

Schedule of Benefits

(GR-9N S-01-001-01)

Employer: State Of Alaska
Group Policy Number: GP-392675
Issue Date: July 3, 2014
Effective Date: July 1, 2014
Schedule: 1A
Cert Base: 1

For: Political Subdivisions Option I - Open Choice (PPO) Medical Vision, Pharmacy, Dental and Hearing

PPO Medical Plan (GR-9N S-10-005-02 AK)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$250	\$250
Family Deductible*	\$750	\$750
Per Admission Deductible	Not Applicable	\$500 per admission
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.		
Plan Maximum Out of Pocket Limit includes plan deductible .		
Plan Maximum Out of Pocket Limit excludes precertification penalties.		
Individual Maximum Out of Pocket Limit:		
<ul style="list-style-type: none">▪ For network expenses: \$750.▪ For out-of-network expenses: \$750.		
Family Maximum Out of Pocket Limit:		
<ul style="list-style-type: none">▪ For network expenses: \$2,250.▪ For out-of-network expenses: \$2,250.		
Lifetime Maximum Benefit per person	Unlimited	Unlimited

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.

*** NOTICE:**

The 90th percentile is used to determine the final benefit payment for Out-of-Network expenses.

You will be responsible for paying any amount of covered expenses that are in excess of the Recognized Charge (as defined in the Glossary section of your Booklet-Certificate).

The coinsurance percentage applies after any Deductible amounts, unless otherwise specified below.

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 Benefits (GR-9N-S-10-010-02 AK)		
Routine Physical Exams Adults and Children. Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	100% per exam No Calendar Year deductible applies.
Maximum Exams per 12 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 Includes coverage for immunizations	100% per exam No Calendar Year deductible applies.	100% per exam No Calendar Year deductible applies.
Maximum Exams		
Under age 3		
first 12 months of life	7 exams	7 exams
13th-24th months of life	3 exams	3 exams
25th-36th months of life	3 exams	3 exams
Maximum Exams per 12 consecutive months		
From age 3 to age 18	1 exam	1 exam

Routine Gynecological Exam	100% per exam No Calendar Year deductible applies.	100% per exam No Calendar Year deductible applies.
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Maximum exams per Calendar Year	1 exam	1 exam
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Newborn Hearing Screening	Payable on the same basis as any other illness .	Payable on the same basis as any other illness .
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Routine Cancer Screenings (GR-9N S-10-015-02 AK)		
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Routine Mammography	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
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Prostate Specific Antigen Test For covered males age 40 and over	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
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Maximum tests per Calendar Year	1 test	1 test
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Routine Digital Rectal Exam For covered males age 40 and over	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
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Maximum tests per Calendar Year	1 test	1 test
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Routine Pap Smears	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
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Maximum tests per Calendar Year	1 test	1 test
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<i>Fecal Occult Blood Test</i>	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	1 test
<i>Sigmoidoscopy</i> Age 50 and over	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
Maximum Tests per 5 consecutive year period	1 test	1 test
<i>Colonoscopy</i> age 50 and over	100% per test No Calendar Year deductible applies.	100% per test No Calendar Year deductible applies.
Maximum Tests per 10 consecutive year period	1 test	1 test
<i>Family Planning Services</i> (GR-9N S-10-015-02 AK)		
<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>Physician Services</i> (GR-9N S-10-025-03 AK)		
<i>Physician Office Visits</i> (<i>non-surgical</i>)	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialist Office Visits	90% per visit after Calendar Year deductible	90% per visit Calendar Year deductible
Physician Office Visits-Surgery	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Walk-In Clinic Non-Emergency Visit <i>(GR-9N S-10-025-03 AK)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Physician Services for Inpatient Facility and Hospital Visits <i>(Billed by Physician)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Administration of Anesthesia	90% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible
Immunizations <i>(when not part of the physical exam)</i>	100% per visit No Calendar Year deductible applies.	100% per visit No Calendar Year deductible applies.
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
Hospital Emergency Facility and Physician	90% after Calendar Year deductible	90% after 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 coinsurance), 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 Emergency Room Facility or physician 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 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	50% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	90% per visit after Calendar Year deductible	90% 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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PLAN FEATURES
Outpatient Diagnostic and Preoperative Testing (GR-9N-S-10-035-01)

Complex Imaging Services		
Complex Imaging	90% per test after Calendar Year deductible	90% per test after Calendar Year deductible

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible

Diagnostic X-Rays		
Diagnostic X-Rays	90% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery (GR-9N-S-10-040-02 AK)		
Outpatient Surgery	90% per visit/surgical procedure after Calendar Year deductible	90% per visit/surgical procedure after Calendar Year deductible
Performed at a Hospital Outpatient Facility	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
Performed at any other Facility	90% per visit/surgical procedure after Calendar Year deductible	90% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses (GR-9N S-10-045-02 AK)		
Birth 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.

Hospital Facility Expenses Room and Board (including maternity)	90% per admission after Calendar Year deductible	\$500 per admission deductible after Calendar Year deductible then the plan pays 70%
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

Skilled Nursing Inpatient Facility	90% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits (GR-9N-S-10-050-02 AK)		
Home Health Care (Outpatient)	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

Maximum Visits per Calendar Year	Unlimited visits	Unlimited visits
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Private Duty Nursing (Outpatient)	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
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Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	90% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	90% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible

Maximum Benefit per lifetime	Unlimited days	Unlimited days
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Hospice Outpatient Visits	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i> (GR-9N-S-10-062-01 AK)		

MENTAL DISORDERS		
<i>Hospital Facility Expenses</i>		
Room and Board	90% per admission after Calendar Year deductible	\$500 per admission deductible after Calendar Year deductible then the plan pays 70%
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	\$500 per admission deductible after Calendar Year deductible then the plan pays 70%
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

<i>Outpatient Treatment Of Mental Disorders</i>		
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<i>Outpatient Services</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	90% per admission after Calendar Year deductible	\$500 per admission deductible after the Calendar Year deductible then the plan pays 70%
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	\$500 per admission deductible after Calendar Year deductible , then the plan pays 70%
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

<i>Outpatient Treatment of Substance Abuse</i>		
<i>Outpatient Treatment</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i> (GR-9N S-10-75-02 AK)			
<i>Transplant Facility Expenses</i>	90% per admission after Calendar Year deductible	\$500 per admission deductible after Calendar Year deductible , then the plan pays 70%	\$500 per admission deductible after Calendar Year deductible , then the plan pays 70%
<i>Transplant Physician Services</i> (including office visits)	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

PLAN FEATURES			
<i>Other Covered Health Expenses</i> (GR-9N-S-10-080-01)			
<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.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible
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<i>Diabetic Equipment, Supplies and Education</i>		
When Diabetic Equipment and Supplies are obtained from a Durable Medical Equipment provider	100% No Calendar Year deductible applies.	90% after Calendar Year deductible
When Diabetic Equipment and Supplies are not obtained from a Durable Medical Equipment provider	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.
Diabetic 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.

Durable Medical and Surgical Equipment and Supplies	90% per item after Calendar Year deductible	90% per item after Calendar Year deductible
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (GR-9N S-10-85-01)	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.
Orthotic and Prosthetic Devices	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 10-090 02-AK)		
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 (GR-9N S-10-95 04 AK)		
Outpatient Physical, Occupational, and Speech Therapy combined	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation (GR-9N S-10-95-01)		
Spinal Manipulation	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Phenylketonuria Services		
Phenylketonuria 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.

Basic Vision Expense Coverage (GR-9N-24-005-02 AK)

Schedule of Basic Vision Expense Benefits (GR-9N-S-24-015-01 AK)

PLAN FEATURES

Eye Exam

Plan Coinsurance: 80%

Vision Eyewear Lenses

Single Vision lenses (2 lenses)

Plan Coinsurance: 80%

Bifocal Vision lenses (2 lenses)

Plan Coinsurance: 80%

Trifocal Vision lenses (2 lenses)

Plan Coinsurance: 80%

Contact Lenses (2 lenses)

Plan Coinsurance: 80%; not to exceed the benefit payable for Single Vision Lenses

Contact Lenses needed to correct visual acuity to 20/70 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.

Vision Eyewear (Frames)

Plan Coinsurance: 80%

Maximums: 1 eye exam and 2 lenses calendar year, and 1 set of frames per 2 calendar years

Pharmacy Benefit (GR-9N S-26-005-02 AK)

Copays/Deductibles (GR-9N-S-26-010-04 AK)

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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Generic Prescription Drugs (GR-9N S-26-005-02 AK)

For each 30 day supply (retail)	\$0	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	\$10	Not Applicable

Preferred Brand-Name Prescription Drugs (GR-9N S-26-005-02 AK)

For each 30 day supply (retail)	The greater of \$15 or 20% of the negotiated charge not to exceed \$50	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	\$30	Not Applicable

Non-Preferred Brand-Name Prescription Drugs (GR-9N S-26-005-02 AK)

For each 30 day supply (retail)	The greater of \$30 or 30% of the negotiated charge not to exceed \$75	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	\$30	Not Applicable

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.

(GR-9N S-26-005-02 AK)

***NOTICE**

The 80th percentile is used to determine the final benefit payment for Out-of-Network expenses.

You will be responsible for paying any amount of covered expenses that are in excess of the **Recognized Charge** (as defined in the **Glossary** section of your **Booklet-Certificate**).

The coinsurance percentage applies after any **Deductible** amounts, unless otherwise specified below.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	80% 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.

Prescription Drug Maximum Out-of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug Maximum Out-of-Pocket Limit	\$1,000 Individual \$3,000 Family	\$1,000 Individual \$3,000 Family

Individual Prescription Drug Maximum Out-of-Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent’s share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person’s **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** coinsurance limit and the family prescription **drug** coinsurance limit. These include:

Expenses applied toward a deductible or copay amount.

Expenses above the **recognized charge**.

Non-covered expenses.

Comprehensive Dental Plan (GR-9N 20-005-01)

Schedule of Comprehensive Dental Benefits

Plan Features

Calendar Year Deductible	\$50 Individual
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The Calendar Year **deductible** applies to all **covered expenses** except Type A Expenses.

(GR-9N 20-005-01)

Plan Coinsurance:

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

Type A Expenses	100%
Type B Expenses	80%
Type C Expenses	50%

(GR-9N 20-005-01)

Calendar Year Maximum Benefit

Calendar Year Maximum Benefit	\$1,500
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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.

Comprehensive Hearing Expense Insurance

Schedule of Comprehensive Hearing Expense Benefits

Plan Features

Plan Coinsurance*	80%
Maximum Benefit per Benefit Period applicable to all covered Hearing expenses (A Benefit Period is a period of three consecutive calendar years, consisting of the current calendar year and the two immediately preceding calendar years.)	\$800

* NOTICE

The 80th percentile is used to determine the final benefit payment for hearing expenses.

You will be responsible for paying any amount of covered expenses that are in excess of the **Recognized Charge** (as defined in the **Glossary** section of your **Booklet-Certificate**).

GR-9N S-25-010-10076 01

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 (Dental Plan)

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.

The following deductible provisions apply to the Medical Plan.

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.

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 *(GR-9N-09-015-01 AK)*

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 expense.

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)*

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.

Maximum Out-of-Pocket Limit

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

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

There is also a Family **Maximum Out-of-Pocket 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 **Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; 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**.

Precertification Benefit Reduction *(GR-9N S-09-30 01)*

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.