# Schedule of Benefits

*(GR-29N 01-01 01 OK)*

**Employer:** **Choctaw Enterprises**

**Group Policy Number:** **GP-819977**

**Issue Date:** March 31, 2010
**Effective Date:** January 1, 2010
**Schedule:** 3A
**Cert Base:** 3

For: Open Choice Medical Plan

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-S-10-005-01)*

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| **Calendar Year Deductible*** | | | |
| ***Individual Deductible**** | $1,500 | $3,000 | $1,500 |
| ***Family Deductible**** | $4,500 | $9,000 | $4,500 |
| **Per Admission Deductible*** | Not applicable | $250 per admission | Not applicable |

*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: $2,000.
- For **out-of-network** expenses: $3,000.

**Family Coinsurance Limit**:

- For **network** expenses: $4,000.
- For **out-of-network** expenses: $6,000.

| | | | |
|---|---|---|---|
| ***Lifetime Maximum Benefit Per Person*** | $2,000,000 | $2,000,000 | $2,000,000 |

***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 and other health care, unless specifically stated otherwise.***

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Wellness Benefits*** *(GR-9N-S-10-005-01) (GR-9N-S-10-010-01)* | | | |
| ***Routine Physical Exams*** Adults only. Includes coverage for immunizations. | $35 exam **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per exam after Calendar Year **deductible** | 80% per exam<br><br>No **deductible** applies. |
| Maximum Exams per 24 consecutive months period | | | |
| Adults, age 18 to 65 | 1 exam | 1 exam | 1 exam |
| Maximum Exams per 12 consecutive months period | | | |
| Adults, age 65 and over | 1 exam | 1 exam | 1 exam |
| ***Well Child Exams*** Includes coverage for immunizations. | $35 exam **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per exam after Calendar Year **deductible** | 80% per exam<br><br>No **deductible** applies. |
| ***Childhood Immunizations Only*** | 100% | 100% | 100% |

| | | | |
|---|---|---|---|
| Maximum Exams per 24 consecutive month period | | | |
| Under age 2 | | | |
| first 12 months of life | 7 exams | 7 exams | 7 exams |
| 13th-24th months of life | 2 exams | 2 exams | 2 exams |
| Maximum Exams per 12 consecutive month period | | | |
| From age 2 to age 18 | 1 exam | 1 exam | 1 exam |
| ***Routine Gynecological Exam*** | $50 exam **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per exam after Calendar Year **deductible** | 80% per exam<br><br>No **deductible** applies. |
| Maximum Exams per 12 consecutive month period | 1 exam | 1 exam | 1 exam |
| ***Hearing Exam Children under age 18*** | $50 exam **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per exam after Calendar Year **deductible** | 80% per exam<br><br>No **deductible** applies. |
| Maximum Exams for Children under age 18 per 24 month period | 1 exam | 1 exam | 1 exam |
| ***Hearing Hardware Children under age 18*** | 80% after Calendar Year **deductible** | 50% per exam after Calendar Year **deductible** | 80% per exam after Calendar Year **deductible** |
| Hearing Supply Maximum per 48 month period | 1 hearing aid per ear | 1 hearing aid per ear | 1 hearing aid per ear |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Routine Cancer Screenings*** *(GR-9N-S-10-15-01 OK)* | | | |
| ***Routine Mammography*** For covered females age 35 and over. | 100% per test<br><br>No **deductible** applies. | 100% per test<br><br>No **deductible** applies. | 100% per test<br><br>No **deductible** applies. |

| | | | |
|---|---|---|---|
| Maximum Benefit per Mammography screening | Unlimited | Unlimited | Unlimited |
| Maximum visits for covered females age 35-39 years of age every 5 years | 1 visit | 1 visit | 1 visit |
| Maximum visits per Calendar Year for covered females age 40 years of age or older | 1 visit | 1 visit | 1 visit |
| ***Prostate Specific Antigen Test and 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. | 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 | 1 test |
| ***Bone Density Test*** *(GR-9N-S-10-15-01 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Benefit per test | $150 | $150 | $150 |
| ***Colorectal Cancer examinations and laboratory tests*** | 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. |
| ***Family Planning Services*** | 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 | OTHER HEALTH CARE |
|---|---|---|---|
| ***Vision Care*** *(GR-9N-S-10-020-01)* | | | |
| ***Eye Examinations*** (including refraction) | $50 exam copay then the plan pays 100%<br><br>No **deductible** applies. | 50% per exam after Calendar Year **deductible** | 80% per exam<br><br>No **deductible** applies. |

| | | | |
|---|---|---|---|
| Maximum Benefit per 24 consecutive month period | 1 exam | 1 exam | 1 exam |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Physician Services*** *(GR-9N-S-10-25-02)* | | | |
| ***Physician Office Visits*** (*non-surgical*) | $35 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |
| ***Alternative to Physician Office Visit*** *(GR-9N-S-10-025-03 OK)* | | | |
| ***E-visit Online Consultation by a Physician*** | $30 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Specialist Office Visits*** | $50 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |
| ***Alternative to Specialist Office Visit*** *(GR-9N-S-10-025-03 OK)* | | | |
| ***E-visit Online Consultation by a Specialist*** | $30 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |
| ***Physician Office Visits-Surgery*** | | | |
| ***Physician*** | $35 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |
| ***Specialist*** | $50 visit **copay** then the plan pays 100%<br><br>No **deductible** applies. | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies. |

| | | | |
|---|---|---|---|
| ***Physician Services for Inpatient Facility and Hospital Visits*** | 80% per visit after Calendar Year **deductible** | 50% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Administration of Anesthesia*** | 80% per procedure after Calendar Year **deductible** | 50% per procedure after Calendar Year **deductible** | 80% 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. | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Immunizations for Adults over the age 18 (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. | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Emergency Medical Services*** *(GR-9N S-10-30-02)* | | | |
| ***Hospital Emergency Facility*** | $150 **copay** per visit then the plan pays 100%<br><br>No **deductible** applies. | $150 **deductible** per visit then the plan pays 100%<br><br>No **deductible** applies. | $150 **deductible** per visit then the plan pays 100%<br><br>No **deductible** applies. |
| ***Non-Emergency Care in a Hospital Emergency Room*** | 50% after Calendar Year **deductible** | 50% after Calendar Year **deductible** | 50% 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)* | $75 **copay** per visit then the plan pays 100%<br><br>No **deductible** applies | 50% after Calendar Year **deductible** | $75 **deductible** per visit then the plan pays 100%<br><br>No **deductible** applies |
| ***Urgent Medical Care*** *(from other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. |
| ***Non-Urgent Use of Urgent Care Provider*** *(at an Emergency Room or a non-hospital free standing facility)* | Not Covered | Not Covered | Not Covered |

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

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

| **PLAN FEATURES** | | | |
|---|---|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** *(GR-9N-S-10-035-01)* | | | |
| ***Diagnostic and Preoperative Testing (except complex imaging services)*** | 80% per procedure after Calendar Year **deductible** | 50% per procedure after Calendar Year **deductible** | 80% 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** | 80% per test after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Diagnostic Laboratory Testing*** | | | |
| ***Diagnostic Laboratory Testing*** | 80% per procedure after Calendar Year **deductible** | 50% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |
| ***Diagnostic X-Rays*** | | | |
| ***Diagnostic X-Rays*** | 80% per procedure after Calendar Year **deductible** | 50% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Outpatient Surgery*** *(GR-9N-S-10-040-01)* | | | |
| ***Outpatient Surgery*** | 80% per visit/surgical procedure after Calendar Year **deductible** | 50% per visit/surgical procedure after Calendar Year **deductible** | 80% per visit/surgical procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Inpatient Facility Expenses*** *(GR-9N 10-045 01) (GR-9N-S-10-040-01)* | | | |
| ***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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Hospital Facility Expenses*** 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% | 80% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 50% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| ***Skilled Nursing Inpatient Facility*** | 80% per admission after Calendar Year **deductible** | 50% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Maximum Days per Calendar Year | 90 days | 90 days | 90 days |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Specialty Benefits*** *(GR-9N 10-050-01)* | | | |
| ***Home Health Care (Outpatient)*** | 80% per visit after Calendar Year **deductible** | 50% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| Maximum Visits per Calendar Year | 100 | 100 | 100 |
| ***Hospice Benefits*** | | | |
| ***Hospice Care –Facility Expenses*** (Room & Board) | 80% per admission after the Calendar Year **deductible** | $250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 50% | 80% per admission after the Calendar Year **deductible** |
| ***Hospice Care – Other Expenses during a stay*** | 80% per admission after the Calendar Year **deductible** | 50% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 80% per visit after the Calendar Year **deductible** | 50% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible** |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Infertility Treatment*** *(GR-9N-S-10-055-01)* | | | |
| ***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. | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Inpatient Treatment of Mental Disorders*** *(GR-9N 10-060 01)* | | | |
| ***Mental Disorders*** | 80% per admission after Calendar Year **deductible** | 50% per admission after Calendar Year **deductible** | 50% per admission after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| ***Outpatient Treatment Of Mental Disorders*** | | | |
| ***Mental Disorders*** | $50 per visit **copay** then the plan pays 100%<br><br>No **deductible** applies | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Inpatient Treatment of Alcoholism and Substance Abuse*** *(GR-9N-S-10-070-01)* | | | |
| ***Inpatient Treatment*** | 100% per admission after Calendar Year **deductible** | 50% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| ***Outpatient Treatment of Alcoholism and Substance Abuse*** | | | |
| ***Outpatient Treatment*** | $50 per visit **copay** then the plan pays 100%<br><br>No **deductible** applies | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies |

| **PLAN FEATURES** | **NETWORK (IOE Facility)** | **NETWORK (Non-IOE Facility)** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|---|
| ***Transplant Services Facility and Non-Facility Expenses*** *(GR-9N-S-10-075-01)* | | | | |
| ***Facility 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. | 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. |
| ***Physician Services*** (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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| **PLAN FEATURES** | | | |
|---|---|---|---|
| ***Other Covered Health Expenses*** *(GR-9N-S-10-80-01 OK)* | | | |
| ***Acupuncture*** | 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. |

| | | | |
|---|---|---|---|
| ***Ground, Air or Water Ambulance*** | 100% after Calendar Year **deductible** | 50% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| ***Diabetic Equipment, Supplies and Education*** | 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. |
| ***Durable Medical and Surgical Equipment*** | 100% per item after Calendar Year **deductible** | 50% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** |
| ***Maximum Benefit per 12 consecutive month period*** | $2,500 | $2,500 | $2,500 |
| ***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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Prosthetic Devices including scalp prosthesis and wigs necessary as a result of chemotherapy or 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Outpatient Therapies*** *(GR-9N-S-10-090-01)* | | | |
| ***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. | 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. | 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. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** *(GR-9N-S-10-095-01)* | | | |
| ***Outpatient Physical, Occupational, and Speech Therapy combined*** | 100% per visit<br><br>No **deductible** applies | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies |
| Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year *(GR-9N S-10-95-01)* | 60 visits | 60 visits | 60 visits |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Spinal Manipulation*** *(GR-9N-S-10-095-01)* | | | |
| | $50 per visit **copay** then the plan pays 100%<br><br>No **deductible** applies | 50% per visit after Calendar Year **deductible** | 80% per visit<br><br>No **deductible** applies |

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

**Copays/Deductibles**

| **PER PRESCRIPTION COPAY/DEDUCTIBLE** | **NETWORK** | **OUT-OF-NETWORK** |
|---|---|---|
| ***Preferred Generic Prescription Drugs*** | | |
| For each 30 day supply | $15 | $15 |
| For more than a 30 day supply but less than a 91 day supply | $30 | Not Applicable |
| ***Preferred Brand-Name Prescription Drugs*** | | |
| For each 30 day supply | $35 | $35 |
| For more than a 30 day supply but less than a 91 day supply | $70 | Not Applicable |

| ***Non-Preferred Generic Prescription Drugs*** | | |
|---|---|---|
| For each 30 day supply | $15 | $15 |
| For more than a 30 day supply but less than a 91 day supply | $30 | Not Applicable |

| ***Non-Preferred Brand-Name Prescription Drugs*** | | |
|---|---|---|
| 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.

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductible** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

**Covered expenses** applied to the per admission **deductible** cannot be applied to any other or **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.

## 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.