Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the employer for additional information.

Prepared for:

Employer:	Segal
Contract number:	MSA-0317774
Plan name:	Traditional Choice - Enhanced Plan
Schedule of benefits:	4A
Plan effective date:	January 1, 2026
Plan issue date:	November 4, 2025

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12-month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

Important note:
Covered services are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a **provider**.

This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentages**, if any, for **covered services** after you meet your **deductible**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Precertification covered services reduction

Your booklet contains a complete description of the **precertification** process. You will find details in the *How your plan works –Medical necessity and precertification requirements* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A $400 benefit reduction applied separately to each type of **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	Amount
Individual	$300 per year
Family	$600 per year

Per admission deductible

Per admission deductible type	Amount
Per admission **deductible**	$100 per admission

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	Amount
Individual	$2,500 per year
Family	$5,000 per year

General coverage provisions
This section explains the **deductible, maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions
The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services**.

Individual deductible
You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible** when one applies.

Per admission cost share or deductible
A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **deductible**.

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**.

Individual maximum out-of-pocket limit
- This plan may have an individual and family **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.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit
After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-urgent use of an urgent care **provider**

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Covered services

Abortion

Description	Cost share
Abortion	Covered based on type of service and where it is received

Acupuncture

Description	Cost share
Acupuncture	80% per visit after **deductible**

Visit limit per year	10

Ambulance services

Description	Cost share
Emergency services	80% per trip after **deductible**
Non-**emergency services** ground, air, or water ambulance	Not covered

Applied behavior analysis

Description	Cost share
Applied behavior analysis	Covered based on type of service and where it is received

Autism spectrum disorder

Description	Cost share
Diagnosis and testing	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	Cost share
Inpatient services-**room and board** including **residential treatment facility**	$100 then the plan pays 80% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	80% per admission after **deductible**

Description	Cost share
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received

Description	Cost share
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	80% per visit after **deductible**

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	Cost share
Inpatient services-**room and board** during a **hospital stay**	$100 then the plan pays 80% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	80% per admission after **deductible**

Description	Cost share
Outpatient office visit to a **physician** or **behavioral health provider**	80% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	80% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received

Description	Cost share
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program	80% per visit after **deductible**

Clinical trials

Description	Cost share
Experimental or investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	Cost share
DME	80% per item after **deductible**

Emergency services

Description	Cost share
Emergency room	80% per visit after **deductible**

Non-emergency care in a **hospital** emergency room	50% per visit after **deductible**

Emergency services important note: You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Habilitation therapy services

Outpatient physical (PT), occupational (OT) therapies

Description	Cost share
PT, OT therapies	Covered based on type of service and where it is received

Outpatient speech therapy (ST)

Description	Cost share
ST therapy	Covered based on type of service and where it is received

Hearing exams

Description	Cost share
Hearing exams	Covered based on type of service and where it is received

Home health care

A visit is a period of 4 hours or less

Description	Cost share
Home health care	80% per visit after **deductible**

Visit limit per year	120

Home health care important note:
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	Cost share
Inpatient services - **room and board**	$100 then the plan pays 80% per admission after **deductible**

Other inpatient services and supplies	80% per admission after **deductible**

Description	Cost share
Outpatient services	80% per visit after **deductible**

Limit per lifetime	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	Cost share
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**

Description	Cost share
Other inpatient services and supplies	80% per admission after **deductible**

Infertility services

Basic infertility

Description	Cost share
Treatment of basic infertility	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Description	Cost share
Outpatient services performed at ART **specialist** office	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Covered based on type of service and where it is received
Fertility preservation	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	Cost share
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	80%per visit after **deductible**
Other services and supplies	80% per visit after **deductible**

Maternity and related newborn care important note:
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

Obesity surgery

Description	Cost share
Inpatient services – **room and board**	$100 then the plan pays 80% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**

Description	Cost share
Outpatient services	80% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	Cost share
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received

Outpatient surgery

Description	Cost share
At **hospital** outpatient department	80% after **deductible**
At facility that is not a **hospital**	80% after **deductible**
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	Cost share
Physician office hours (not surgical, not preventive)	80% per visit after **deductible**
Physician surgical services	80% per visit after **deductible**

Description	Cost share
Physician visit during inpatient **stay**	80% per visit after **deductible**

Description	Cost share
Physician telemedicine consultation	80% per visit after **deductible**

Specialist

Description	Cost share
Specialist office hours (not surgical, not preventive)	80% per visit after **deductible**
Specialist surgical services	80% per visit after **deductible**

Description	Cost share
Specialist telemedicine consultation	80% per visit after **deductible**

All other services not shown above

Description	Cost share
All other services	80% per visit after **deductible**

Prescription drugs - outpatient

Description	Cost share
Prescription drugs	100% per supply, no **deductible** applies

Preventive care

Description	
Preventive care services	100% per visit, no **deductible** applies
Breast feeding counseling and support	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Generic preventive care female contraceptives (birth control)	100%

Preventive care drugs and supplements	100%
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	100%
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	100%
Limit	Two 90 day treatments only
Routine cancer screenings	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam per year after that age, up to age 22; 1 exam per year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Private duty nursing

Up to 8 hours equals one shift

Description	Cost share
Outpatient services	80% per visit after **deductible**

Visit/shift limit per year	70

Prosthetic devices

Description	Cost share
Prosthetic devices	Covered based on type of service and where it is received

Reconstructive surgery and supplies

Including breast **surgery**

Description	Cost share
Surgery and supplies	Covered based on type of service and where it is received

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

Description	Cost Share
Cardiac rehabilitation	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	Cost Share
Pulmonary rehabilitation	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	Cost Share
Cognitive rehabilitation	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	Cost share
	80% per visit after **deductible**

Spinal Manipulation

Description	Cost share
	80% per visit after **deductible**

Skilled nursing facility

Description	Cost share
Inpatient services - **room and board**	$100 then the plan pays 80% per admission after **deductible**
Other inpatient services and supplies	80% per admission after **deductible**

Day limit per year	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	Cost share
	80% per visit after **deductible**

Diagnostic lab work

Description	Cost share
	80% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	Cost share
	80% per visit after **deductible**

Therapies

Chemotherapy

Description	Cost share
Chemotherapy services	Covered based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	Cost share
Services and supplies	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	Cost share
In **physician** office	80% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received
In the home	80% per visit after **deductible**
At **hospital** outpatient department	80% per visit after **deductible**
At facility that is not a **hospital**	80% per visit after **deductible**

Radiation therapy

Description	Cost share
Radiation therapy	Covered based on type of service and where it is received

Respiratory therapy

Description	Cost share
Respiratory therapy	Covered based on type of service and where it is received

Transplant services

Description	Cost share
Inpatient services and supplies	$100 then the plan pays 80% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	Cost share
Urgent care facility	80% per visit after **deductible**

Non-urgent use of an urgent care facility or **provider**	Not covered

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic.**

Description	Cost share
Non-**emergency services**	80% per visit after **deductible**
Preventive care immunizations	100% per visit, no **deductible** applies
Preventive care immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	100% per visit, no **deductibl**e applies
Preventive screening and counseling limits	See the *Preventive care* section of the schedule