Schedule of Benefits

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

Employer: **Vanderbilt University Postdoctoral Trainee Benefits Program**

Group Policy Number: **GP-480610**

Issue Date: September 8, 2014
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Schedule: 1A
Cert Base: 1

For: Open Choice - 90/70 Plan

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

PPO Medical Plan *(GR-9N-S-10-005-01)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
Individual Deductible*	$250	$500	$250
Family Deductible*	$500	$1,000	$500
Per Admission Copayment	$150 per admission	Not applicable	Not applicable
Per Admission Deductible*	Not applicable	$250 per admission	$150 per admission

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

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $1,000.
- For **out-of-network** expenses: $2,000.

Family Maximum Out of Pocket Limit:

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

Lifetime Maximum Benefit Per Person	Unlimited	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Coinsurance Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance percentage. 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
Preventive Care Benefits			
Routine Physical Exams			
Office Visits *(GR-9N S 10-016 02 NG TN)*	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
(GR-9N S 10-016 02 NG TN)			
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*
Covered Persons ages 22 but less than 65: Maximum Visits per 24 consecutive month period	1 visit	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per 12 consecutive month period	1 visit	1 visit	1 visit

Preventive Care Immunizations *(GR-9N S 10-016 02 NG TN)*			
Performed in a facility or ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician****, log onto the Aetna website www.aetna.com or call the number on the back of your ID card*	70% per visit after Calendar Year **deductible** Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician****, log onto the Aetna website www.aetna.com or call the number on the back of your ID card*	100% per visit No **deductible** applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician****, log onto the Aetna website www.aetna.com or call the number on the back of your ID card*

(GR-9N S 10-016 02 NG TN)

Screening & Counseling Services - Office Visit **Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products**	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
Obesity (GR-9N S 10-016 02 NG TN)			
Maximum Visits per 12 consecutive month period *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only* 10 *visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******	26 visits *(however, of these only* 10 *visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)******
***Misuse of Alcohol and/or Drugs** (GR-9N S 10-016 02 NG TN)*			
Maximum Visits per 12 consecutive month period	5 visits*	5 visits*	5 visits*

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products *(GR-9N S 10-016 02 NG TN)* Maximum Visits per 12 consecutive month period	8 visits*****	8 visits*****	8 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Well Woman Preventive Visits *(GR-9N S 10-016 02 NG TN)* ***Office Visits***	100% per visit No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per exam No **deductible** applies.

(GR-9N S 10-016 02 NG TN)

Maximum Visits per Calendar Year	1 visit	1 visit	1 visit

Routine Cancer Screenings *(GR-9N S 10-016 02 NG TN)* ***Outpatient***	100% per visit No copay or **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.

Maximums *(GR-9N S 10-016 02 NG TN)*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.* *ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*

Prenatal Care *(GR-9N S 10-016 02 NG TN)*			
Office Visits	100% per visit No **deductible** applies.	70% per visit after Calendar Year **deductible.**	100% per visit No **deductible** applies.
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			

Comprehensive Lactation Support and Counseling Services *(GR-9N S 10-016 02 NG TN)*			
Lactation Counseling Services - Facility or Office Visits	100% per visit No copay or **deductible** applies	70% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies
(GR-9N S 10-016 02 NG TN)			
Lactation Counseling Services Maximum Visits per Calendar Year either in a group or individual setting	6* visits	6* visits	6* visits
***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*			

Breast Pumps & Supplies *(GR-9N S 10-016 02 NG TN)*	100% per item. No copay or **deductible** applies.	70% per item after Calendar Year **deductible**	100% per item. No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.			

Family Planning Services *(GR-9N S 10-016 02 NG TN)*			
Female Contraceptive Counseling Services - Office Visits.	100% per visit. No **copay** or **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.

Contraceptive Counseling Services - Maximum Visits per 12 months either in a group or individual setting *(GR-9N S 10-016 02 NG TN)*	2* visits	2* visits	2* visits
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*			

Family Planning Services - Female Voluntary Sterilization *(GR-9N S 10-016 02 NG TN)*			
Inpatient	100% per admission. No **copay** or **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission. No **deductible** applies.
Outpatient	100% per visit/surgical procedure. No **copay** or **deductible** applies.	70% per visit/surgical procedure after Calendar Year **deductible**	100% per visit/surgical procedure. No **deductible** applies.

(GR-9N S 10-016 02 NG TN)

PLAN FEATURES	**PLAN COINSURANCE**
Family Planning Services - Female Contraceptives	
Female Contraceptive Generic Prescription Drugs	100% per prescription or refill No **deductible** applies.
Female Contraceptive Devices	100% per prescription or refill No **deductible** applies.

Important Note:
Refer to the Outpatient Prescription Drug Expenses section of your Schedule of Benefits for more information on other prescription drug coverage under this Plan.

Family Planning Services – Other *(GR-9N S-10-017-01)*			
Voluntary Sterilization for Males			
Outpatient	90% per visit/surgical procedure after Calendar Year **deductible**.	70% per visit/surgical procedure after Calendar Year **deductible**.	80% per visit/surgical procedure after Calendar Year **deductible**.
Voluntary Termination of Pregnancy			
Outpatient	90% per visit/surgical procedure after Calendar Year **deductible**.	70% per visit/surgical procedure after Calendar Year **deductible**.	80% per visit/surgical procedure after Calendar Year **deductible**.

Hearing Aids for Covered Person under Age 18 *(GR-9N-S-10-080-04 TN)*	90% per item after Calendar Year **deductible**	70% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
Maximum Benefit per individual hearing aid, per ear, every 3 years *(GR-9N-S-10-080-04 TN)*	$1,000	$1,000	$1,000

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.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Maximum Benefit per 24 consecutive month period	1 exam	Not Covered	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services *(GR-9N-S-10-25-02)*			
Physician Office Visits (*non-surgical*)	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Alternative to Physician Office Visit *(GR-9N-S-10-025-01)*			
E-visit Online Consultation by a Physician	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Alternative to Specialist Office Visit *(GR-9N-S-10-025-01)*			
E-visit Online Consultation by a Specialist	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies
Physician Office Visits-Surgery	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Walk-In Clinic Non-Emergency Visit *(GR-9N-S-10-025-01)*	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Allergy Injections	90% per visit after Calendar Year **deductible**.	70% per visit after Calendar Year **deductible**.	80% per visit after Calendar Year **deductible**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Emergency Medical Services *(GR-9N 10-030 01 TN)*			
Hospital Emergency Facility and Physician	$150 **copay** per visit then the plan pays 90% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. See Important Note Below	Paid the same as the Network level of benefits. 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 **payment percentage)**, 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**	50% per visit after Calendar Year **deductible**

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$50 **copay** per visit then the plan pays 90% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	$50 **deductible** per visit then the plan pays 80% No Calendar Year **deductible** applies.
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

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

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

PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035 01 TN)*

Complex Imaging Services			
Complex Imaging	90% per test after Calendar Year **deductible**	70% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**

Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

Diagnostic X-Rays			
Diagnostic X-Rays	90% per procedure after Calendar Year **deductible**	70% 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-10-040-02 TN)*			
Outpatient Surgery	90% per visit/surgical procedure after Calendar Year **deductible**	70% 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)	\$150 per admission **copay** after Calendar Year **deductible**, then the plan pays 90%	\$250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 70%	\$150 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Other than Room and Board	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits *(GR-9N-10-50-01)*			
Home Health Care (Outpatient)	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	120	120	120
Private Duty Nursing (Outpatient)	90% per visit after the Calendar Year **deductible**	70% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

Maximum Visit Limit per Calendar Year	40 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	40 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	40 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)	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**	80% per admission after the Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	90% per admission after the Calendar Year **deductible**	70% 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	90% per visit after the Calendar Year **deductible**	70% 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-10-055-02 TN)*			
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 TN)*			
MENTAL DISORDERS			
Hospital Facility Expenses Room and Board	$150 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$250 per admission **deductible** after Calendar Year **deductible** then the plan pays 70%	$150 per admission **deductible** after Calendar Year **deductible** then the plan pays 80%
Other than Room and Board	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	$150 per admission **copay** after Calendar Year **deductible**, then the plan pays 90%	$250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 70%	$150 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%

Outpatient Treatment Of Mental Disorders			
Outpatient Services	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Inpatient Treatment of Substance Abuse			
Hospital Facility Expenses			
Room and Board	$150 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	$250 per admission **deductible** after Calendar Year **deductible**, then the plan pays 70%	$150 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Other than Room and Board	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	$150 per admission **copay** after Calendar Year **deductible**, then the plan pays 90%	$250 per admission **deductible** after the Calendar Year **deductible**, then the plan pays 70%	$150 per admission **deductible** after Calendar Year **deductible**, then the plan pays 80%
Outpatient Treatment of Substance Abuse			
Outpatient Treatment	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.

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-10-075-02 TN)*				
Transplant Facility Expenses	$150 per admission **copay** after Calendar Year **deductible,** then the plan pays 90%	$250 per admission **deductible** after Calendar Year **deductible,** then the plan pays 70%	$250 per admission **deductible** after Calendar Year **deductible,** then the plan pays 70%	$250 per admission **deductible** after Calendar Year **deductible,** then the plan pays 70%
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-10-080-04 TN)*			
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	90% after Calendar Year **deductible**	70% after Calendar Year **deductible**	80% 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.
Test Strip Maximum per Calendar Year for Non-Insulin Using Diabetics	12 bottles of 50 test strips per bottle	12 bottles of 50 test strips per bottle	12 bottles of 50 test strips per bottle
Durable Medical and Surgical Equipment	90% per item after Calendar Year **deductible**	70% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
Treatment of Jaw Joint Disorders	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.

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.
Orthotic and Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Dietary Food Formulas For the Treatment of Phenylketonuria *(GR-9N S-10-090-01 TN)*	Payable as any other covered medical expense.	Payable as any other covered medical expense.	Payable as any other covered medical expense.
Clinical Trial Expenses	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.
Reconstructive Breast Surgery *(GR-9N S-10-090-01 TN)*	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.
Treatment of Cleft Lip or Palate of Dependent Children Under Age 18 *(GR-9N S-10-090-01 TN)*	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**
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 *(GR-9N-S-10-095-02 TN)*			
Outpatient Physical and Occupational Therapy Only	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Short Term Outpatient Rehabilitation Therapies *(GR-9N-S-10-095-02 TN)*			
Speech Therapy Only	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Spinal Manipulation *(GR-9N-S-10-095-02 TN)*			
Spinal Manipulation	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Treatment of Autism Spectrum Disorders	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
Anesthesia and Associated Charges for Certain Dental Care Services *(GR-9N S-10-081-02 TN)*			
	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.

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

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

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	Not Covered
For more than a 30 day supply but less than a 91 day supply (retail)	$30	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$35	Not Covered
For more than a 30 day supply but less than a 91 day supply (retail)	$70	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$70	Not Covered
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$15	Not Covered
For more than a 30 day supply but less than a 91 day supply (retail)	$30	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$30	Not Covered
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$50	Not Covered
For more than a 30 day supply but less than a 91 day supply (retail)	$100	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$100	Not Covered
Self-injectable Prescription Drugs		
For each 30 day supply	20% of the **negotiated charge**	None

(GR-9N S 26-023 02 NG TN)

Copay and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs; generic** devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide **out-of-network pharmacy** benefits under the Prescription Drug Plan, the per **prescription copay/deductible** and any applicable **prescription drug** Calendar Year **deductible** continue to apply.

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- For contraceptive methods that are:
  - **brand-name prescription drugs** and brand name devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Not Covered

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**.

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

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

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Copayments and Benefit Deductible Provisions *(GR-9N-09-015-01 TN)*

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.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** 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 **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Coinsurance Provisions *(GR-9N S-09-020 01)*

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "**Plan Coinsurance**". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

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

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

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

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

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 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 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.