Schedule of Benefits

Employer: **American Air Liquide Holdings Inc.**

MSA: 867981

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For: Aetna Choice POS II – Premium Pre 65 Retirees 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*	$600	$600
Family Deductible*	$1,200	$1,200
Per Admission Copayment	$300 per admission	Not Applicable
Per Admission Deductible*	Not Applicable	$300 per admission

*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: $3,100.
- For **out-of-network** expenses: $5,600.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,200.
- For **out-of-network** expenses: $11,200.

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 Benefits		
Routine Physical Exams Office Visits	100% per visit No **copay** or **deductible** applies.	90% per visit after Calendar Year **deductible**
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	1 visit
Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies.	90% per visit after Calendar Year **deductible**
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	90% per visits after Calendar Year **deductible**
Obesity Maximum Visits per Calendar Year *(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 Calendar Year	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 Calendar Year	8 visits*	8 visits*
Note: *In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Sexually Transmitted Infections Benefit Maximums Maximum Visits per Calendar Year	2 visits*	2 visits*
Note: *In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		
Well Woman Preventive Visits ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	90% per visit after Calendar Year **deductible**
Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit
Hearing Exam	100% per exam No Calendar Year **deductible** applies.	90% per exam after Calendar Year **deductible**
Maximum exams per 12 month period	1 exam	1 exam
Routine Cancer Screening ***Outpatient***	100% per visit No Calendar Year **deductible** applies.	90% per visit after Calendar Year **deductible**
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*

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.

Prenatal Care		
Office Visits	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**

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.

Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	80% per visit after Calendar Year **deductible**

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per Calendar Year	Not Applicable

***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies	100% per item No **copay** or **deductible** applies	80% per item after Calendar Year **deductible**

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

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

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives		
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item. No **copay** or **deductible** applies.	80% per item after Calendar Year **deductible**

Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males Outpatient	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

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

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Family Planning Services - Female Contraceptives		
Female Contraceptive Generic Prescription Drugs For each 30 day supply filled at a retail **pharmacy**	100% per prescription or refill No **deductible** applies.	80% per prescription or refill after **deductible**.
Female Contraceptive Devices	100% per prescription or refill No **deductible** applies.	80% per prescription or refill after **deductible**.
FDA-Approved Female Generic Emergency Contraceptives	100% per prescription or refill No **deductible** applies.	80% per prescription or refill after **deductible**.
FDA-Approved Female and Male Generic Over-the-Counter Contraceptives	100% per prescription or refill. No **deductible** applies.	80% per prescription or refill after **deductible**.
Important Note: Refer to the *Outpatient Prescription Drug Expenses* section of your *Schedule of Benefits* for more information on other prescription drug coverage under this Plan.		

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Specialist Office Visits	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	90% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	90% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	90% per visit after Calendar Year **deductible**
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.		
All Other Services	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Allergy Injections	100% per visit No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$100 **copay** per visit after the Calendar Year **deductible** then the plan pays 90%	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)*	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	80% 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	90% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	90% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery		
Outpatient Surgery	90% per visit/surgical procedure after Calendar Year **deductible**	80% 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) Other than Room and Board	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 90% 90% per admission after Calendar Year **deductible**	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 80% 80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 80%
Maximum Days per Calendar Year	60 days	60 days

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	40 visits	40 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board) ***Hospice Care - Other Expenses during a stay***	100% per admission after Calendar Year **deductible** 100% per admission after Calendar Year **deductible**	100% per admission after Calendar Year **deductible** 100% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	100% per visit after Calendar Year **deductible**

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	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 80%
Other than Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$300 per admission **deductible** after Calendar Year **deductible** then the plan pays 80%
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
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 the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$300 per admission **deductible** after the Calendar Year **deductible** then the plan pays 80%
Other than Room and Board	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 90%	$300 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Inpatient Residential Treatment Facility Expenses Physician Services	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

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**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	90% per visit after the Calendar Year **deductible**	Not Covered

Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	$300 per admission **copay** after Calendar Year **deductible,** then the plan pays 90%	Not Covered
Outpatient Morbid Obesity Surgery	90% per service after Calendar Year **deductible**	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	$300 per admission **copay** after Calendar Year **deductible,** then the plan pays 90%	$300 per admission **deductible** after Calendar Year **deductible,** then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible,** then the plan pays 80%
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	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Ground, Air or Water Ambulance	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	90% per item after the Calendar Year **deductible**	80% per item after the Calendar Year **deductible**
Durable Medical and Surgical Equipment	90% per item after the Calendar Year **deductible**	80% per item after the Calendar Year **deductible**
Clinical Trial Therapies (Experimental or Investigational 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.
Routine Patient Costs	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.
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	90% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Therapies		
Chemotherapy	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.
Infusion Therapy	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.
Radiation Therapy	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
Autism Spectrum Disorder		
Autism - Physical Therapy, Occupational Therapy, Speech Therapy		
Office Visits	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Non-Office Visits	90% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Autism - Behavioral Therapy	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies *<11SECTION095>*		
Outpatient Physical, Occupational and Speech Therapy combined		
Office – Visit	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after Calendar Year **deductible**
Non – Office Visit	90% per visit after Calendar Year deductible	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	80% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	35 visits	35 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 not be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will not 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
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 Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **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 **network provider Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **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 **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 **network provider 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. You have separate **Maximum Out-of-Pocket Limit** for in-network and out-of-network benefits. **Maximum Out-of-Pocket Limit** amounts paid by you for in-network and out -of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one 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**;
- 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 reduced payment percentage of 50% will apply separately to the eligible expenses incurred for each type of service or supply.

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.