

# Schedule of Benefits

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

**Employer:** The City of Glenn Heights Employee Benefits Trust  
**Group Policy Number:** GP-839061  
**Issue Date:** September 30, 2011  
**Effective Date:** October 1, 2011  
**Schedule:** 1A  
**Cert Base:** 1

For: Open Access Managed Choice POS Plan

## POS Medical Plan (GR-9N S-11-05-01)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>		
<b>Individual Deductible*</b>	\$500	\$1,000
<b>Family Deductible*</b>	\$1,000	\$2,000

\*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

**Plan Coinsurance Limit** excludes plan **deductible, copayments and preauthorization** penalties.

### Individual Coinsurance Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$4,000.

### Family Coinsurance Limit:

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$8,000.

<b>Lifetime Maximum Benefit per person</b>	Unlimited	Unlimited
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(GR-9N S-11-10-01 TX)

**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.**

**In no event will the covered amount for Network charges exceed more than 30% of the covered amount for Out-of-Network changes.**

*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
<b>Wellness Benefit</b>		
<b>Routine Physical Exams</b> Adults only.  Includes coverage for immunizations for adults and for children age 6 and over.	100% per exam  No Calendar Year <b>deductible</b> applies.	60% per exam after Calendar Year <b>deductible</b>
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
<b>Well Child Exams</b>		
	100% per exam  No Calendar Year <b>deductible</b> applies.	60% per exam after Calendar Year <b>deductible</b>
<b>Immunizations for Dependent Children to age 6</b>	Covered at 100%  No <b>copay</b> applies  No Calendar Year <b>deductible</b> applies	Covered at 100%  No <b>copay</b> applies  No Calendar Year <b>deductible</b> 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		
For age 3 to 18	1 exam	1 exam

<b><i>Routine Gynecological Exam</i></b>	100% per exam  No Calendar Year <b>deductible</b> applies.	60% per exam after Calendar Year <b>deductible</b>
Maximum exams per Calendar Year	1 exam	1 exam
<b><i>Hearing Exam</i></b> (GR-9N-S-11-10-01) (Excluding Newborn Screening, Diagnosis and Treatment)	100% per exam  No Calendar Year <b>deductible</b> applies.	60% per exam after Calendar Year <b>deductible</b>
Maximum exams per 24 month period (Excluding Newborn Hearing Screening, Diagnosis and Treatment)	1 exam	1 exam
<b><i>Newborn Screening Test for Hearing Loss and Necessary Follow-up Care Related to Test.</i></b>	100% per test  No Calendar Year <b>deductible</b> applies.	60% per test  No Calendar Year <b>deductible</b> applies.
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Routine Cancer Screenings</i></b> (GR-9N-S-11-15-01)		
<b><i>Routine Mammography</i></b> For covered females age 35 and over.	100% per test  No Calendar Year <b>deductible</b> applies.	60% per test after Calendar Year <b>deductible</b>
<b><i>Prostate Specific Antigen Test</i></b> For covered males age 40 and over.	100% per test  No Calendar Year <b>deductible</b> applies.	60% per test after Calendar Year <b>deductible</b>
Maximum tests per Calendar Year	1 test	1 test
<b><i>Routine Digital Rectal Exam</i></b> For covered males age 40 and over.	100% per test  No Calendar Year <b>deductible</b> applies.	60% per test after Calendar Year <b>deductible</b>

<b><i>Routine Pap Smears</i></b>	100% per test  No Calendar Year <b>deductible</b> applies.	60% per test after Calendar Year <b>deductible</b>
Maximum tests per Calendar Year	1 test	1 test
<b><i>Fecal Occult Blood Test</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
<b><i>Sigmoidoscopy</i></b> 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.
Maximum Tests per 5 consecutive year period	1 test	1 test
<b><i>Double Contrast Barium Enema (DCBE)</i></b> 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.
Maximum Tests per 5 consecutive year period	1 test	1 test
<b><i>Colonoscopy</i></b> 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.
Maximum Tests per 10 consecutive year period	1 test	1 test
<b><i>Family Planning Services</i></b> (GR-9N 10-015 01 TX)		
<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
<b><i>Vision Care</i></b> (GR-9N-S-11-020-01)		
<b><i>Eye Examinations</i></b> including refraction	100% per exam  No Calendar Year <b>deductible</b> applies.	60% per exam after Calendar Year <b>deductible</b>
Maximum Benefit per 24 consecutive month period	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Physician Services</i></b> (GR-9N-S-11-020-01) (GR-9N S-11-25-03)		
<b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non-specialist	\$20 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>

<b><i>Alternatives to Physicians' Office Visits</i></b> (GR-9N S 11-25 01)		
<b><i>E-Visit Online Internet Consultation by a PCP</i></b>	\$20 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>

<b><i>Specialist Office Visits</i></b>	\$35 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>
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<b><i>Alternative to Specialist Office Visit</i></b> (GR-9N 11-25-01 TX)		
<b><i>E-visits Online Internet Consultation by a Specialist</i></b>	\$30 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>

<b><i>Physician Office Visits-Surgery</i></b>		
<b><i>Physician</i></b>	\$20 visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
<b><i>Specialist</i></b>	No Calendar Year <b>deductible</b> applies. \$35 visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
<b><i>Specialist</i></b>	No Calendar Year <b>deductible</b> applies.	
<b><i>Walk-In Clinics Non-Emergency Visit (GR-9N 10-025 01 TX)</i></b>		
	\$20 visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies.	
<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>		
	80% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
<b><i>Administration of Anesthesia</i></b>		
	80% per procedure after Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>
<b><i>Allergy Testing and Treatment</i></b>		
	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.
<b><i>Allergy Injections</i></b>		
	100% per visit No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>
<b><i>Immunizations when not part of the physical exam</i></b>		
	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.
<b><i>Immunizations for dependent children covered at 100%</i></b>		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b> (GR-9N 11-030-01 TX)		
<b>Hospital Emergency Facility</b>	\$100 <b>copay</b> per visit then the plan pays 100%	\$100 <b>deductible</b> per visit then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
		See Important Note Below
<p><b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b>), 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 provider 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>		
<b>Non-Emergency Care in a Hospital Emergency Room</b>	Not covered	Not covered
<p><b>Important Notice:</b> A separate <b>hospital</b> emergency room <b>deductible</b> or <b>copay</b> applies for each visit to an emergency room for emergency care. If you are admitted to a <b>hospital</b> as an inpatient immediately following a visit to an emergency room, your <b>deductible</b> or <b>copay</b> is waived.</p> <p>Covered expenses that are applied to the emergency room <b>deductible</b> or <b>copay</b> cannot be applied to any other <b>deductible</b> or <b>copay</b> under your plan. Likewise, covered expenses that are applied to any of your plan's other <b>deductibles</b> or <b>copays</b> cannot be applied to the emergency room <b>deductible</b> or <b>copay</b>.</p>		
<b>Urgent Care Services</b>		
<b>Urgent Medical Care</b> (at a non-hospital free standing facility)	\$50 <b>copay</b> per visit then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies.	
<b>Urgent Medical Care</b> (from other than a non-hospital free standing facility)	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.
<b>Non-Urgent Use of Urgent Care Provider</b> (at an Emergency Room or a non-hospital free standing facility)	Not covered	Not covered

**Important Notice:**

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Outpatient Diagnostic and Preoperative Testing</b> (GR-9N-11-035 01 TX)		
<b>Complex Imaging Services</b>		
<b>Complex Imaging</b>	80% per test after Calendar Year <b>deductible</b>	60% per test after Calendar Year <b>deductible</b>
<b>Diagnostic Laboratory Testing</b>		
<b>Diagnostic Laboratory Testing</b>	100% per procedure  No Calendar Year <b>deductible</b> applies.	60% per procedure after Calendar Year <b>deductible</b>
<b>Diagnostic X-Rays(except Complex Imaging Services)</b>		
<b>Diagnostic X-Rays</b>	\$20 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Outpatient Surgery</b> (GR-9N-S-11-040-01)		
<b>Outpatient Surgery</b>	80% per visit/surgical procedure after Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Inpatient Facility Expenses</b> (GR-9N S-11-045-01-TX)		
<b>Birth Center</b>	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.
<b>Hospital Facility Expenses</b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Room and Board (including maternity)		
Other than Room and Board	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

<b><i>Skilled Nursing Inpatient Facility</i></b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
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Maximum Days per Calendar Year	60 days	60 days
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b><i>Specialty Benefits</i></b> <small>(GR-9N S-10-50-01-TX) (GR-9N-11-050-01)</small>		
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<b><i>Home Health Care (Outpatient)</i></b>	80% per visit after the Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
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Maximum Visits per Calendar Year	60 visits	60 visits
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<b><i>Private Duty Nursing (Outpatient)</i></b>	80% per visit after the Calendar Year <b>deductible</b>	60% per visit after the Calendar Year <b>deductible</b>
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Maximum Visit Limit per <i>Calendar Year</i>	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.
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<b><i>Hospice Benefits</i></b>		
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<b><i>Hospice Care - Facility Expenses</i></b> (Room & Board)	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
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<b><i>Hospice Care - Other Expenses during a stay</i></b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
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Maximum Benefit per lifetime	Unlimited days	Unlimited days
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<b><i>Hospice Outpatient Visits</i></b>	80% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b><i>Infertility Treatment</i></b> <small>(GR-9N S-11-55-01)</small>		
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<b><i>Basic Infertility Expenses</i></b> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.	Payable in accordance with type of expense incurred. Refer to the Physician Services and other sections of this Schedule to determine what the plan pays.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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***Inpatient Treatment of Mental Disorders*** (GR-9N-S-11-062-01 TX)

***MENTAL DISORDERS***

***Hospital Facility Expenses***

Room and Board	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Physician Services	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
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<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	80% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>
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***Outpatient Treatment Of Mental Disorders***

<b><i>Outpatient Services</i></b>	\$35 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	60% per visit after the Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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***Inpatient Treatment of Substance Abuse***

***Hospital Facility Expenses***

Room and Board	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
Physician Services	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	80% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>

<b><i>Outpatient Treatment of Substance Abuse</i></b>		
<b><i>Outpatient Treatment</i></b>	\$35 per visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies	

<b>PLAN FEATURES</b>	<b>NETWORK (IOE Facility)</b>	<b>NETWORK (Non-IOE Facility)</b>	<b>OUT-OF-NETWORK</b>
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b> (GR-9N S-11-065-01) (GR-9N 11-080-01 TX)			
<b><i>Transplant Facility Expenses</i></b>	80% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services</i></b> (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

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Other Covered Health Expenses</i></b> (GR-9N 11-65-01 TX) (GR-9N 11-080-01 TX)		

<b><i>Acupuncture in lieu of anesthesia</i></b>	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.
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<b><i>Ground, Air or Water Ambulance</i></b>	80% after Calendar Year <b>deductible</b>	80% after Calendar Year <b>deductible</b>
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<b><i>Diabetic Equipment, Supplies and Education</i></b>	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.
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<b><i>Durable Medical and Surgical Equipment</i></b>	80% per item after Calendar Year <b>deductible</b>	60% per item after Calendar Year <b>deductible</b>
<b><i>Does not apply to Diabetic Equipment, Supplies and Education</i></b>		

Maximum Benefit per Calendar Year	\$2,500	\$2,500
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<b><i>Jaw Joint Disorder Treatment</i></b>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible
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(GR-9N 11-085-01 TX) (GR-9N 11-080-01 TX)

<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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.
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<b><i>Prosthetic Devices</i></b>	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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Therapies</i></b> (GR-9N 11-090-01 TX)		

<b><i>Chemotherapy</i></b>	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.
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<b><i>Infusion Therapy</i></b>	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.
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<b><i>Radiation Therapy</i></b>	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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b> (GR-9N 11-095 01 TX)		

<b><i>Outpatient Physical and Occupational combined and Spinal Manipulation</i></b>	\$35 per visit copay then the plan pays 100%  No Calendar Year deductible applies	60% per visit after Calendar Year deductible
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Combined Physical and Occupational and Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Short Term Outpatient Rehabilitation Therapies</b> (GR-9N 11-095 01 TX)		
<b>Speech Therapy only</b>	\$35 per visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies	
Speech Therapy Maximum visits per Calendar Year	20 visits	20 visits

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

### Copays/Deductibles (GR-9N-26-10-01 TX)

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Preferred Generic Prescription Drugs</b>		
For each 30 day supply (retail)	\$15	\$15
For more than a 30 day supply but less than a 91 day supply (mail order)	\$30	Not Applicable
<b>Preferred Brand-Name Prescription Drugs</b>		
For each 30 day supply (retail)	\$35	\$35
For more than a 30 day supply but less than a 91 day supply (mail order)	\$70	Not Applicable
<b>Non-Preferred Generic Prescription Drugs</b>		
For each 30 day supply (retail)	\$15	\$15
For more than a 30 day supply but less than a 91 day supply (mail order)	\$30	Not Applicable
<b>Non-Preferred Brand-Name Prescription Drugs</b>		
For each 30 day supply (retail)	\$50	\$50
For more than a 30 day supply but less than a 91 day supply (mail order)	\$100	Not Applicable

## Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the <b>negotiated charge</b>	70% of the <b>recognized charge</b>

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

## Expense Provisions (GR-9N 09-05 01 TX)

**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.

In no event will the covered amount for In- Network charges exceed more than 30% of the covered amount for Out-of- Network charges.

**Keep This Schedule of Benefits With Your Booklet-Certificate.**

## Deductible Provisions (GR-9N 09-05 01 TX)

### 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**.

## **Copayments and Benefit Deductible Provisions** (GR-9N 09-15 01 TX)

### **Copayment, Copay**

This is a specified dollar amount or percentage of the **recognized 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.

## **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.

### **Coinsurance Limit**

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

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

There is also a Family **Coinsurance Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual **Coinsurance Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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

### **Expenses That Do Not Apply to Your Coinsurance Limit**

Certain covered expenses do not apply toward your plan **coinsurance** limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Expenses that are not paid, or **preauthorization** benefit reductions because a required **preauthorization** for the service(s) or supply was not obtained from **Aetna**.
- Durable Medical Equipment Expenses, and
- Out of Network Transplant Services

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

### **Calendar Year Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

### **Preauthorization Benefit Reduction** (GR-9N-09-30-01 TX)

The Booklet-Certificate contains a complete description of the **preauthorization** program. Refer to the “Understanding Preauthorization” section for a list of services and supplies that require **preauthorization**.

Failure to preauthorize 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.

### **Wellness Incentive** (GR-9N S-31-005-01)

Benefit Award Amount:	\$50
Calendar Year Individual Maximum Benefit:	\$50
Calendar Year Family Maximum Benefit:	\$100