

Schedule of Benefits

(GR-29N 01-01 01 OK)

Employer: Choctaw Enterprises

Group Policy Number: GP-819977

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Schedule: 1A

Cert Base: 1

For: Open Access Managed Choice- Contract Employees

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

PPO Medical Plan (GR-9N 11-005 02)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$1,500	\$3,000
Family Deductible*	\$4,500	\$9,000
<i>Per Admission Deductible</i>	Not Applicable	\$250 per admission

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

Plan Coinsurance Limit excludes plan **deductible, copayments and precertification** penalties.

Individual Coinsurance Limit:

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

Family Coinsurance Limit:

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

<i>Lifetime Maximum Benefit per person</i>	\$2,000,000	\$2,000,000
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(GR-9N 11-010 -01 OK)

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. 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.	\$35 exam copay then the plan pays 100% No deductible applies.	50% per exam after Calendar Year deductible
Maximum Exams per 24 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	\$35 exam copay then the plan pays 100% No deductible applies.	50% per exam after Calendar Year deductible
Child Immunizations	100%	100%
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	\$50 exam copay then the plan pays 100% No deductible applies.	50% per exam after Calendar Year deductible
Maximum exams for Adults per Calendar Year	1 exam	1 exam

Hearing Exam for children under age 18 only (GR-9N 11-010 -01 OK)	\$50 exam copay then the plan pays 100%	50% per exam after Calendar Year deductible
	No deductible applies.	
Maximum exams per 24 month period	1 exam	1 exam
Hearing Hardware for children under age 18	80% after Calendar Year deductible	50% per exam after Calendar Year deductible
Hearing Supply Maximum per 48 month period	1 hearing aid per ear	1 hearing aid per ear
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings (GR-9N-S-11-15-01 OK)		
Routine Mammography	100%	100%
Maximum Benefit per Mammography screening	Unlimited	Unlimited
Maximum visits for covered females age 35-39 years of age every 5 years	1 visit	1 visit
Maximum visits per Calendar Year for covered females age 40 years of age or older	1 visit	1 visit
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.
Bone Density Test (GR-9N-S-11-15-01 OK)	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 Benefit per test	\$150	\$150

<i>Routine Pap Smears</i>	100% per test No deductible applies.	50% per test after Calendar Year deductible
Maximum tests per Calendar Year	1 test	1 test
<i>Fecal Occult Blood Test</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>Sigmoidoscopy</i> 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.
<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.	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
<i>Colonoscopy</i> 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 10 consecutive year period	1 test	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.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Care</i> (GR-2N 11-020-01 OK)		
<i>Eye Examinations</i> including refraction	\$50 exam copay then the plan pays 100% No deductible applies.	50% per exam after Calendar Year deductible
Maximum Benefit per 12 consecutive month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services (GR-9N-S-11-25-06 OK)		
<i>Physicians and Specialists Office Visits (non-surgical)- This includes non-surgical visits to a physician or specialist, E-visit online consultation, routine OB/GYN exam, vision exam, routine hearing exam, outpatient mental illness, outpatient physical therapy, outpatient occupational therapy, outpatient speech therapy, and outpatient spinal manipulation.</i>		
<i>Primary Care Physician</i>	\$35 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
Alternatives to Physicians' Office Visits (GR-9N S-11-25-02)		
<i>E-Visit Online Internet Consultation by a PCP</i>	\$30 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
<i>Specialist Office Visits</i>	\$50 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
Alternative to Specialist Office Visit (GR-9N S-11-25-02)		
<i>E-visits Online Internet Consultation by a Specialist</i>	\$30 per visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
Physician Office Visits-Surgery		
<i>Physician</i>	\$35 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
<i>Specialist</i>	\$50 visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies.	
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible	50% 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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Allergy Injections	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.
Immunizations (when not part of the physical exam)	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.
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 (GR-9N 11-030 -01 OK)		
Hospital Emergency Facility	\$150 copay per visit then the plan pays 100%	\$150 deductible per visit then the plan pays 100%
	No deductible applies	No deductible applies
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
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)	\$75 copay per visit then the plan pays 100%	50% after Calendar Year deductible
	No deductible applies	
Urgent Medical Care (from other than a non-hospital free standing facility)	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

(at an Emergency Room or a non-hospital free standing facility)

Not covered

Not covered

Important Notice:

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

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 (GR-9N 11-035-01 OK)

Diagnostic and Preoperative Testing
(except complex imaging services)

80% per procedure after Calendar Year **deductible**

50% per procedure after Calendar Year **deductible**

Complex Imaging Services

Complex Imaging

80% per test after Calendar Year **deductible**

50% per test after Calendar Year **deductible**

Diagnostic Laboratory Testing

Diagnostic Laboratory Testing

80% per procedure after Calendar Year **deductible**

50% per procedure after Calendar Year **deductible**

Diagnostic X-Rays (except Complex Imaging Services)

Performed at a Hospital Outpatient Facility

80% per procedure after Calendar Year **deductible**

50% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible	50% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
<i>Birthing 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> Room and Board (including maternity)	80% per admission after Calendar Year deductible	\$250 per admission deductible after Calendar Year deductible then the plan pays 50%
Other than Room and Board	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
Maximum Days per Calendar Year	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits (GR-9N 10-050-01) (GR-9N 11-050-01)		
<i>Home Health Care (Outpatient)</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	100 visits	100 visits

<i>Private Duty Nursing (Outpatient)</i>	80% per visit after the Calendar Year deductible	50% per visit after the Calendar Year deductible
Maximum Visit Limit per <i>Calendar Year</i>	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.

Hospice Benefits		
<i>Hospice Care - Facility Expenses</i> (Room & Board)	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	80% per admission after Calendar Year deductible	50% per admission after Calendar Year deductible

Maximum Benefit per lifetime	Unlimited days	Unlimited days
<i>Hospice Outpatient Visits</i>	80% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible
<i>Comprehensive Infertility 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i> (GR-9N 11-060-01) (GR-9N 10-060 01)		

<i>Mental Disorders</i>	80% per admission after Calendar Year deductible	\$250 per admission deductible after Calendar Year deductible then the plan pays 50%
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<i>Outpatient Treatment Of Mental Disorders</i>		
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<i>Mental Disorders</i>	\$50 per visit copay then the plan pays 100%	50% per visit after the Calendar Year deductible
	No deductible applies	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Alcoholism and Substance Abuse</i> (GR-9N 11-070-01)		

<i>Inpatient Treatment</i>	80% per admission after Calendar Year deductible	\$250 per admission deductible after Calendar Year deductible then the plan pays 50%
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<i>Outpatient Treatment of Alcoholism and Substance Abuse</i>		
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<i>Outpatient Treatment</i>	\$50 per visit copay then the plan pays 100%	50% per visit after Calendar Year deductible
	No deductible applies	

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i> (GR-9N S-11-065-01) (GR-9N S-11-075-01) (GR-9N S-11-080-01)			
<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.
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i> (GR-9N S-11-65-01) (GR-9N S-11-080-01)		
<i>Acupuncture</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	50% 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.
<i>Durable Medical and Surgical Equipment</i>	80% per item after the Calendar Year deductible	50% per item after the Calendar Year deductible
Maximum Benefit per Calendar Year	\$2,500	\$2,500
(GR-9N-S-11-085-01) (GR-9N S-11-080-01)		
<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 including scalp prosthesis and wigs necessary as a result of chemotherapy or 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
Outpatient Therapies (GR-9N 11-090-01)		
Chemotherapy	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.
Infusion Therapy	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.
Radiation Therapy	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
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined	\$50 per visit copay then the plan pays 100% No deductible applies	50% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	\$50 per visit copay then the plan pays 100% No deductible applies	50% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Anesthesia and Hospital Charges for Dental Care (GR-9N S-11-80-04 OK)		
	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.

Basic Vision Expense Coverage <24SECTION005>

<24SECTION005>

Vision Supply Maximum- \$200 per 12 month period.

Pharmacy Benefit (GR-9N-S-26-005-01)

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each 30 day supply	\$15	\$15
For more than a 30 day supply but less than a 91 day supply	\$30	Not Applicable
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply	\$35	\$35
For more than a 30 day supply but less than a 91 day supply	\$70	Not Applicable
<i>Non-Preferred Generic Prescription Drugs</i>		
For each 30 day supply	\$15	\$15
For more than a 30 day supply but less than a 91 day supply	\$30	Not Applicable
<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply	\$60	\$60
For more than a 30 day supply but less than a 91 day supply	\$120	Not Applicable
Coinsurance		
	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	50% of the recognized charge

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 (GR-9N S-09-05 01)

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*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions *(GR-9N S-09-05 01)*

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**.

Per Admission Deductible

A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

Covered expenses applied to the per admission **deductible** cannot be applied to any other **deductible** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayment** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Coinsurance Provisions (GR-9N S-09-020 01 OK)

Coinsurance

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 Coinsurance**”. 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 **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Coinsurance Limit

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

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

There is also a Family **Coinsurance Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family **Coinsurance 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 **Coinsurance Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Coinsurance Limit** will be applied to satisfy the in-network **Coinsurance Limit** and **covered expenses** applied to the in-network **Coinsurance Limit** will be applied to satisfy the out-of-network **Coinsurance Limit**.

Expenses That Do Not Apply to Your Coinsurance Limit

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

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- 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**;
- 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 (GR-9N S-09-025 01 OK)

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 will not deny benefits for certain covered expenses in any one Calendar Year.

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.

The Lifetime Maximum Benefit will not deny benefits for certain covered expenses.

Precertification Benefit Reduction *(GR-9N S-09-030 01 OK)*

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

General *(GR-9N S-28-01 01)*

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-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.