Schedule of Benefits

Employer: **Denison University**

ASA: 478811

Issue Date: February 9, 2009
Effective Date: April 15, 2009
Schedule: 1A
Booklet Base: 1

For: Aetna Choice POS II Medical Plan

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

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$300.00	$450.00
Family Deductible*	$600.00	$900.00

*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: $1,250.00.
- For **out-of-network** expenses: $2,500.00.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $1,875.00.
- For **out-of-network** expenses: $3,750.00.

Lifetime Maximum Benefit per person	$2,000,000.00	$2,000,000.00

Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, copayments, 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
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	$15.00 exam **copay** then the plan pays 100% No **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum Exams per 12 consecutive month period		
Adults age 18 to 65	1 exam	1 exam
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	$15.00 exam **copay** then the plan pays 100% No **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum Exams per 24 consecutive month period		
Under age 2		
first 12 months of life	7 exams	7 exams
13th-24th months of life	2 exams	2 exams
Maximum Exams per 12 consecutive month period		
For age 2 to 18	1 exam	1 exam
Routine Gynecological Exam	$15.00 exam **copay** then the plan pays 100% No **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum exams per Calendar Year	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography For covered females age 35-39 One Baseline Mammogram. For covered females age 40 and over.	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year (For covered females age 40 and over)	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	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.
Maximum tests per Calendar Year	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	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.
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears	$15.00 exam **copay** then the plan pays 100% No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Fecal Occult Blood Test	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.
Maximum tests per Calendar Year	1 test	1 test

Sigmoidoscopy Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	1 test
Colonoscopy age 50 and over	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.
Maximum tests per Calendar Year	1 test	1 test

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services *<11SECTION025>*		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$15.00 visit **copay** then the plan pays 100% No **deductible** applies.	70% per visit after Calendar Year **deductible**
Specialist Office Visits *All Specialists except those specifically listed in this schedule.*	$30.00 visit **copay** then the plan pays 100% No **deductible** applies.	70% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery		
Physician	$15.00 visit **copay** then the plan pays 100% No **deductible** applies.	70% per visit after Calendar Year **deductible**
Specialist	$30.00 visit **copay** then the plan pays 100% No **deductible** applies.	70% per visit after Calendar Year **deductible**

Walk-In Clinics Non-Emergency Visit	$15.00 visit **copay** then the plan pays 100% No **deductible** applies.	70% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	70% per exam after Calendar Year **deductible**
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.	70% per exam after Calendar Year **deductible**.
Immunizations (when not part of the physical exam)	100% per visit No **deductible** applies.	70% per visit after Calendar Year **deductible**
Prenatal 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services *<11SECTION030>*		
Hospital Emergency Facility	$100.00 **copay** per visit then the plan pays 100% No **deductible** applies	$100.00 **deductible** per visit then the plan pays 100% No **deductible** applies
Non-Emergency Care in a Hospital Emergency Room	70% after Calendar Year **deductible**	70% after Calendar Year **deductible**

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 *(at a non-hospital free standing facility)*	$35.00 **copay** per visit then the plan pays 100% No **deductible** applies	70% after Calendar Year **deductible**
Non-Urgent Use of Urgent Care Provider *(at a non-hospital free standing facility)*	70% after Calendar Year **deductible**	70% after Calendar Year **deductible**

Important Notice:
A separate **urgent care copay** or **deductible** 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 **copay/deductible** is waived.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing (except complex imaging services)	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
Complex Imaging Services		
Complex Imaging	90% per test after Calendar Year **deductible**	70% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Performed at a Hospital Outpatient Facility	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	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.
Hospital Facility Expenses		
Room and Board (including maternity)	90% per admission after Calendar Year **deductible**	70% 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**
Skilled Nursing Inpatient Facility	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit after the Calendar Year **deductible**	70% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	40 visits	40 visits
Maximum Visit Limit per *Calendar Year*	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Hospice Outpatient Visits	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses 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.
Comprehensive Infertility Expenses	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.
Artificial Insemination Maximum Benefit*	6 courses of treatment per lifetime*	6 courses of treatment per lifetime*
Ovulation Induction Maximum Benefit*	6 courses of treatment per lifetime*	6 courses of treatment per lifetime*
*Does not apply toward the plan max out of pocket limit		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
Mental Disorders	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**
Maximum per Calendar Year	30 days	30 days
Outpatient Treatment Of Mental Disorders		
Mental Disorders	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Alcoholism and Substance Abuse		
Inpatient Treatment	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**
Maximum Days per Calendar Year	30 days	30 days

Outpatient Treatment of Alcoholism and Substance Abuse		
Outpatient Treatment	50% per visit after the Calendar Year **deductible**	50% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	60 visits	60 visits

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

Transplant Services Facility and Non-Facility Expenses

Your coverage will be considered network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Facility Expenses	100% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services (including office visits)	100% per admission after Calendar Year **deductible**	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	Payable in accordance with the type of expense incurred and the place where service is provided.	70% per exam after Calendar Year **deductible**
Ground, Air or Water Ambulance	90% per trip after Calendar Year **deductible**	90% per trip after Calendar Year **deductible**
Durable Medical and Surgical Equipment	90% per item after the Calendar Year **deductible**	70% per item after the Calendar Year **deductible**

Jaw Joint Disorder Treatment	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	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.

Prescription Drugs		
Contraceptive Coverage and Diabetic Supplies and Insulin	90% per prescription or refill, after the Calendar Year **deductible**	70% per prescription or refill, after the Calendar Year **deductible**
Prosthetic Devices	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**
Outpatient Therapies		
Chemotherapy	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Infusion Therapy	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Radiation Therapy	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Short Term Outpatient Rehabilitation Therapies *<11SECTION095>*		
Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation	$30.00 **copay** per visit then the plan pays 100% No **deductible** applies	70% per visit after the Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy and Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic Prescription Drugs		
For each 30 day supply	$5.00	50% Deductible waived
For more than a 30 day supply but less than a 91 day supply	$10.00	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply	20% of the **negotiated charge** with a maximum of $35.00	50% Deductible waived
For more than a 30 day supply but less than a 91 day supply	20% of the **negotiated charge** with a maximum of $70	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply	30 % of the **negotiated charge** with a maximum of $55.00	50%, Deductible waived
For more than a 30 day supply but less than a 91 day supply	30% of the **negotiated charge** with a maximum of $110.00	Not Applicable

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.

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**.

Network Family Deductible Limit

When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a 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 *<09SECTION15>*

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 Summary 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;
- Expenses incurred for outpatient treatments, including any outpatient **prescription drugs**, **mental disorder** treatment expenses, **substance abuse** and alcoholism treatment expenses;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- 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**.

Maximum Benefit Provisions

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.

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.

Precertification Benefit Reduction

The Booklet-Certificate 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 $200 benefit reduction will be applied separately to **certain designated procedures covered under the outpatient precertification program**.
- **A $400 benefit reduction will be applied separately to each type of expense shown in the List of Services and Supplies Which Require Precertification**.

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.