Schedule of Benefits

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

Employer: **State of Alaska**

Group Policy Number: **GP-392675**

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Schedule: 2A
Cert Base: 2

For: Political Subdivisions Option IV - Open Choice 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*	$2,000	$2,000
Family Deductible*	$4,000	$4,000
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 **deductibles**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

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

Family Maximum Out of Pocket Limit:

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

Out of Network Hospital Maximum Out of Pocket Limit (applies in addition to the Maximum Out of Pocket Limit above):

- For **out-of-network** hospital expenses only:
  Maximum Out of Pocket Limit (Individual and Family): $2,000

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 month period		
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.
Maximum exams per Calendar Year	1 exam	1 exam
Hearing Exam	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.
Maximum exams per 24 month period	1 exam	1 exam
Newborn Hearing Screening	Payable on the same basis as any other **illness**.	Payable on the same basis as any other **illness**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screenings *(GR-9N S-10-015-02 AK)*		
Routine Mammography For covered women age 40 and over	100% per test No Calendar Year **deductible** applies.	100% per test No Calendar Year **deductible** applies.
Prostate Specific Antigen Test For covered males age 35 and over	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
Routine Digital Rectal Exam For covered males age 40 and over	100% per test No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears	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

Fecal Occult Blood Test	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
Sigmoidoscopy 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
Double Contrast Barium Enema (DCBE) 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
Colonoscopy 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
Family Planning Services *(GR-9N S-10-015-02 AK)*		
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.
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care *(GR-9N-S-10-020-02 AK)*		
Eye Examinations (including refraction)	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible** applies.
Maximum Benefit per 12 consecutive month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services *(GR-9N S-10-025-03 AK)*		
Physician Office Visits *(non-surgical)*	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialist Office Visits	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Walk-In Clinic Non-Emergency Visit *(GR-9N S-10-025-03 AK)*	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits (Billed by a Physician)	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Immunizations (when not part of the physical exam)	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	80% after Calendar Year **deductible**	80% after Calendar Year **deductible** See Important Note Below

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.

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 *(at a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
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.

PLAN FEATURES		
Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035-01)*		
Complex Imaging Services		
Performed in a Physician's office	80% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Performed in a Physician's office	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays		
Performed in a Physician's Office	80% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery *(GR-9N-S-10-040-02 AK)*		
Performed in a Physician's Office	80% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**
Performed at a Hospital Outpatient Facility	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
Performed at any other Facility	80% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses *(GR-9N S-10-045-02 AK)*		
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.
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 80%
Maximum Days per Calendar Year	120 days	120 days
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits *(GR-9N-S-10-050-02 AK)*		
Home Health Care (Outpatient)	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	60 visits	60 visits
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Maximum Visit Limit per *Calendar Year*	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Hospice Care – Other Expenses during a stay	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
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
Inpatient Treatment of Mental Disorders *(GR-9N-S-10-062-01 AK)*		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible** then the plan pays 60%
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders		
Outpatient Services	80% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after the Calendar Year **deductible** then the plan pays 60%
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible**, then the plan pays 60%
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF- NETWORK**
Transplant Services Facility and Non-Facility Expenses *(GR-9N S-10-75-02 AK)*			
Transplant Facility Expenses	80% per admission after Calendar Year **deductible**	$500 per admission **deductible** after Calendar Year **deductible**, then the plan pays 60%	$500 per admission **deductible** after Calendar Year **deductible**, then the plan pays 60%
Transplant Physician Services (including office visits)	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES		
Other Covered Health Expenses *(GR-9N-S-10-080-01)*		
Acupuncture in lieu of anesthesia	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	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Diabetic Equipment, Supplies and Education		
When Diabetic Equipment and Supplies **<u>are obtained</u>** from a Durable Medical Equipment provider	100% No Calendar Year **deductible** applies.	80% after Calendar Year **deductible**
When Diabetic Equipment and Supplies **<u>are not obtained</u>** 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	80% per item after Calendar Year **deductible**	80% 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.
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	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation *(GR-9N S-10-95-01)*		
Spinal Manipulation	80% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	25 visits	25 visits

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
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: 2 lenses per calendar year and 1 set of frames per 2 calendar years.

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

Copays

PER PRESCRIPTION COPAY	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs *(GR-9N S-26-005-02 AK)*		
For each 30 day supply (retail)	$10	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Applicable
Preferred Brand-Name Prescription Drugs *(GR-9N S-26-005-02 AK)*		
For each 30 day supply (retail)	$20	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	$40	Not Applicable

Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Applicable

Non-Preferred Brand-Name Prescription Drugs *(GR-9N S-26-005-02 AK)*		
For each 30 day supply (retail)	$35	Not Applicable
For more than a 30 day supply but less than a 91 day supply (mail order)	$60	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.

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

Schedule of Comprehensive Dental Benefits

Plan Features	
Calendar Year Deductible	$50 Individual

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

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.

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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**.

Individual Deductible
The Individual **deductible** is the amount of **network** or **out of network covered expenses** you must incur in a Calendar Year before benefits are paid. For purposes of this Plan, an individual means a single covered person enrolled for self only coverage.

Family Deductible
The Family **deductible** is the amount of **network** or **out of network covered expenses** that you and your covered dependents must incur in a Calendar Year before benefits are paid during the Calendar Year for any family members. For purposes of this Plan, a family means a covered person enrolled with one or more dependents. The family deductible can be met by one family member, or a combination of family members.

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 percent of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The limit applies to both **network** and **out-of-network** benefits.

This plan has an Individual and Family **Maximum Out-of-Pocket Limit**. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

Once the amount of eligible expenses you have paid during the Calendar Year meet the Individual **Maximum Out-of-Pocket Limit** the plan will pay 100% of **covered expenses** for that person for the remainder of the Calendar

Year.

The Family **Maximum Out-of-Pocket Limit** can be met with a combination of family members or by any single individual within the family. When this limit is reached, your plan will pay 100% of the family's **covered expenses** for the rest of the Calendar Year.

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**.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

This plan has an additional Individual and Family **Out of Network Hospital Maximum Out-of-Pocket Limit**. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents. The **Out of Network Hospital Maximum Out-of-Pocket Limit** applies to out of network hospital benefits.

Once the amount of eligible out of network hospital expenses you have paid during the Calendar Year meet the Individual **Out of Network Hospital Maximum Out-of-Pocket Limit** the plan will pay 100% of **covered out of network hospital expenses** for that person for the remainder of the Calendar Year.

The Family **Out of Network Hospital Maximum Out-of-Pocket Limit** can be met with a combination of family members or by any single individual within the family. When this limit is reached, your plan will pay 100% of the family's **covered out of network hospital expenses** for the rest of the Calendar Year.

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**;
- 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**.

Maximum Benefit Provisions *(GR-9N S-09-025 01)*

Calendar Year Maximum Benefit (Dental Plan Only)
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.

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.