit then the plan pays 70% No **deductible** applies
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$35 **copay** per visit then the plan pays 70% No **deductible** applies	50% 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)*	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/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing (except complex imaging services)	$25 per procedure **copay** then the plan pays 100% No **deductible** applies	50% per procedure after Calendar Year **deductible**
Complex Imaging Services		
Complex Imaging	$25 per visit **copay** then the plan pays 100% No **deductible** applies	50% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	$25 per visit **copay** then the plan pays 100% No **deductible** applies	50% per procedure after Calendar Year **deductible**
Diagnostic X-Rays(except Complex Imaging Services)		
Diagnostic X-Rays	$25 per visit **copay** then the plan pays 100% No **deductible** applies	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	70% per visit/surgical procedure after Calendar Year **deductible**	50% 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 (including maternity)	$250 per admission **copay** after Calendar Year **deductible** then the plan pays 70%	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Other than Room and Board	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**

Skilled Nursing Inpatient Facility	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	70% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	30 days	30 days
Hospice Outpatient Visits	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Maximum Benefit per lifetime	$5,000	$5,000

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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	$250 per admission **copay** after Calendar Year **deductible** then the plan pays 70%	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Other than Room and Board	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$250 per admission **copay** after Calendar Year **deductible** then the plan pays 70%	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Inpatient Residential Treatment Facility Expenses Physician Services	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days
Outpatient Treatment Of Mental Disorders		
Mental Disorders	$35 per visit **copay** then the plan pays 100% No **deductible** applies	50% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	$250 per admission **copay** after Calendar Year **deductible** then the plan pays 70%	$500 per admission **deductible** after the Calendar Year **deductible** then the plan pays 50%
Other than Room and Board	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$250 per admission **copay** after Calendar Year **deductible**, then the plan pays 70%	$500 per admission **deductible** after Calendar Year **deductible**, then the plan pays 50%
Inpatient Residential Treatment Facility Expenses Physician Services	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$35 per visit **copay** then the plan pays 100% No **deductible** applies	50% per visit after Calendar Year **deductible**

Transplant Services Facility and Non-Facility Expenses			
PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Facility Expenses	70% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Physician Services (including office visits)	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Ground, Air or Water Ambulance	70% after Calendar Year **deductible**	70% 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	70% per item after the Calendar Year **deductible**	50% 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	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Infusion Therapy	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Radiation Therapy	70% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined	$35 per visit **copay** then the plan pays 100% No **deductible** applies	50% 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		
	$35 per visit **copay** then the plan pays 100% No **deductible** applies	50% 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	$20	$20
For more than a 30 day supply but less than a 91 day supply	$40	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply	$40	$40
For more than a 30 day supply but less than a 91 day supply	$80	Not Applicable
Non-Preferred Generic 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 Brand-Name Prescription Drugs		
For each 30 day supply	$70	$70
For more than a 30 day supply but less than a 91 day supply	$140	Not Applicable

Coinsurance

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

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 applicable expense.

Per Admission Deductible
A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductible** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **deductible** cannot be applied to any other or **deductible** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

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 both network and out-of-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 *Schedule of Benefits*, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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

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 **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.