Schedule of Benefits

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

MSA: 867981

Issue Date: August 4, 2015
Effective Date: January 1, 2015
Schedule: 3A
Booklet Base: 3

For: PPO Medical Plan - Out of Area Standard PPO

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
Individual Deductible*	$750	$750	$750
Family Deductible*	$1,500	$1,500	$1,500
Per Admission Copayment	$300 per admission	Not applicable	Not applicable
Per Admission Deductible*	Not applicable	$300 per admission	$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: $3,250.
- For **out-of-network** expenses: $3,250.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,500.
- For **out-of-network** expenses: $6,500.

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 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 Benefits			
Routine Physical Exams			
Office Visits	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
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. *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 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 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.*
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	1 visit	1 visit

Preventive Care Immunizations			
Performed in a facility or ***physician's*** *office*	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
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)* *****	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 *****	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 *****	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*****	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.	100% per visit No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.
Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
Hearing Exam	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.
Maximum Exams per 12 month period	1 exam	1 exam	1 exam
Hearing Supply Maximum per 12 month period	1 hearing aid per ear	1 hearing aid per ear	1 hearing aid per ear

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Routine Cancer Screenings			
Routine Cancer Screenings Outpatient	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
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.*	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*****	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 **deductible** applies.	100% per visit No **deductible** applies.	100% 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.			

Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services - Facility or Office Visits	100% per visit. No **deductible** applies.	100% per visit No **deductible** applies.	100% per visit No **deductible** applies.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per **calendar year**	6* visits per **calendar year**	6* visits per **calendar year**
***Important Note**: Visits in excess of the Lactation Counseling 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.	100% per item No Calendar Year **deductible** applies.	100% per item. No **copay** or **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	80% per visit after Calendar Year **deductible**	80%per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Voluntary Termination of Pregnancy			
Outpatient	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	100% per visit. No **copay** or Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or Calendar Year **deductible** applies.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months	2* visits per 12 months
*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.*			
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.	100% per item No Calendar Year **deductible** applies.	100% per item No **copay** or **deductible** applies.
Family Planning Services - Female Voluntary Sterilization			
Inpatient	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
Outpatient	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% 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 For each 30 day supply filled at a retail **pharmacy**)	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.
Female Contraceptive Devices	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.
FDA-Approved Female Generic Emergency Contraceptives	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.
FDA-Approved Female and Male Generic Over-the-Counter Contraceptives	100% per prescription or refill. No **deductible** applies.	100% per prescription or refill No **deductible** applies.	100% per prescription or refill No **deductible** applies.
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	OTHER HEALTH CARE
Physician Services			
Physician Office Visits (*non-surgical*) – *When part of office visit*	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Physician Office Visits (*non-surgical*) – *When not part of office visit*	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits - *When part of office visit*	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Specialist Office Visits - *When not part of office visit*	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	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.	100% per visit No Calendar Year **deductible** applies.	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.
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
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	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.	100% per visit No Calendar Year **deductible** applies.	100% per visit No **copay** or **deductible** applies.
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	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	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$15 visit **deductible** then the plan pays 100% No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.

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

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Emergency Medical Services			
Hospital Emergency Facility and Physician	$200 **copay** per visit after Calendar Year **deductible** then the plan pays 80%	Paid the same as the Network level of benefits. See Important Note Below	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	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 100% No Calendar Year **deductible** applies.	$40 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$40 **deductible** per visit then the plan pays 100% 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	80% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays			
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery			
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**

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)	$300 per admission **copay** after Calendar Year **deductible**, then the plan pays 80%	$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%
Other than Room and Board	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	$300 per admission **copay** after Calendar Year **deductible,** then the plan pays 80%	$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%
Maximum Days per Calendar Year	60 days	60 days	60 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	100% per visit after Calendar Year **deductible**	100% per visit after Calendar Year **deductible**	100% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	40	40	40

Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	100% per admission after the Calendar Year **deductible**	100% per admission after the Calendar Year **deductible**	100% per admission after the Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	100% per admission after the Calendar Year **deductible**	100% per admission after the Calendar Year **deductible**	100% per admission after the Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after the Calendar Year **deductible**	100% per visit after the Calendar Year **deductible**	100% 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.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
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 80%	$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%
Other than Room and Board	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	80% 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 80%	$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%
Physician Services	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders			
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	100% 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	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	$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%
Other than Room and Board	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	80% 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 80%	$300 per admission **deductible** after the Calendar Year **deductible**, then the plan pays 80%	$300 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Physician Services	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse			
Outpatient Treatment	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	100% 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)	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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 80%	$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%
Outpatient Morbid Obesity Surgery	80% per service after Calendar Year **deductible**	80% per service after Calendar Year **deductible**	80% per service after Calendar Year **deductible**
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	$300 per admission **copay** after Calendar Year **deductible,** then the plan pays 80%	$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%	$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	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES			
Other Covered Health Expenses			
Acupuncture	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	80% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**	80% per item after 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.	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.	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.	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**	80% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
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.	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.	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.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Autism Spectrum Disorder			
Autism - Physical Therapy, Occupational Therapy, Speech Therapy	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Autism - Behavioral Therapy	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	$15 per visit **deductible** then the plan pays 100% No Calendar Year **deductible** applies	$15 per visit **deductible** then the plan pays 100% No Calendar Year **deductible** applies

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Occupational, and Speech Therapy combined	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Spinal Manipulation			
Spinal Manipulation	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	35 visits	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 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 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 a **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 a **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:

> 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 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**;
- 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**.

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.