

Schedule of Benefits

Employer: Michigan Technological University

ASA: 478821

Issue Date: June 2, 2009

Effective Date: January 1, 2009

Schedule: 1A

Booklet Base: 1

For: Open Choice (PPO Medical Plan) - Active or Fixed-Term Husky Care & Retiree Husky Care 1

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$500	\$1,000	\$500
<i>Family Deductible*</i>	\$1,000	\$2,000	\$1,000

*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: \$1,500.
- For **out-of-network** expenses: \$3,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$3,000.
- For **out-of-network** expenses: \$6,000.

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

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

<i>Lifetime Maximum Benefit Per Person</i>	\$3,000,000	\$3,000,000	\$3,000,000
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Coinsurance 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
Wellness Benefits			
Routine Physical Exams Adults only.	100% per exam No deductible applies.	No Coverage	90% per exam No deductible applies.
Maximum Exams per 12 consecutive months period			
Adults, age 18 to 65	1 exam	No Coverage	1 exam
Maximum Exams per 12 consecutive months period			
Adults, age 65 and over	1 exam	No Coverage	1 exam
Well Child Exams Includes coverage for immunizations.	100% per exam No deductible applies.	No Coverage	90% per exam No deductible applies.
Maximum Exams per 24 consecutive month period			
Under age 2			
first 12 months of life	7 exams	No Coverage	7 exams
13th-24th months of life	2 exams	No Coverage	2 exams
Maximum Exams per 12 consecutive month period			
From age 2 to age 18	1 exam	No Coverage	1 exam

<i>Routine Gynecological Exam</i>	100% per exam No deductible applies.	No Coverage	90% per exam No deductible applies.
Maximum Exams per 12 consecutive month period	1 exam	No Coverage	1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Routine Cancer Screenings</i>			
<i>Routine Mammography</i>	100% per test No deductible applies.	No Coverage	90% per test No deductible applies.
Maximum tests per 12 consecutive month period	1 test	No Coverage	1 test
<i>Prostate Specific Antigen Test</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 12 consecutive month period	1 test	No Coverage	1 test
<i>Routine Digital Rectal Exam</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 12 consecutive month period	1 test	No Coverage	1 test
<i>Routine Pap Smears</i>	100% per test No deductible applies.	No Coverage.	90% per test No deductible applies.
Maximum Tests per 12 consecutive month period	1 test	No Coverage	1 test

<i>Fecal Occult Blood Test</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 12 consecutive month period	1 test	No Coverage	1 test
<i>Sigmoidoscopy</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	No Coverage	1 test
<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	No Coverage	1 test
<i>Colonoscopy</i> age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	No Coverage	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 10 consecutive year period	1 test	No Coverage	1 test
<i>Family Planning Services</i>	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
<i>Physician Services</i>			
<i>Physician Office Visits (non-surgical)</i>	65% per visit No deductible applies.	65% per visit after Calendar Year deductible	90% per visit No deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Physician Services</i>			
<i>Physician Office Visits (non-surgical)</i>	65% per visit No deductible applies.	65% per visit after Calendar Year deductible	90% per visit No deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialist Office Visits</i> <i>All Specialists except those specifically listed in this schedule</i>	65% per visit No deductible applies.	65% after Calendar Year deductible	90% per visit No deductible applies.

<i>Walk-In Clinic Non-Emergency Visit</i>	65% per visit No deductible applies.	Not Covered	Not Covered
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<i>Physician Services for Inpatient Facility and Hospital Visits</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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<i>Administration of Anesthesia</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible
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<i>Allergy Testing and Treatment</i>	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.
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<i>Allergy Injections</i>	65% per visit No deductible applies.	65% per visit after Calendar Year deductible .	90% per visit No deductible applies.
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<i>Prenatal Visits</i>	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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services			
Hospital Emergency Facility	\$75 copay per visit then the plan pays 100% No deductible applies.	\$75 copay per visit then the plan pays 100% No deductible applies.	\$75 copay per visit then the plan pays 100% No deductible applies.
Non-Emergency Care in a Hospital Emergency Room	\$75 copay per visit then the plan pays 100% No deductible applies.	\$75 copay per visit then the plan pays 100% No deductible applies.	\$75 copay per visit then the plan pays 100% No deductible applies.

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 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 <i>(at a non-hospital free standing facility)</i>	\$50 copay per visit then the plan pays 100% No deductible applies	70% after Calendar Year deductible	\$50 copay per visit then the plan pays 90% No deductible applies
Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	\$50 copay per visit then the plan pays 100% No deductible applies	70% after Calendar Year deductible	\$50 copay per visit then the plan pays 100% No deductible applies

Important Notice

A separate **urgent care deductible** or **copay** applies for each visit to an **urgent care provider** for **urgent care**. If you are admitted to a **hospital** as an inpatient immediately following a visit to an urgent care provider, this **deductible** or **copay** is waived.

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

<i>Diagnostic and Preoperative Testing (except complex imaging services) Performed at a Hospital Outpatient Facility</i>	90% per procedure No deductible applies.	70% per procedure after Calendar Year deductible	90% per procedure No deductible applies
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Complex Imaging Services

<i>Complex Imaging</i>	90% per test No deductible applies	70% per test after Calendar Year deductible	90% per test No deductible applies
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Diagnostic Laboratory Testing

<i>Diagnostic Laboratory Testing</i>	90% per procedure No deductible applies	70% per procedure after Calendar Year deductible	90% per procedure No deductible applies
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Diagnostic X-Rays

<i>Diagnostic X-Rays</i>	90% per procedure No deductible applies.	70% per procedure after Calendar Year deductible	90% per procedure No deductible applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Outpatient Surgery</i>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible	90% per visit/surgical procedure after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Inpatient Facility Expenses</i>			
<i>Birth Center</i>	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.

<i>Hospital Facility Expenses</i> Room and Board (including maternity)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	120 days	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	100% per visit No deductible applies.	70% per visit after Calendar Year deductible	90% per visit No deductible applies.

<i>Private Duty Nursing (Outpatient)</i>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
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<i>Hospice Benefits</i>			
<i>Hospice Care –Facility Expenses</i> (Room & Board)	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible

Maximum Benefit per lifetime	30 days	30 days	30 days
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<i>Hospice Outpatient Visits</i>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
Maximum Benefit per lifetime	\$5,000	\$5,000	\$5,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> 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
<i>Inpatient Treatment of Mental Disorders</i>			
<i>Mental Disorders</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
Maximum Days per Calendar Year	40 days	40 days	40 days

<i>Outpatient Treatment Of Mental Disorders</i>			
<i>Mental Disorders</i>	65% No deductible applies.	65% per visit after Calendar Year deductible	90% No deductible applies.
Maximum Visits per Calendar Year	40 visits	40 visits	40 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Alcoholism and Substance Abuse</i>			
<i>Inpatient Treatment</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
Maximum Days per Calendar Year.	120 days	120 days	120 days

Outpatient Treatment of Alcoholism and Substance Abuse

Outpatient Treatment	65%	65% per visit after Calendar Year deductible	90%
	No deductible applies.		No deductible applies.

Maximum Visits per Calendar Year.	40 visits	40 visits	40 visits
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Important Notice:

Both **network** and **out of network** alcoholism and **substance abuse** and **mental disorders** treatment expenses accumulate toward any maximum shown above for alcoholism and **substance abuse** and **mental disorders** treatment expenses.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Obesity Treatment Surgical and Non Surgical

Outpatient Obesity Treatment (non surgical)	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
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Related Outpatient Morbid Obesity Surgery Services	90% per service after Calendar Year deductible	70% per service after Calendar Year deductible	90% per service after Calendar Year deductible
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited
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This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna.

Important Notice: If the overall plan Maximum Benefit shown in the Schedule of Benefits is exhausted, no additional **morbidity obesity** surgical treatment expenses are covered.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Transplant Services Facility and Non-Facility Expenses</i>				
<i>Facility Expenses</i>	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.
<i>Physician Services</i> (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				
<i>Other Covered Health Expenses</i>				
<i>Acupuncture</i>	65% No deductible applies.	65% after Calendar Year deductible	90% No deductible applies.	
Maximum Visits per Calendar Year.	20 visits	20 visits	20 visits	
<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible	90% after Calendar Year deductible	
<i>Diabetic Equipment, Supplies and Education</i>	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.	
<i>Durable Medical and Surgical Equipment</i>	65% per item No deductible	65% per item after Calendar Year deductible	90% per item No deductible	
<i>Jaw Joint Disorder Treatment</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	

<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	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.
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<i>Prosthetic Devices</i>	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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Outpatient Therapies</i>			
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<i>Chemotherapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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<i>Infusion Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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<i>Radiation Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Short Term Outpatient Rehabilitation Therapies</i>			
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<i>Outpatient Physical, Occupational, and Speech Therapy combined</i>	65% per visit No deductible	60% per visit after Calendar Year deductible	90% per visit No deductible
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<i>Outpatient Massage Therapy by a Licensed Massage Therapist</i>	65% per visit No deductible	60% per visit after Calendar Year deductible	90% per visit No deductible
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Combined Physical, Occupational, Massage Therapy and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits	60 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Spinal Manipulation</i>			
	65% per visit	60% per visit after Calendar Year deductible	90% per visit
	No deductible		No deductible
Spinal Manipulation Maximum visits per Calendar Year	24 visits	24 visits	24 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Generic Prescription Drugs</i>		
For each 30 day supply	The greater of \$5 or 10% of the negotiated charge not to exceed \$20	Not Covered
For more than a 30 day supply but less than a 91 day supply	The greater of \$10 or 10% of the negotiated charge not to exceed \$40	Not Covered

<i>Brand-Name Prescription Drugs</i>		
For each 30 day supply	The greater of \$10 or 25% of the negotiated charge not to exceed \$40	Not Covered
For more than a 30 day supply but less than a 91 day supply	The greater of \$80 or 25% of the negotiated charge not to exceed \$80	Not Covered

Coinsurance

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Plan Coinsurance</i>	100% of the negotiated charge	Not Covered

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.

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

Network Calendar Year Deductible

This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

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. Once you satisfy the **Maximum Out-of-Pocket Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Maximum Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Maximum Out-of-Pocket Limit**. This means once the amount of eligible expenses you or

your covered dependent have paid during the Calendar Year meets the Family **Maximum Out-of-Pocket Limit** amount in the *Schedule of Benefits*, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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**;
- Expenses to which a copayment is applied;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for outpatient treatments, including any outpatient **prescription drugs, mental disorder treatment expenses, substance abuse** and alcoholism treatment expenses;
- Non-covered expenses;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), 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**.

Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

The Calendar Year maximum benefit applies to the medical and **prescription drug** expense coverage described in the Booklet.

Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

The Lifetime Maximum Benefit applies to the medical and prescription drug expense coverage described in this Booklet-Certificate.

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 \$400 benefit reduction will be applied separately to each type of expense.

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.