Schedule of Benefits

Employer: Yale University
ASA: 877076
Issue Date: March 2, 2015
Effective Date: January 1, 2015
Schedule: 12A
Booklet Base: 12

For: Aetna Select - Clerical & Technical and Service & Maintenance Employees Electing EPO MD Including Prescription Drug.

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

Aetna Select Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Maximum Out of Pocket Limit</td>
<td>includes plan copayments.</td>
<td></td>
</tr>
<tr>
<td>Plan Maximum Out of Pocket Limit</td>
<td>excludes precertification penalties.</td>
<td></td>
</tr>
<tr>
<td>Individual Maximum Out of Pocket Limit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ For network expenses: $6,350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Maximum Out of Pocket Limit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ For network expenses: $12,700</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit per person</strong></td>
<td>Unlimited</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits -</strong></td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons through age 21:</strong></td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum Age &amp; Visit Limits per Calendar Year</td>
<td>For details, contact your <strong>physician</strong> log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons ages 22 but less than 65:</strong></td>
<td>1 visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum Visits per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons age 65 and over:</strong></td>
<td>1 visit</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Maximum Visits per Calendar Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Preventive Care Immunizations

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performed in a facility or physician's office</strong></td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

#### Screening & Counseling Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong></td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

### Obese

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Visits per Calendar Year</strong></td>
<td>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)*</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

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

### Misuse of Alcohol and/or Drugs

<table>
<thead>
<tr>
<th>Service</th>
<th>Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Visits per Calendar Year</strong></td>
<td>5 visits*</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.*
<table>
<thead>
<tr>
<th><strong>Use of Tobacco Products</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per Calendar Year</td>
<td>8 visits*</td>
<td>Not Covered.</td>
</tr>
<tr>
<td><strong>Note:</strong> In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Well Woman Preventive Visits</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maximun Visits per Calendar Year</strong></th>
<th>1 visit</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Early Intervention Services</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child to age 3</strong></td>
<td>100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Exam</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 exam <strong>copay</strong> then the plan pays 100%</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maximum exams per 24 month period</strong></th>
<th>1 exam</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Pediatric Hearing Aids</strong> (children age 12 and younger)</th>
<th>100% covered</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Supply Maximum per 24 month period (GR.9N.5-25-005-01)</strong></th>
<th>1 hearing aid per ear</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Routine Cancer Screening Outpatient</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100% covered.</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maximums</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Prenatal Care Office Visits</th>
<th>100% covered.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Comprehensive Lactation Support and Counseling Services</th>
<th>100% covered.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation Counseling Services Facility or Office Visits</td>
<td></td>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

Lactation Counseling Services Maximum Visits either in a group or individual setting 6* visits per 12 months Not Covered

**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.

<table>
<thead>
<tr>
<th>Breast Pumps &amp; Supplies</th>
<th>100% per item.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No copay or deductible applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Planning - Other</th>
<th>100% covered.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Termination of Pregnancy Outpatient</td>
<td></td>
<td>No deductible applies.</td>
</tr>
</tbody>
</table>

Voluntary Sterilization for Males Outpatient 100% covered. Not Covered

No deductible applies.

<table>
<thead>
<tr>
<th>Family Planning Services</th>
<th>100% covered.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Contraceptive Counseling Services -Office Visits.</td>
<td></td>
<td>No Calendar Year deductible applies.</td>
</tr>
</tbody>
</table>

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

*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.

<table>
<thead>
<tr>
<th>Family Planning - Female Voluntary Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning Services - Female Contraceptives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Contraceptive Generic Prescription Drugs</td>
<td>100% per prescription or refill</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For each 30 day supply filled at a retail pharmacy</td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Female Contraceptive Devices</td>
<td>100% per prescription or refill</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td>FDA-Approved Female Generic Emergency Contraceptives</td>
<td>100% per prescription or refill</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td></td>
</tr>
<tr>
<td>FDA-Approved Female and Male Generic Over-the-Counter Contraceptives</td>
<td>100% per prescription or refill.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eye Examinations</strong> (including refraction)</td>
<td>$20 exam copay then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits to Primary Care Physician</td>
<td>$10 visit <strong>copay</strong> then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Office visits (non-surgical) to non-specialist</td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

| Specialist Office Visits | $20 visit **copay** then the plan pays 100% | Not Covered |
|                         | No Calendar Year **deductible** applies. | |

<table>
<thead>
<tr>
<th>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician, log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</td>
<td></td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Tobacco Use</td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of Benefits for maximums that may apply to these types of services</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Obesity</td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No <strong>copay</strong> or <strong>deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of Benefits for maximums that may apply to these types of services</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

*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.
<table>
<thead>
<tr>
<th><strong>All Other Services</strong></th>
<th>$10 visit copay then the plan pays 100%</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Physician Office Visits - Surgery</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician</strong></td>
<td>$10 per visit copay then the plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>$20 per visit copay then the plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
</tr>
</tbody>
</table>

| **Physician Services for Inpatient Facility and Hospital Visits** | 100% covered. | Not Covered |

<table>
<thead>
<tr>
<th><strong>Administration of Anesthesia</strong></th>
<th>100%</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Allergy Injections</strong></th>
<th>100% covered.</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PLAN FEATURES</strong></th>
<th><strong>NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Emergency Facility and Physician</strong></td>
<td>$100 copay per visit then the plan pays 100%</td>
<td>Paid the same as the Network level of benefits.</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td><em>See Important note below</em></td>
</tr>
</tbody>
</table>

*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 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 Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.
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.

<table>
<thead>
<tr>
<th>Urgent Care Services</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Medical Care</strong> (at a non-hospital free standing facility)</td>
<td>$20 copay per visit then the plan pays 100% No Calendar Year deductible applies.</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

| 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 |

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Diagnostic and Preoperative Testing</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complex Imaging Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complex Imaging</strong></td>
<td>100% per test No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Laboratory Testing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Laboratory Testing</strong></td>
<td>100% per procedure No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic X-Rays</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic X-Rays (except Complex Imaging Services)</strong></td>
<td>100% per procedure No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>100% per visit/surgical procedure No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Inpatient Facility Expenses

<table>
<thead>
<tr>
<th>Network Feature</th>
<th>Description</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birthing Center</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Hospital Facility Expenses

<table>
<thead>
<tr>
<th>Network Feature</th>
<th>Description</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Room and Board</strong> (including maternity)</td>
<td>100% per admission No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Other than Room and Board</strong></td>
<td>100% per admission No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Skilled Nursing Inpatient Facility

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Maximum Days per Calendar Year

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 days</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Specialty Benefits

### Home Health Care (Outpatient)

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% covered.</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Maximum Visits per Calendar Year

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 visits</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Private Duty Nursing (Outpatient)

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% covered.</td>
<td>No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Maximum Visit Limit per Calendar Year

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Hospice Benefits

### Hospice Care – Facility Expenses (Room & Board)

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per admission</td>
<td>No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Hospice Care – Other Expenses during a stay

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per admission</td>
<td>No Calendar Year deductible applies.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Maximum Benefit per lifetime</strong></td>
<td>Unlimited days</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hospice Outpatient Visits</strong></td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Infertility Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Infertility Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Expenses for Comprehensive Infertility services will not be used to satisfy the plan <strong>Maximum Out-of-Pocket Limit</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial Insemination Maximum Benefit</td>
<td>4 courses of treatment per lifetime</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ovulation Induction Maximum Benefit</td>
<td>4 courses of treatment per lifetime</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum per lifetime</td>
<td>$20,000</td>
<td>Not Covered</td>
</tr>
<tr>
<td>The Comprehensive Infertility services maximum per lifetime amount shown above will not be used to satisfy the plan <strong>Maximum Out-of-Pocket Limit</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced Reproductive Technology (ART) Expenses</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan <strong>Maximum Out-of-Pocket Limit</strong>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>Sex Reassignment Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex Reassignment Surgery</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
# PLAN FEATURES

## NETWORK

<table>
<thead>
<tr>
<th>Inpatient Treatment of Mental Disorders</th>
</tr>
</thead>
</table>

## OUT-OF-NETWORK

### MENTAL DISORDERS

#### Hospital Facility Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

### Inpatient Residential Treatment Facility Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Residential Treatment Facility Expenses</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

### Inpatient Residential Treatment Facility Expenses Physician Services

<table>
<thead>
<tr>
<th>Item</th>
<th>Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Residential Treatment Facility Expenses Physician Services</td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Treatment Of Mental Disorders

#### Outpatient Services

<table>
<thead>
<tr>
<th>Item</th>
<th>Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$10 per visit copay then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><em>Inpatient Treatment of Substance Abuse</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Hospital Facility Expenses</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient Residential Treatment Facility Expenses</em></td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient Residential Treatment Facility Expenses Physician Services</em></td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Outpatient Treatment of Substance Abuse</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Outpatient Services</em></td>
<td>$10 per visit <strong>copay</strong> then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>PLAN FEATURES</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Obesity Treatment Non Surgical</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Outpatient Obesity Treatment</em> (non surgical)</td>
<td>100% covered.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient Morbid Obesity Surgery</em> (includes Surgical procedure and Acute Hospital Services)*</td>
<td>100% per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Morbid Obesity Surgery</strong></td>
<td>100% per service</td>
<td>Not Covered</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)</td>
<td>Unlimited</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PLAN FEATURES</strong></th>
<th><strong>NETWORK (IOE Facility)</strong></th>
<th><strong>NETWORK (Non-IOE Facility)</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplant Services Facility and Non-Facility Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant Facility Expenses</strong></td>
<td>100% per admission</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Transplant Physician Services</strong> (including office visits)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PLAN FEATURES</strong></th>
<th><strong>NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Covered Health Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture in lieu of anesthesia</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Ground, Air or Water Ambulance</strong></td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Durable Medical and Surgical Equipment</strong></td>
<td>100% per item</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PLAN FEATURES</strong></th>
<th><strong>NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

**Outpatient Therapies**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Short Term Outpatient Rehabilitation Therapies**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Physical and Occupational Therapy only</strong></td>
<td>$20 per visit <strong>copay</strong> then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Spinal Manipulation**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spinal Manipulation</strong></td>
<td>$20 per visit <strong>copay</strong> then the plan pays 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Pharmacy Benefit

**Copays/Deductibles**

<table>
<thead>
<tr>
<th>PER PRESCRIPTION OPCAY/DEDUCTIBLE</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each 31 day supply (retail)</td>
<td>$5</td>
<td>The greater of $5 or 20% of the recognized charge</td>
</tr>
<tr>
<td>For more than a 31 day supply but up to a 100 day supply (mail order)</td>
<td>$10</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Brand-Name Prescription Drugs</td>
<td>For each 30 day supply (retail)</td>
<td>$20</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>For more than a 30 day supply but up to a 91 day supply (mail order)</td>
<td>$40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Preferred Brand-Name Prescription Drugs</th>
<th>For each 31 day supply (retail)</th>
<th>$35</th>
<th>The greater of $35 or 20% of the recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For more than a 31 day supply but up to a 100 day supply (mail order)</td>
<td>$70</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

| Diabetic prescription drugs, supplies and insulin | For each 30 day supply filled at a retail pharmacy | 100% of the negotiated charge | 100% of the negotiated charge |

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the brand-name prescription drug. If you request a covered brand-name prescription drug where a generic prescription drug equivalent is available you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug equivalent, plus the applicable cost sharing.

**Copay and Deductible Waiver**

**Waiver for Prescription Drug Contraceptives**

The per prescription copay/deductible and any prescription drug Calendar Year deductible will not apply to contraceptive methods that are:

- generic prescription drugs; contraceptive devices; or
- FDA-approved female generic emergency contraceptives, when obtained at a network pharmacy.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide out-of-network pharmacy benefits under the Prescription Drug Plan, the per prescription copay/deductible and any applicable prescription drug Calendar Year deductible continue to apply.

The per prescription copay/deductible and any prescription drug Calendar Year deductible continue to apply:

- For contraceptive methods that are:
  - brand-name prescription drugs and devices and
  - FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent, or generic alternative available within the same therapeutic drug class unless you are granted a medical exception.
The *prescription drug* plan *coinsurance* is the percentage of *prescription drug covered expenses* that the plan pays after any applicable *deductibles* and *copays* have been met.

*Precertification* and *step therapy* for certain *prescription drugs* is required. If *precertification* is not obtained, the *prescription drug* will not be covered.

### Prescription Drug Plan Coinsurance

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of the <em>negotiated charge</em></td>
<td>80% of the <em>recognized charge</em></td>
</tr>
</tbody>
</table>

### 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.**

### 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.

### 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 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.

Covered expenses that are subject to the Maximum Out-of-Pocket Limit include prescription drug expenses provided under the Medical or Prescription drug Plans, as applicable.

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.