Schedule of Benefits

Employer: **Howard County Public School System**

ASA: 622787

Issue Date: November 14, 2013
Effective Date: January 1, 2013
Schedule: 1A
Booklet Base: 1

For: PPO Medical Plan

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
*Individual Deductible**	None	$100	None
*Family Deductible**	None	$300	None

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

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $500.
- For **out-of-network** expenses: $1,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $1,500.
- For **out-of-network** expenses: $3,000.

Lifetime Maximum Benefit Per Person	Unlimited	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, 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 and other health care, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Preventive Care			
Routine Physical Exams Adults only. Includes coverage for immunizations. *Copay waived for lab services when physician's office visit is not charged.	$15 exam **copay** then the plan pays 100%* No **deductible** applies.	80% per exam after Calendar Year **deductible**	80% per exam No **deductible** applies.
Maximum Exams 12 consecutive months period			
Adults, age 18 to 65	1 exam	1 exam	1 exam
Maximum Exams per 12 consecutive months period			
Adults, age 65 and over	1 exam	1 exam	1 exam
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No **deductible** applies.
Well Child Exams Includes coverage for immunizations. *Copay waived for lab services when physician's office visit is not charged.	$15 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Exams Under age 2			
first 12 months of life	7 exams	7 exams	7 exams

13th-24th months of life Maximum Exams per Calendar Year From age 2 to age 18	2 exams 1 exam	2 exams 1 exam	2 exams 1 exam
Well Woman Preventive Visits Office Visits	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
Routine Gynecological Exam *Copay waived for lab services when physician's office visit is not charged.	$15 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 12 consecutive month period	1 exam	1 exam	1 exam
Hearing Exam	$15 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Hearing Supply Hearing Supply Maximum per 36 month period to age 19	100% per hearing aid No Calendar Year **deductible** applies. 1 hearing aid per ear up to a maximum of $1,400	80% per hearing aid after Calendar Year **deductible** 1 hearing aid per ear up to a maximum of $1,400	80% per hearing aid No Calendar Year **deductible** applies. 1 hearing aid per ear up to a maximum of $1,400

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	80% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over. *Copay waived for lab services when physician's office visit is not charged.	$15 visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over. *Copay waived for lab services when physician's office visit is not charged.	$15 visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Routine Pap Smears	100% per test No Calendar Year **deductible** applies.	80% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies.
Maximum Tests per 12 consecutive month period	1 test	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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 12 consecutive month period	1 test	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.	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	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.	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	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.	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	1 test
Prenatal Care Office Visits	100% per visit No **deductible** applies.	80% per visit after Calendar Year **deductible.**	80% per visit No **deductible** applies.
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			
Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	80% per item after Calendar Year **deductible**	80% per item. No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.			

Family Planning Services - Other Voluntary Sterilization for Males			
Outpatient	100% per visit No **deductible** applies.	80% per visit after Calendar Year **deductible.**	80% per visit No **deductible** applies.
Voluntary Termination of Pregnancy			
Outpatient	100% per visit No **deductible** applies.	80% per visit after Calendar Year **deductible.**	80% per visit No **deductible** applies.

Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	100% per visit. No copay or Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

Family Planning Services - Female Voluntary Sterilization			
Inpatient	100% per visit. No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No **copay** or **deductible** applies.
Outpatient	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No **copay** or **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Family Planning Services - Female Contraceptives			
Female Contraceptive Generic Prescription Drugs (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year **deductible** applies.	80% per prescription or refill after calendar year **deductible**.	80% per prescription or refill No calendar year **deductible** applies.
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year **deductible** applies.	80% per prescription or refill after calendar year **deductible**.	80% per prescription or refill No calendar year **deductible** applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year **deductible** applies.	80% per prescription or refill after calendar year **deductible**.	80% per prescription or refill No calendar year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Vision Care			
Eye Examinations (including refraction)	$20 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
Physician Office Visits (*non-surgical*) *Copay waived for lab services when physician's office visit is not charged.	$15 visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits *Copay waived for lab services when physician's office visit is not charged.	$20 per visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Physician Office Visits-Surgery	100% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Walk-In Clinic Non-Emergency Visit	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Physician Services for Inpatient Facility and Hospital Visits	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies

Administration of Anesthesia	100% per procedure No Calendar Year **deductible** applies	80% per procedure after Calendar Year **deductible**	80% per procedure No Calendar Year **deductible** applies
Allergy Injections	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Emergency Medical Services			
Hospital Emergency Facility	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$50 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies. See Important Note Below	$50 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies. See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	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** or **copay** 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**.

Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	$25 **deductible** per visit then the plan pays 80% No Calendar Year **deductible** applies.

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.	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	Not Covered

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

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

PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing

Complex Imaging Services			
Complex Imaging	100% per test No Calendar Year **deductible** applies	80% per test after Calendar Year **deductible**	80% per test No Calendar Year **deductible** applies

Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	100% per procedure No Calendar Year **deductible** applies	80% per procedure after Calendar Year **deductible**	80% per procedure No Calendar Year **deductible** applies

Diagnostic X-Rays			
Diagnostic X-Rays	100% per procedure No Calendar Year **deductible** applies.	80% per procedure after Calendar Year **deductible**	80% per procedure No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery			
Outpatient Surgery	100% per visit/surgical procedure No Calendar Year **deductible** applies	80% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure No Calendar Year **deductible** applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses			
Room and Board (including maternity)	100% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies
Other than Room and Board	100% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies
Skilled Nursing Inpatient Facility	100% per admission No Calendar Year **deductible** applies	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies
Maximum Days per Calendar Year	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

Maximum Visits per Calendar Year	120	120	120

Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	100% per admission No Calendar Year **deductible** applies	80% per admission after the Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies
Hospice Care – Other Expenses during a stay	100% per admission No Calendar Year **deductible** applies	80% per admission after the Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses Expenses for Comprehensive Infertility services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	6 courses of treatment per lifetime	6 courses of treatment per lifetime

The Comprehensive Infertility services maximum per lifetime amounts shown above will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.

Advanced Reproductive Technology (ART) Expenses Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	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 per lifetime	$100,000	$100,000	$100,000

The Advanced Reproductive Technology (ART) Expenses Maximum per lifetime amount shown above will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Inpatient Treatment of Mental Disorders			
MENTAL DISORDERS ***Hospital Facility Expenses***			
Room and Board	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.
Physician Services	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.

Inpatient Residential Treatment			
Facility Expenses	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**.	80% per admission No Calendar Year **deductible** applies.
Physician Services	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**.	80% per visit No Calendar Year **deductible** applies.

Outpatient Treatment Of Mental Disorders			
Outpatient Services	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.
Physician Services	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission No Calendar Year **deductible** applies.

Inpatient Residential Treatment			
Facility Expenses	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**.	80% per admission No Calendar Year **deductible** applies.
Physician Services	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**.	80% per visit No Calendar Year **deductible** applies.

Outpatient Treatment of Substance Abuse			
Outpatient Treatment	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Obesity Treatment Non Surgical			
Outpatient Obesity Treatment (non surgical)	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Transplant Services Facility and Non-Facility Expenses				
Transplant Facility Expenses	100% per admission No Calendar Year **deductible** applies.	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES

Other Covered Health Expenses

Acupuncture	100% per visit No Calendar Year **deductible** applies	100% per visit after No Calendar Year **deductible**	100% per visit No Calendar Year **deductible**
Ground, Air or Water Ambulance	100% No Calendar Year **deductible** applies.	100% No Calendar Year **deductible** applies. Non-Emergency Use: 80% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies. Non-Emergency Use: 80% No Calendar Year **deductible** applies.
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	100% per item No Calendar Year **deductible** applies	80% per item after Calendar Year **deductible**	80% per item No Calendar Year **deductible** applies
Maximum Benefit per Calendar Year	$10,000	$10,000	$10,000
Jaw Joint Disorder Treatment	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
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.	Payable in accordance with the type of expense incurred and the place where service is provided.

Prosthetic Devices	100% per item No Calendar Year **deductible** applies	80% per item after Calendar Year **deductible**	80% per item No Calendar Year **deductible** applies

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Outpatient Therapies			
Chemotherapy	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
Infusion Therapy	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
Radiation Therapy	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical and Occupational Therapy Only	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Combined Physical and Occupational Therapy Maximum visits per Calendar Year	120 visits	120 visits	120 visits

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Short Term Outpatient Rehabilitation Therapies			
Speech Therapy Only	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies

Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Spinal Manipulation			
Spinal Manipulation	100% per visit No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits	30 visits

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

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Out-of-Network Provider and Other Health Care Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** and for **other health care** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** and for **other health care** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

Two covered persons must individually meet their Calendar Year **deductible** in a Calendar Year.

When this occurs in a calendar year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions

Copayment, Copay

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

Payment Provisions

Payment Percentage

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

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider and Other Health Care Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** and **other health care** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider** and **other health care Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **network provider** and **other health care Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider** and **other health care Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider** and **other health care Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider** and **other health care Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out -of-network benefits. **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**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

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

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

- A $300 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.