

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: 2A

Cert Base: 2

For: Traditional Choice- Contract Employees

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

Comprehensive Medical Plan (GR-9N-S-13-10-01-OK)

PLAN FEATURES

Calendar Year Deductible*	\$1,500
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Family Deductible*	\$4,500
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*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

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

Individual Coinsurance Limit: \$2,000

Family Coinsurance Limit: \$4,000

PLAN FEATURES

<i>Lifetime Maximum Benefit per person</i>	\$2,000,000
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Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, 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.

PLAN FEATURES

Wellness Benefits (GR-9N-S-13-10-01-OK)

<i>Routine Physical Exams</i> Adults only Includes coverage for immunizations.	100% per exam No deductible applies.
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Maximum Exams per 24 consecutive month period	
Age 18 to age 65	1 exam
Maximum Exams per 12 consecutive month period	
Age 65 and over	1 exam

<i>Well Child Exams</i> Includes coverage for immunizations. Child Immunizations Only	100% per exam No deductible applies. 100%
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<i>Routine Gynecological Exam</i>	100% per exam No deductible applies.
Maximum per 12 consecutive month period	1 exam

<i>Hearing Exam</i> Children under age 18	100% per exam after Calendar Year deductible
Maximum Exam for Children under age 18 per 24 month period	1 exam

<i>Hearing Hardware</i> Children under age 18	80% per exam after Calendar Year deductible
Hearing Supply Maximum per 48 month period	1 hearing aid per ear

PLAN FEATURES
Routine Cancer Screenings (GR-9N-S-13-15-01 OK)

<i>Routine Mammography</i> For covered females age 35 and over.	100% per test No deductible applies.
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Maximum Benefit per Mammography screening	Unlimited
Maximum visits for covered females age 35-39 years of age every 5 years	1 visit
Maximum visits per Calendar Year for covered females age 40 years of age or older	1 visit
Maximum Test per Calendar Year	1 test
<i>Bone Density Test</i> (GR-9N-S-13-15-01 OK)	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Benefit per test	\$150
<i>Colorectal Cancer Examinations and Laboratory tests</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Fecal Occult Blood Test</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Family Planning Services</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
PLAN FEATURES	
<i>Vision Care</i> (GR-9N-S-13-20-01)	
<i>Eye Examinations</i> (including refraction)	100% per visit after Calendar Year deductible
Maximum Benefit per 24 consecutive month period:	1 exam
PLAN FEATURES	
<i>Physician Services</i> (GR-9N-S-13-25-01)	
<i>Physician Office Visits</i> (<i>non-surgical</i>)	80% per visit after Calendar Year deductible
<i>Specialist Office Visits</i>	80% per visit after Calendar Year deductible

<i>Physician Office Visit (Surgery)</i>	80% per visit after Calendar Year deductible
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible
<i>Allergy Injections</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Immunizations for Adults over the age of 18 (when not part of the physical exam)</i>	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.
PLAN FEATURES	
<i>Emergency Medical Services (GR-9N-S-13-30-01)</i>	
<i>Hospital Emergency Facility</i>	80% per visit after Calendar Year deductible
<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not Covered
PLAN FEATURES	
<i>Outpatient Diagnostic and Preoperative Testing (GR-9N-S-13-35-01)</i>	
<i>Diagnostic and Preoperative Testing (except complex imaging services)</i>	80% per procedure after Calendar Year deductible
<i>Complex Imaging Services</i>	
<i>Complex Imaging</i>	80% per procedure after Calendar Year deductible
<i>Diagnostic Laboratory Testing</i>	
<i>Diagnostic Laboratory Testing</i>	80% 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

PLAN FEATURES***Outpatient Surgery*** (GR-9N-S-13-40-01)

<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible
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PLAN FEATURES***Inpatient Facility Expenses*** (GR-9N-S-13-45-01)

<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
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<i>Hospital Facility Expenses</i> Room and Board (including maternity)	80% per admission after Calendar Year deductible
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Other than Room and Board	80% per admission after Calendar Year deductible
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<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	90 days
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PLAN FEATURES***Specialty Benefits*** (GR-9N-S-13-50-01)

<i>Home Health Care</i> <i>(Outpatient)</i>	80% per visit after the Calendar Year deductible
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Maximum Visits per Calendar Year	100 visits
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Hospice Benefits

<i>Hospice Care – Facility Expenses</i> (Room & Board)	80% per admission after Calendar Year deductible
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<i>Hospice Care</i> <i>(Other Expenses during a stay)</i>	80% per admission after Calendar Year deductible
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Maximum Benefit per lifetime	Unlimited days
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<i>Hospice Outpatient Visits</i>	80% per visit after Calendar Year deductible
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PLAN FEATURES

Infertility Treatment (GR-9N-S-13-55-01)

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.

Comprehensive Infertility Expenses

Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES

Inpatient Treatment of Mental Disorders

Mental Disorders

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

Outpatient Treatment of Mental Disorders (GR-9N-S-13-65-01)

Mental Disorders

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

PLAN FEATURES

Inpatient Treatment of Alcoholism and Substance Abuse (GR-9N-S-13-70-01)

Inpatient Treatment

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

Outpatient Treatment of Alcoholism and Substance Abuse

Outpatient Treatment

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

PLAN FEATURES

IOE Facility

Transplant Expenses (GR-9N-S-13-75-01)

Facility Expenses

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.

PLAN FEATURES

Other Covered Health Expenses (GR-9N-S-13-80-01)

Acupuncture

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
<i>Diabetic Equipment, Supplies and Education</i>	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 Calendar Year deductible
Maximum Benefit per Calendar Year	\$2,500

<small>(GR-9N-S-13-80-01)</small> <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.
<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.

PLAN FEATURES
Outpatient Therapies (GR-9N-S-13-90-01)

<i>Chemotherapy</i>	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.
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES
Short Term Outpatient Rehabilitation Therapies (GR-9N-S-13-095-01)

<i>Outpatient Physical, Occupational and Speech Therapy</i>	80% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits

PLAN FEATURES
Spinal Manipulation (GR-9N-S-13-095-01)

Spinal Manipulation80% per visit after Calendar Year **deductible****Basic Vision Expense Coverage**

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)

Calendar Year Deductible

This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. The Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Family Deductible Limit

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

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.

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 Summary of Benefits, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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.

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 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.