Schedule of Benefits

Employer:	**Alief Independent School District**
ASA:	100085
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Schedule:	3A
Booklet Base:	3

For: Aexcel Plus Choice POSII

This is not an ERISA 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*	$1,000	$2,000
Family Deductible*	$3,000	$6,000
Per Admission Copayment	$500 per admission	Not Applicable
Per Admission Deductible*	Not Applicable	$1,000 per admission

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

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

Plan Out-of-Network **Payment Limit** does not include plan **deductible** and **copayments.**

Plan In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit** excludes **precertification** penalties.

Individual In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit**:

- For network expenses: $3,000.
- For out-of-network expenses: $6,000.

Family In-Network Maximum Out of Pocket Limit and Out-of-Network Payment Limit:

- For network expenses: $6,000.
- For out-of-network expenses: $12,000.

Lifetime Maximum Benefit per person	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 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
Preventive Care		
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No Calendar Year **deductible** applies.	50% per exam after Calendar Year **deductible**
Maximum Exams per 1 consecutive month period Adults age 18 to 65	1 exam	1 exam
Maximum Exams per 1 consecutive month period Adults age 65 and over	1 exam	1 exam
Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	50% per visit after Calendar Year **deductible** Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*

Well Child Exams Includes coverage for immunizations	100% per exam No Calendar Year **deductible** applies.	50% per exam after Calendar Year **deductible**

Maximum Exams		
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

Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	50% per visits after Calendar Year **deductible**

Obesity and/or Healthy Diet Maximum Visits per 12 consecutive month *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive month	5 visits*	5 visits*

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products Maximum Visits per 12 consecutive month	8 visits*	8 visits*

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.	50% per exam after Calendar Year **deductible**
Maximum exams per Calendar Year	1 exam	1 exam
Lung Cancer Screening Maximum	One screening every 12 months*	One screening every 12 months*

Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography For covered females age 35 and over.	100% per test No Calendar Year **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.	100% per test No Calendar Year **deductible** applies.	50% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test

Routine Digital Rectal Exam For covered males age 40 and over.	100% per test No Calendar Year **deductible** applies.	50% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears	100% per test No Calendar Year **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	100% per test No Calendar Year **deductible** applies.	50% per test after Calendar Year **deductible**

Maximum Tests per 10 consecutive year period	1 test	1 test

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	$30 PCP or $40 Specialist exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Voluntary Sterilization for Males		
Outpatient	$30 PCP or $40 Specialist exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Family Planning - Female Voluntary Sterilization		
Inpatient	$30 PCP or $40 Specialist exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Outpatient	$30 PCP or $40 Specialist exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Specialist Office Visits	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
Non-Designated Network Specialist	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
Non-Designated Network Specialist	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable
Non-Designated Network Specialist	65% per visit after Calendar Year **deductible**	Not applicable
Out of Network Provider Specialist	Not applicable	50% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**.
Allergy Injections	$30 visit **copay** then the plan pays 100% No Calendar Year **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 and Physician	$350 **copay** per visit then the plan pays 80% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. 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 Emergency Room Facility or **physician** 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
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)*	$40 **copay** per visit then the plan pays 80% No Calendar Year **deductible** applies.	50% per visit 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		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	50% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% 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)	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Other than Room and Board	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%

Maximum Days per Calendar Year	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visit Limit per *Calendar Year*	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	50% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	30 days	30 days
Hospice Outpatient Visits	80% 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		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Mental Disorders	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after the Calendar Year **deductible** then the plan pays 50
Maximum Benefit per Calendar Year	45 days	45 days
Outpatient Treatment Of Mental Disorders		
Mental Disorders	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	30 visits	30 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Alcoholism and Substance Abuse		
Inpatient Treatment	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
Maximum Days per Calendar Year	45 days	45 days
Outpatient Treatment of Alcoholism and Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	50% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	30 visits	30 visits

Important Notice:
Both **network** and **out of network** alcoholism and substance abuse and mental illness treatment expenses accumulate toward any maximum shown above for alcoholism and substance abuse and mental illness treatment expenses.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	$500 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%	$1,000 per admission **deductible** after Calendar Year **deductible** then the plan pays 50%
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	50% after Calendar Year **deductible**
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	50% per item after the Calendar Year **deductible**
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	80% per item after Calendar Year **deductible**	50% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Infusion Therapy	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Radiation Therapy	80% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	50% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	50% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Autism – Physical therapy, Occupational Therapy, Speech Therapy	100% after a $40.00 **copay** No **deductible** applies	50% after **deductible**
Autism - behavioral therapy	80% after **deductible**	50% after **deductible**
Autism - Applied Behavior Analysis	80% after **deductible**	50% after **deductible**
Combined Autism Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 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

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

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**.

Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** 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 a **network provider** 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:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit 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.

Out-of-Network Provider 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** 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** 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:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit 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.

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.

Maximum Out of Pocket Limit/Payment Limit

The in-network **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 in-network **Maximum Out of Pocket Limit**. As to the individual in-network **Maximum Out of Pocket Limit**, each of you must meet your in-network **Maximum Out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

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

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

Certain **covered expenses** do not apply toward the out-of-network **Payment Limit**. See list below.

Network Provider

Individual

Once the amount of eligible in-network **Maximum Out of Pocket Limit** expenses you or your covered dependents have paid during the Calendar Year meets the individual in-network **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

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

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

> The family in-network **Maximum Out of Pocket Limit** is a cumulative in-network **Maximum Out of Pocket Limit** for all family members. The family in-network **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 in-network **Maximum Out of Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider

Individual

Once the amount of eligible out-of-network **Payment Limit** expenses you or your covered dependents have paid during the Calendar Year meets the individual out-of-network **Payment 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
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year out-of-network **Payment Limit,** these expenses will also count toward a family out-of-network **Payment Limit**.

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

The family **Payment Limit** is a cumulative out-of-network **Payment Limit** for all family members. The family out-of-network **Payment 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 **Payment Limit** amount in a Calendar Year.

The **Maximum Out of Pocket Limit** applies to in-network benefits and the **Payment Limit** applies to out -of-network benefits. **Covered expenses** applied to the out-of-network **Payment 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 **Payment Limit**.

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

- Charges over the **recognized charge**;
- 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**.

Expenses That Do Not Apply to Your Out-of-Network Payment Limit
Certain covered expenses do not apply toward your plan out-of-network **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**; 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 $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.