

# SCHEDULE OF MEDICAL BENEFITS

## AETNA

## CHOICE POS II PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2009

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Deductible
<b>Network</b>	\$250	Individual	\$1,000	Individual	\$100 per day, not to exceed \$600 per admission
	\$500	Family	\$2,000	Family	
<b>Non-Network</b>	\$500	Individual	\$3,000	Individual	
	\$1,000	Family	\$6,000	Family	

### Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 Million Individual

The following schedule summarizes coinsurance amounts paid by the Plan, benefit maximums, and any additional explanation needed for your benefits. The Plan's coinsurance will be reduced if you do not follow the procedures outlined in the "Clinical Management" section of this Handbook. Please refer to the text for additional Plan provisions that may affect your benefits.

The copayment refers to the copayment amount, whether it is expressed as a dollar amount (e.g. \$25 per visit) or as a percentage (e.g. 10%).

**Our Benefits:** Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition.

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAYMENT APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
<b>Acupuncture Services</b>	<b>Network</b> 50%	No	No	Limited to 12 visits per year. Benefits are not subject to reduction for usual and customary charges.
	<b>Non-Network</b> 50%	Yes	No	
<b>Allergy Testing (Injections)</b>	<b>Network</b> \$25 per visit if office visit charged	No	No	Benefit includes allergy injections/serum and physician allergy testing/treatment. You must pay a \$25 copay per visit to a network provider if professional services charged in addition to the injection for serum preparation or physician supervision.
	<b>Non-Network</b> 30%	Yes	Yes	
<b>Ambulance Services - Emergency Only</b>	<b>Network &amp; Non-Network</b> 10%	Yes	No	
<b>Diagnostic Tests/X-Ray and Laboratory Services</b>	<b>Network</b> 20%	Yes	No	Benefit for services performed in an independent lab facility or doctor's office not related to a routine exam.
	<b>Non-Network</b> 20%	Yes	No	
<b>Durable Medical Equipment (DME)</b>	<b>Network</b> 10%	Yes	No	You should notify Aetna by calling the toll-free number prior to purchasing or renting any durable medical equipment.
	<b>Non-Network</b> 30%	Yes	Yes	

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<b>Emergency Room Services</b>	<b>Network &amp; Non-Network</b> \$50 per visit	No	No	Your \$50 copay will be waived if you are admitted to the hospital. There is no coverage for non-emergency treatment.
<b>Home Health Care</b>	<b>Network</b> 10% <b>Non-Network</b> 30%	Yes  Yes	Yes  Yes	Limited to 200 visits per plan year; precertification is required. You should notify Aetna by calling the toll-free number prior to receiving any home health care.
<b>Hospice Care</b>	<b>Network</b> 10% <b>Non-Network</b> 30%	Yes  Yes	Yes  Yes	Limited to 210 visits per member. Benefits include bereavement counseling.
<b>Hospital Services (Inpatient)</b>	<b>Network</b> 10%  \$100 per day copay, \$600 maximum per inpatient stay. <b>Non-Network</b> 30%	Yes  No  Yes	No  No  Yes	The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Clinical Management Program. This penalty does not apply to the out-of-pocket maximum. Benefits include, but are not limited to, hospital semi-private room, miscellaneous fees, anesthesia, surgeons' fees, physician visits, x-ray, lab and therapy expenses.
<b>Hospital Services (Outpatient)</b>	<b>Network</b> 10% <b>Non-network</b> 30%	Yes  Yes	Yes  Yes	Benefits include but are not limited to outpatient surgery, physician, anesthesiology, x-ray & laboratory, and therapy expenses in a hospital or ambulatory surgical center.
<b>Maternity Services Hospital Services</b>	<b>Network</b> 10%  Subject to a \$100 copay per day, \$600 maximum per inpatient stay <b>Non-Network</b> 30%.	Yes  No  Yes	No  No  Yes	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
<b>Outpatient Services</b>	<b>Network</b> \$25 for first visit only <b>Non-Network</b> 30%	No  Yes	No  Yes	

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<b>Mental Health/ Substance Abuse Services - Inpatient</b>				See CIGNA Mental Health/Substance Abuse Schedule
<b>Mental Health/ Substance Abuse Services - Outpatient</b>				See CIGNA Mental Health/Substance Abuse Schedule
<b>Nutritional Counseling</b>	<b>Network</b> \$25 per visit	No	No	Limited to 6 visits/sessions per calendar year.
	<b>Non-Network</b> \$25 per visit	No	No	
<b>Outpatient Therapy Services</b>	<b>Network</b> \$25 per visit	No	No	Benefits include physical, occupational, and speech therapy. Limited to 60 visits each per year.
	<b>Non-Network</b> 30%	Yes	Yes	
<b>Physician's Office Services</b>	<b>Network</b> \$25 per visit	No	No	Your copay applies to the office visit only. All services performed during the visit will be considered as "All Other Covered Medical Expenses" or according to regular plan provisions. To locate a network provider, contact Aetna via the toll-free number or check the web site.
	<b>Non-Network</b> 30%	Yes	Yes	
<b>Routine &amp; Preventive Services</b>	<b>Network</b> \$10 per visit	No	No	Your copay applies to the office visit only. Benefits include the office visit and vaccinations, inoculations, and immunizations. Copay will be waived for immunizations if office visit is not billed. Well-Child checkups are limited to 7 exams 1st 12 months; 2 exams age 13 to 24 months; and 1 exam per year for children age 24 months to age 18. Adult exams are limited to 1 exam per year. Benefits include routine physicals, including gynecological exams and mammograms, limited to 1 age 35-39, then 1 per year age 40 and older, and digital rectal exam males age 40 and older, limited to 1 per year.
<b>Routine Exams</b>	<b>Non-Network</b>			
<b>Routine Exam X-Rays &amp; Laboratory Services</b>	30%	Yes	Yes	
<b>Well-Child Checkups</b>				
<b>Mammograms</b>				
<b>Routine Colonoscopy</b>				
<b>Routine Sigmoidoscopy</b>				
<b>Other Routine Services</b>				
<b>Skilled Nursing Facility</b>	<b>Network</b> 10%	Yes	Yes	Limited to 60 days per year.
	<b>Non-Network</b> 30%	Yes	Yes	

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<b>Smoking Cessation Program</b>	<b>Network</b> 0%	No	No	\$200 individual annual maximum. Benefits include hypnosis and counseling. Prescription smoking cessation drugs are excluded under the medical plan, but are available through Medco. Please refer to Acupuncture for a description of your acupuncture benefits.
	<b>Non-Network</b> 0%	No	No	
<b>Spinal Treatment</b>	<b>Network</b> \$25 per visit	No	No	Limited to 20 visits per year for spinal manipulation.
	<b>Non-Network</b> 30%	Yes	Yes	
<b>Surgical Treatment of Morbid Obesity</b>	<b>Network</b> 10%	Yes	Yes	Limited to 1 procedure per lifetime. Must be preauthorized by Aetna.
	<b>Non-Network</b> 30%	Yes	Yes	
<b>Urgent Care Services</b>	<b>Network &amp; Non-Network</b> \$25	No	No	Benefits are limited to urgent care only. Non-urgent care received at an urgent care facility is not covered.
<b>Additional Benefits</b>				
<b>All Other Covered Medical Expenses</b>	<b>Network</b> 10%	Yes	Yes	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.
	<b>Non-Network</b> 30%	Yes	Yes	

**Clinical Management Program toll-free number: (877) 235-4005**

NOTES: The word "lifetime" refers to the period of time you or your eligible dependents participate in this plan or any other plan funded by the Medical Trust.

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.