Appendix A

SCHEDULE OF BENEFITS:

BENEFITS	IN NETWORK	OUT OF NETWORK
Preventative Services		
Health Maintenance Exam	Covered at 100%, one per calendar year, age 16 - Adult	Not Covered
Annual Gynecological Exam	Covered at 100%, one per calendar year	Not Covered
Pap Smear - Lab Services Only	Covered at 100%, one per calendar year	Not Covered
Well Baby and Child Care Visits	Covered at 100% *6 vsts birth through 1 year *2 vsts per year age 2 & 3 *1 vst per year age 4 through 15	Not Covered
Immunizations	Covered at 100%, up through age 15	Not Covered
Fecal Occult Blood Screening	Covered at 100%, one per calendar year	Not Covered
Flexible Sigmoidoscopy Exam- Colonoscopy covered per AMA guidelines	Covered at 100%, one per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered at 100%, one per calendar year	Not Covered
Chemical Profile	Covered at 100%, one per calendar year	Not Covered
Complete Blood Count	Covered at 100%, one per calendar year	Not Covered
Urinalysis	Covered at 100%, one per calendar year	Not Covered
Mammography Screening - one per calendar year, no age limit	Covered at 100%	Covered at 80% after deductible
Physician Office Services (Must be Medically Necessary)		
Office Visits	Covered at 100% after $5 copay	Covered at 80% after deductible; must be medically necessary
Outpatient and Home Visits	Covered at 100%	Covered at 80% after deductible; must be medically necessary
Office Consultations	Covered at 100%, after $5 copay	Covered at 80% after deductible; must be medically necessary
Urgent Care Center	Covered at 100%, after a $10 copay	Covered at 80% after deductible; must be medically necessary

Appendix A

SCHEDULE OF BENEFITS:

BENEFITS	IN NETWORK	OUT OF NETWORK
Emergency Medical Care		
Hospital Emergency Room - with approved diagnosis	Covered at 100% after a $25 copay. Waived if admitted or for an accidental injury.	Covered at 100% after a $25 copay. Waived if admitted or for an accidental injury.
Ambulance Services - Emergencies and when Medically Necessary and Prescribed by a Physician	Covered at 100%	Covered at 100% of approved amount
Diagnostic Services		
Laboratory and Pathology Tests	Covered at 100%	Covered at 80% after deductible
Diagnostic Tests and X-rays	Covered at 100%	Covered at 80% after deductible
Radiation Therapy	Covered at 100%	Covered at 80% after deductible
Maternity Services Provided by a Physician (includes care provided by a certified nurse midwife)		
Pre-and Post-Natal Care	Covered at 100%	Covered at 80% after deductible
Delivery and Nursery Care	Covered at 100%	Covered at 80% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (Unlimited Days)	Covered at 100%	Covered at 80% after deductible
Inpatient Consultations	Covered at 100%	Covered at 80% after deductible
Chemotherapy	Covered at 100%	Covered at 80% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care (up to 120 days per calendar year)	Covered at 100%	Covered at 100%
Hospice Care (limited to the lifetime dollar maximum which is adjusted annually by the state)	Covered at 100%	Covered at 100%
Home Health Care (unlimited visits)	Covered at 100%	Covered at 100%
Home Infusion Therapy - medically necessary	Covered at 100%	Covered at 100%
Surgical Services		
Surgery, including all related surgical services, anesthesia, and surgical assistance	Covered at 100%	Covered at 80% after deductible
Voluntary Sterilization	Covered at 100%	Covered at 80% after deductible

Consolidated Benefit Trust

Appendix A

SCHEDULE OF BENEFITS:

BENEFITS	IN NETWORK	OUT OF NETWORK
Human Organ Transplant		
Liver, Heart, Lung, Pancreas, and Heart-Lung (up to One Million Dollar lifetime maximum per transplant)	Covered at 100%	Covered at 100% (designated facilities only)
Bone Marrow	Covered at 100%	Covered at 80% after deductible
Kidney, Cornea, Skin and Bone Marrow	Covered at 100%	Covered at 80% after deductible
Mental Health Care and Substance Abuse		
Inpatient Mental Health Care	Covered at 100%	Covered at 80% after deductible
Inpatient Substance Abuse Care (unlimited days, up to state maximum)	Covered at 100%	Covered at 80% after deductible
Outpatient Mental Health Care, 50 vsts per year		
* Facility and Clinic	Covered at 90%	Covered at 80% after deductible
* Physician's Office	Covered at 90%	Covered at 80% after deductible
Outpatient Substance Abuse Care (up to the state dollar amount which is adjusted annually) (in approved facilities only)	Covered at 90%	Covered at 80% after deductible
Other Services		
Allergy Testing and Therapy	Covered at 100%	Covered at 80% after deductible
Chiropractic Spinal Manipulation (up to 38 visits per calendar year)	Covered at 100%	Covered at 80% after deductible
Outpatient Physical, Speech, and Occupational Therapy (up to 60 visits per calendar year)		
Facility and Clinic	Covered at 100%	Covered at 80% after deductible
Physician's Office - excludes speech and occupational therapy	Covered at 100%	Covered at 80% after deductible
Outpatient Diabetes Management Program (ODMP)	Covered at 100%	Covered at 80% after deductible
Durable Medical Equipment	Covered at 100%	Covered at 100%
Prosthetic and Orthotic Appliances	Covered at 100%	Covered at 100%
Private Duty Nursing	Covered at 90%	Covered at 90% after deductible
Hearing Care (includes exam and 1 aid per ear) - Plan maximum applies	Covered at 100% every 36 months	Covered at 80% after deductible every 36 months

Appendix A

SCHEDULE OF BENEFITS:

BENEFITS	IN NETWORK	OUT OF NETWORK
Deductibles and Copayments		
Deductible (per Benefit Year)	None	$250 per member, $500 per family per calendar year
Copayments * For Fixed (per service)	$5 office visits, $25 emergency room visits	$25 for emergency room visits
* For Percent (% of Allowable Charge)	10% for outpatient mental health care, outpatient substance abuse care and private duty nursing	20% for general services, mental health care, substance abuse care and private duty nursing. Services without a network are covered at the In Network level.
Out of Pocket Maximum * Fixed	None	None
* Percent, excludes mental health care, substance abuse and private duty nursing copayments	Not Applicable	$2,000 per member, $4,000 per family per calendar year

Dollar Maximums: Unlimited Lifetime maximum for covered services and as noted above for individual services; One Million Dollar ($1,000,000) lifetime per covered specified human organ transplant type.

The above schedule of benefits is meant only to be an easy-to-read summary; it is not a contract or a summary plan document. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the Plan Description. Payment amounts are based on the Aetna approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.