Schedule of Benefits

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

Employer: **Government of the District of Columbia**

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For: PPO High Deductible Health Plan with Health Savings Account Medical Plan

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
*Individual Deductible**	$1,250	$2,500	$1,250
*Family Deductible**	$2,500	$5,000	$2,500

*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:

- For **network** expenses: $6,050.
- For **out-of-network** expenses: $6,050.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $12,100.
- For **out-of-network** expenses: $12,100.

Lifetime Maximum Benefit Per Person	Unlimited	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.

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			
Routine Physical Exams Adults and Children. Includes coverage for immunizations.	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 12 consecutive months period			
Adults, age 22 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.	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Preventive Health Services Care	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.	60% per exam No Calendar Year **deductible** applies.	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 12 consecutive month period	1 exam	1 exam	1 exam

Hearing Exam	100% per exam No Calendar Year **deductible** applies.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 24 month period	1 exam	Not Covered	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-015-02 DC)*			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	60% per test No Calendar Year **deductible** applies.	80% per test No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per visit No Calendar Year **deductible** applies.	60% per No Calendar Year **deductible** applies.	80% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	100% per visit No Calendar Year **deductible** applies.	60% per visit No Calendar Year **deductible** applies.	80% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Cervical Cytologic Screenings	100% per test No Calendar Year **deductible** applies.	60% per test No Calendar Year **deductible** applies.	80% per test No Calendar Year **deductible** applies.
Maximum Tests per 12 consecutive month period	1 test	1 test	1 test

Fecal Occult Blood Test	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 12 consecutive month period	1 test	1 test	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 10 consecutive year period	1 test	1 test	1 test
Family Planning Services *(GR-9N-S-10-015-01 DC)*			
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)	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Benefit per 12 consecutive month period	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services *(GR-9N-S-10-25-03 DC)*			
Physician Office Visits *(non-surgical)*	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Alternative to Physician Office Visit *(GR-9N-S-10-25-03 DC)*			
E-visit Online Consultation by a Physician	85% per visit after Calendar Year **deductible**	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Alternative to Specialist Office Visit *(GR-9N-S-10-25-03 DC)*			
E-visit Online Consultation by a Specialist	85% per visit after Calendar Year **deductible**	Not Covered	Not Covered
Physician Office Visits-Surgery	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Walk-In Clinic Non-Emergency Visit *(GR-9N-S-10-25-03 DC)*	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	85% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	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 10-030 01)*			
Hospital Emergency Facility and Physician	85% per visit after Calendar Year **deductible**	85% per visit after Calendar Year **deductible**	85% per visit 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	Not Covered	Not Covered	Not Covered
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	85% per visit after Calendar Year **deductible**	60% 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.	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

PLAN FEATURES			
Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035-01)*			
Complex Imaging Services			
Complex Imaging	85% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	85% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays			
Diagnostic X-Rays	85% per procedure after Calendar Year **deductible**	60% 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	85% per visit/surgical procedure after Calendar Year **deductible**	60% 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 S-10-45-01)*			
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)	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 days	60 days	60 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits *(GR-9N-10-50-01)*			
Home Health Care (Outpatient)	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	60	60	60
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	85% per admission after the Calendar Year **deductible**	60% per admission after the Calendar Year **deductible**	80% per admission after the Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	85% per admission after the Calendar Year **deductible**	60% 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	85% per visit after the Calendar Year **deductible**	60% 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Mental Disorders *(GR-9N-S-10-062-01 DC)*			
MENTAL DISORDERS			
Hospital Facility Expenses			
Room and Board	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment			
Facility Expenses	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	85% after Calendar Year **deductible**	60% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders			
Outpatient Services	85% per visit after the Calendar Year **deductible** for the first 40 visits, 85% for each visit thereafter	75% per visit after the Calendar Year **deductible** for the first 40 visits, 60% for each visit thereafter	80% per visit after the Calendar Year **deductible** for the first 40 visits, 80% for each visit thereafter

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment			
Facility Expenses	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	85% after Calendar Year **deductible**	60% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse			
Outpatient Services	85% per visit after Calendar Year **deductible** for the first 40 visits, 85% for each visit thereafter	75% per visit after Calendar Year **deductible** for the first 40 visits, 60% for each visit thereafter	80% per visit after Calendar Year **deductible** for the first 40 visits, 80% for each visit thereafter

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Obesity Treatment Non Surgical *(GR-9N-S-10-065-01)*			
Outpatient Obesity Treatment (non surgical)	85% per visit after Calendar Year **deductible**	Not Covered	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Obesity Treatment Surgical *(GR-9N S-11-065-01)*			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	85% per admission after Calendar Year **deductible**	Not Covered	80% per admission after Calendar Year **deductible**
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Unlimited

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)*				
Transplant Facility Expenses	85% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Transplant 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-10-080-01)*			
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Ground, Air or Water Ambulance	85% after Calendar Year **deductible**	85% after Calendar Year **deductible**	85% 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	85% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
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	85% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Therapies *(GR-9N S-10-90-01)*			
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			
Outpatient Physical, Occupational, and Speech Therapy combined	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year *(GR-9N S-10-95-01)*	60	60	60

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Spinal Manipulation			
Spinal Manipulation	85% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits

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

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

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	$10
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	$30
For more than a 30 day supply but less than a 91 day supply (mail order)	$60	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	$10
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		
For each 30 day supply (retail)	$60	$60
For more than a 30 day supply but less than a 91 day supply (mail order)	$120	Not Applicable

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.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

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**.

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

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.

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 S-09-15 01)*

Copayment
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 pharmacy expense.

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.

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;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; 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 02 DC)*

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.