

Schedule of Benefits

Employer: Brand Services, LLC

ASA: 667000

Issue Date: January 6, 2012

Effective Date: January 1, 2012

Schedule: 3A

Booklet Base: 3

For: Choice POS II (Aetna Choice POS II) - Option C

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*	\$2,500	\$5,000
Family Deductible*	\$7,500	\$15,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Payment Limit excludes plan **deductible**, **copayments** and **precertification** penalties

Individual Payment Limit:

- For **network** expenses: \$3,500.
- For **out-of-network** expenses: \$7,000.

Family Payment Limit:

- For **network** expenses: \$10,500.
- For **out-of-network** expenses: \$21,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited
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Payment Percentage 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, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered
Maximum Exams per 12 consecutive month period		
Adults age 18 to 65	1 exam	Not Covered
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	Not Covered
Well Child Exams Includes coverage for immunizations	100% per exam No Calendar Year deductible applies.	Not Covered
Maximum Exams		
Under age 3		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	3 exams	Not Covered
25th-36th months of life	3 exams	Not Covered
Maximum Exams per 12 consecutive month period		
For age 3 to 18	1 exam	Not Covered
Routine Gynecological Exam	100% per exam No Calendar Year deductible applies.	Not Covered

Maximum exams per Calendar Year	1 exam	Not Covered
<i>Hearing Exam</i>	100% per exam No Calendar Year deductible applies.	Not Covered
Maximum exams per 12 month period	1 exam	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Cancer Screenings</i>		
<i>Routine Mammography</i>	100% per test No Calendar Year deductible applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Prostate Specific Antigen Test</i> For covered males age 40 and over	80% per test No Calendar Year deductible applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Routine Digital Rectal Exam</i> For covered males age 40 and over	80% per test No Calendar Year deductible applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Routine Pap Smears</i>	100% per test No Calendar Year deductible applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not covered

<i>Fecal Occult Blood Test</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Sigmoidoscopy</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum Tests per 5 consecutive year period	1 test	Not Covered
<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.	Not Covered
Maximum Tests per 5 consecutive year period	1 test	Not Covered
<i>Colonoscopy</i> age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum Tests per 10 consecutive year period	1 test	Not Covered
<i>Family Planning Services</i>		
<i>Family Planning Services</i>	80% after Calendar Year deductible	60% after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Care</i>		
<i>Eye Examinations</i> including refraction	100% per exam No Calendar Year deductible applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Physician Services</i>		
<i>Office Visits to Primary Care Physician</i> Office visits (non-surgical) to non-specialist	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Specialist Office Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Physician Office Visits-Surgery</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Walk-in Clinics Non-Emergency Visit</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
<i>Allergy Injections</i>	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.
<i>Immunizations (when not part of the physical exam)</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.
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
See Important Note Below		
<p>Important Note: Please note that as these providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and payment percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
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Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

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.
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Non-Urgent Use of Urgent Care Provider <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not covered	Not covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible

<i>Diagnostic Laboratory Testing</i>		
<i>Diagnostic Laboratory Testing</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible

<i>Diagnostic X-Rays (except Complex Imaging Services)</i>		
<i>Diagnostic X-Rays</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<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.

<i>Hospital Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	100 days	100 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	100% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
<i>Private Duty Nursing (Outpatient)</i>	100% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Hospice Outpatient Visits	100% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		

MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year deductible	60% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Inpatient Treatment of Substance Abuse

Hospital Facility Expenses

Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
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<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
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Transplant Services Facility and Non-Facility Expenses

<i>Transplant 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.
<i>Transplant 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</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.
<i>Ground, Air or Water Ambulance</i>	80% after Calendar Year deductible	80% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	80% per item after the Calendar Year deductible	60% per item after the 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.
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</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.
<i>Infusion Therapy</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.
<i>Radiation Therapy</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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical and Occupational Therapy only</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

Combined Physical and Occupational Therapy Maximum visits per Calendar Year	40 visits	40 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Speech Therapy only</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

Speech Therapy Maximum visits per Calendar Year	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	26 visits	26 visits
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Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each 30 day supply (retail)	\$10	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$20	Not Covered

<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply (retail)	\$40	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$80	Not Covered

Non-Preferred Generic Prescription Drugs

For each 30 day supply (retail)	\$10	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$20	Not Covered

Non-Preferred Brand-Name Prescription Drugs

For each 30 day supply (retail)	\$60	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	\$120	Not Covered

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

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.

Precertification 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

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 pharmacy 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.

Payment Limit

The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Payment Limit** applies to both network and out-of-network benefits.

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

There is also a Family **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets three times the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

The **Payment Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Payment Limit** will be applied to satisfy the in-network **Payment Limit** and **covered expenses** applied to the in-network **Payment Limit** will be applied to satisfy the out-of-network **Payment Limit**.

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; 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.

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 shown in the List of Services and Supplies Which Require Precertification.
- A \$200 benefit reduction will be applied separately to certain designated procedures covered under the outpatient precertification program.

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.