

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

This schedule of benefits (schedule) lists the _____, _____ or _____, if any apply to the _____ you receive under the plan. You should review this schedule to become aware of these and

The _____ is the amount you pay for _____ each year before the plan starts to pay. This is in addition to any _____ or _____ you pay when you get _____ from an in-network, _____ . This schedule shows the _____ amounts that apply to your plan. Once you have met your _____ , we will start sharing the cost when you get _____ . You will continue to pay _____ or _____ , if any, for _____ after you meet your _____ .

You will pay the _____ cost share when you get _____ from any _____ .

This schedule shows the _____ that apply to your plan. Once you reach your _____ , your plan will pay for _____ for the remainder of that year.

We are here to answer questions. See the _____ section in your booklet.

The _____, if any, for _____ is the most you will pay per year in _____, _____ and _____ apply to the in-network and out-of-network _____.

- This plan may have an individual and family _____ . As to the individual _____, each of you must meet your _____ separately.
- After you or your covered dependents meet the individual _____, this plan will pay 100% of the eligible charge for _____ that would apply toward the limit for the rest of the year for that person.

After you or your covered dependents meet the family _____, this plan will pay 100% of the eligible charge for _____ that would apply toward the limit for the remainder of the year for all covered family members. The family _____ is a cumulative _____ for all family members.

To satisfy this _____ for the rest of the year, the following must happen:

- The family _____ is met by a combination of family members
- No one person within a family will contribute more than the individual _____ amount in a year

If the _____ does not apply to a _____, your cost share for that service will not count toward satisfying the _____ amount.

Coverage provided is the same as for any other illness

Inpatient services- including	80% per admission after	60% per admission after

Outpatient office visit to a or	\$25 then the plan pays 100% per visit, no applies	60% per visit after

or

PT, OT therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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ST	Covered based on type of service and where it is received	Covered based on type of service and where it is received
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A visit is a period of 4 hours or less

Home health care	100% per visit after	60% per visit after
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Visit limit per year	130	130
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Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Inpatient services -	100% after	60% after
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Outpatient services	100% per visit after	60% per visit after
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At outpatient department	80% per visit after	60% per visit after
At facility that is not a	80% per visit after	60% per visit after
At the office	80% per visit after	60% per visit after

office hours (not-surgical, not preventive)	\$25 then the plan pays 100% per visit, no applies	60% per visit after
surgical services	\$25 then the plan pays 100% per visit, no applies	60% per visit after

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Counseling for obesity, healthy diet	100% per visit, no applies	60% per visit after
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no applies	60% per visit after
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no applies	60% per visit after
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	Your plan provides coverage. Contact member Services / Aetna Concierge to review the eligible health services available to you within category of coverage.	Your plan provides coverage. Contact member Services / Aetna Concierge to review the eligible health services available to you within category of coverage.
Family planning services (female contraception counseling) limit	Your plan provides coverage. Contact member Services / Aetna Concierge to review the eligible health services available to you within category of coverage.	Your plan provides cove

Preventive care risk
reducing breast cancer
drugs limit

Subject to any sex, age, medical
condition, family history and frequency
guidelines as recommended by the
USPSTF

For a current list of covered preventive
care drugs and supplements or more
information, see the _____ section

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Including breast

and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

	\$25 then the plan pays 100% per visit, no applies	60% per visit after

Visit limit per year In-network and out-of-network combined	10	10
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Inpatient services -	80% per admission after	60% per admission after
Other inpatient services and supplies	80% per admission after	60% per admission after

Day limit per year	90	90
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	80% per visit after	60% per visit after

	80% per visit after	
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consultation for non- through a	100% per visit, no applies	Covered based on type of service and where it is received	Not covered
consultation for preventive screening and counseling services through a	100% per visit, no applies	Covered based on type of service and where it is received	Not covered

A _____ listed in the directory under _____ as a _____ for your plan.

A _____ listed in the directory under the _____ tab as a _____ for your plan.
See the _____ section if you have questions.

You will pay less cost share when you use a designated network _____. Non-designated
network _____ are available to you, but the cost share will be at a higher level when these
_____ are used.