Schedule of Benefits

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

MSA: 867981

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For: Aetna Choice POS II - Choice Savings HSA

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

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$1,500	$4,500
Family Deductible*	$3,000	$9,000

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

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

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $3,400.
- For **out-of-network** expenses: $10,500.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,800.
- For **out-of-network** expenses: $21,000.

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 Benefits		
Routine Physical Exams		
Office Visits	100% per visit No **copay** or **deductible** applies.	80% 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.	80% per visit after Calendar Year **deductible**
Screening & Counseling Services	100% per visit	80% per visits after Calendar Year **deductible**
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***	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)* *
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.	80% 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.	80% 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.	80% 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.	60% 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.	60% 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	60% 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.	60% 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.	60% per item after Calendar Year **deductible**
Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males Outpatient	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**
Outpatient	100% per visit No **copay** or **deductible** applies.	60% 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.	60% per prescription or refill after **deductible**.
Female Contraceptive Devices	100% per prescription or refill No **deductible** applies.	60% per prescription or refill after **deductible**.
FDA-Approved Female Generic Emergency Contraceptives	100% per prescription or refill No **deductible** applies.	60% per prescription or refill after **deductible**.
FDA-Approved Female and Male Generic Over-the-Counter Contraceptives	100% per prescription or refill. No **deductible** applies.	60% 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	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Specialist Office Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	60% 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.	80% per visit after Calendar Year **deductible**
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	80% per visits 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.	80% per visits 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	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	80% per visit after the Calendar Year **deductible**	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

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	60% 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
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	60% 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**	60% 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	80% per admission after Calendar Year **deductible** 80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible** 60% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 days	60 days

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits		
Home Health Care (Outpatient)	100% per visit after the Calendar Year **deductible**	100% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	40 visits	40 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	60% 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	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	80% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after the Calendar Year **deductible**	Not Covered
Outpatient Morbid Obesity Surgery	80% 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	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	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.
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	60% 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	80% per item after Calendar Year **deductible**	60% 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	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Autism - Behavioral Therapy	80% per visit after Calendar Year **deductible**	60% 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	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	80% per visit after Calendar Year **deductible**	60% 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**. This Plan has individual and family Calendar Year **deductibles**.

For purposes of Calendar Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you incur each Calendar Year from a **network provider** for which no benefits will be paid. 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
This is the amount of **covered expenses** that you and your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this family Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from a **network provider** for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

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

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.

For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

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 and family **Maximum Out-of-Pocket Limit**.

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

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

You have a separate **Maximum Out-of-Pocket Limit** for **network provider and out-of-network provider** benefits.
You are not able to combine **network provider and out-of-network provider covered expenses** and apply them toward one limit.

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you 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
The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** expenses paid during the Calendar Year meets this family **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 all covered family members.

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

Individual
Once the amount of eligible **out-of-network provider** expenses you 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
The Family **Maximum Out-of-Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the Calendar Year meets this family **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 all covered family members.

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.