

# Schedule of Benefits

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

**Employer:** United Food and Commercial Workers Local 951  
**Group Policy Number:** GP-892315  
**Issue Date:** February 1, 2012  
**Effective Date:** January 1, 2012  
**Schedule:** 1A  
**Cert Base:** 1

For: PPO Medical Plan for Under 65 Meijer Retirees (Employees Only)

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

## PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Calendar Year Deductible*</b>			
<b>Individual Deductible*</b>	\$500	\$500	\$500

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

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

### Individual Coinsurance Limit:

- For network expenses: \$5,000.
- For out-of-network expenses: \$10,000.

<b>Lifetime Maximum Benefit Per Person</b>	\$1,000,000	\$1,000,000	\$1,000,000
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*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
<b>Wellness Benefits</b>			
<b>Routine Physical Exams</b> Adults only.  Includes coverage for immunizations.	70% per exam after Calendar Year <b>deductible</b>	50% per exam after Calendar Year <b>deductible</b>	70% per exam after Calendar Year <b>deductible</b>
Maximum Exams per 12 consecutive months period			
Adults, age 18 to 65	1 exam	1 exam	1 exam
<b>Routine Gynecological Exam</b>	70% per exam after Calendar Year <b>deductible</b>	50% per exam after Calendar Year <b>deductible</b>	70% per exam after Calendar Year <b>deductible</b>
Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Routine Cancer Screenings</b> (GR-9N S-10-015 02)			
<b>Routine Mammography</b>	70% per test after Calendar Year <b>deductible</b>	50% per test after Calendar Year <b>deductible</b>	70% per test after Calendar Year <b>deductible</b>
Maximum visits	<ul style="list-style-type: none"> <li>▪ 1 visit for a baseline mammogram for females age 35 through 39</li> <li>▪ 1 visit per calendar year for females age 40 and over</li> </ul>	<ul style="list-style-type: none"> <li>▪ 1 visit for a baseline mammogram for females age 35 through 39</li> <li>▪ 1 visit per calendar year for females age 40 and over</li> </ul>	<ul style="list-style-type: none"> <li>▪ 1 visit for a baseline mammogram for females age 35 through 39</li> <li>▪ 1 visit per calendar year for females age 40 and over</li> </ul>
<b>Prostate Specific Antigen Test</b> For covered males age 40 and over.	70% per visit after Calendar Year <b>deductible.</b>	50% per visit after Calendar Year <b>deductible.</b>	70% per visit after Calendar Year <b>deductible.</b>

Maximum tests per Calendar Year	1 test	1 test	1 test
<b><i>Routine Digital Rectal Exam</i></b> For covered males age 40 and over.	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Maximum tests per Calendar Year	1 test	1 test	1 test
<b><i>Routine Pap Smears</i></b>	70% per test after Calendar Year <b>deductible</b>	50% per test after Calendar Year <b>deductible</b>	70% per test after Calendar Year <b>deductible</b>
Maximum Tests per Calendar Year	1 test	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.	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	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.	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
<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.	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

<b>Colonoscopy</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.	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b>Physician Services</b> (GR-9N-S-10-25-03 MI)			
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<b>Physician Office Visits</b> (non-surgical)	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b>Specialist Office Visits</b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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<b>Alternative to Specialist Office Visit</b> (GR-9N-S-10-25-03 MI)			
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<b>E-visit Online Consultation by a Specialist</b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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<b>Physician Office Visits-Surgery</b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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<b>Walk-In Clinic Non-Emergency Visit</b> (GR-9N-S-10-25-03 MI)	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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<b>Physician Services for Inpatient Facility and Hospital Visits</b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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<b>Administration of Anesthesia</b>	70% per procedure after Calendar Year <b>deductible</b>	50% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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<b>Allergy Testing and Treatment</b>	70% per visit after Calendar Year <b>deductible.</b>	50% per visit after Calendar Year <b>deductible.</b>	70% per visit after Calendar Year <b>deductible.</b>
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<b>Allergy Injections</b>	70% per visit after Calendar Year <b>deductible.</b>	50% per visit after Calendar Year <b>deductible.</b>	70% per visit after Calendar Year <b>deductible.</b>
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<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.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Prenatal Visits</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.	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
<b><i>Emergency Medical Services</i></b> (GR-9N 10-030 01)			
<b><i>Hospital Emergency Facility</i></b>	\$200 <b>copay</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%	\$200 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%	\$200 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%
<b><i>Non-Emergency Care in a Hospital Emergency Room</i></b>	Not Covered	Not Covered	Not Covered

**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**.

<b><i>Urgent Care Services</i></b>			
<b><i>Urgent Medical Care (at a non-hospital free standing facility)</i></b>	\$100 <b>copay</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%	50% per visit after Calendar Year <b>deductible</b>	\$100 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%
<b><i>Urgent Medical Care (from other than a non-hospital free standing facility)</i></b>	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.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

<b>Non-Urgent Use of Urgent Care Provider</b> <i>(at an Emergency Room or a non-hospital free standing facility)</i>	Not Covered	Not Covered	Not Covered
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### 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)

<b>Diagnostic and Preoperative Testing</b> <i>(except complex imaging services)</i>	70% per procedure after Calendar Year <b>deductible</b>	50% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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### *Complex Imaging Services*

<b>Complex Imaging</b>	70% per test after Calendar Year <b>deductible</b>	50% per test after Calendar Year <b>deductible</b>	70% per test after Calendar Year <b>deductible</b>
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### *Diagnostic Laboratory Testing*

<b>Diagnostic Laboratory Testing</b>	70% per procedure after Calendar Year <b>deductible</b>	50% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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### *Diagnostic X-Rays*

<b>Diagnostic X-Rays</b>	70% per procedure after Calendar Year <b>deductible</b>	50% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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## PLAN FEATURES

### NETWORK

### OUT-OF-NETWORK

### OTHER HEALTH CARE

### *Outpatient Surgery* (GR-9N-S-10-040-01)

<b>Outpatient Surgery</b>	70% per visit/surgical procedure after Calendar Year <b>deductible</b>	50% per visit/surgical procedure after Calendar Year <b>deductible</b>	70% per visit/surgical procedure after Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Facility Expenses</i></b> (GR-9N S-10-45-01)			
<b><i>Birthing Center</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.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Hospital Facility Expenses</i></b> Room and Board (including maternity)	70% per admission after Calendar Year <b>deductible</b>	50% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	70% per admission after Calendar Year <b>deductible</b>	50% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
<b><i>Skilled Nursing Inpatient Facility</i></b>	70% per admission after Calendar Year <b>deductible</b>	50% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Maximum Days per Calendar Year	60 days	60 days	60 days
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Specialty Benefits</i></b> (GR-9N-10-50-01)			
<b><i>Home Health Care (Outpatient)</i></b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Maximum Visits per Calendar Year	60	60	60
<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care –Facility Expenses</i></b> (Room & Board)	70% per admission after the Calendar Year <b>deductible</b>	50% per admission after the Calendar Year <b>deductible</b>	70% per admission after the Calendar Year <b>deductible</b>
<b><i>Hospice Care – Other Expenses during a stay</i></b>	70% per admission after the Calendar Year <b>deductible</b>	50% per admission after the Calendar Year <b>deductible</b>	70% per admission after the Calendar Year <b>deductible</b>
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days

<b><i>Hospice Outpatient Visits</i></b>	70% per visit after the Calendar Year <b>deductible</b>	50% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b><i>Infertility Treatment</i></b> (GR-9N-S-10-055-01)			
<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 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
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<b><i>Inpatient Treatment of Mental Disorders</i></b>			
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b><i>Mental Disorders</i></b>	70% per admission after Calendar Year <b>deductible</b>	50% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
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<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b><i>Mental Disorders</i></b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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Maximum Visits per Calendar Year	Unlimited visits	Unlimited visits	Unlimited visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b><i>Inpatient Treatment of Alcoholism and Substance Abuse</i></b>			
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<b><i>Inpatient Treatment</i></b>	70% per admission after Calendar Year <b>deductible</b>	50% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
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<b><i>Outpatient Treatment of Alcoholism and Substance Abuse</i></b>			
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<b><i>Outpatient Treatment</i></b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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Maximum Benefit per Calendar Year	\$4,500	\$4,500	\$4,500
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b> (GR-9N-S-10-075-01)				
<b><i>Transplant Facility Expenses</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.	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>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.	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)

<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.	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>	\$100 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%	\$100 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 50%	\$100 <b>deductible</b> per visit after Calendar Year <b>deductible</b> then the plan pays 70%
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<b><i>Durable Medical and Surgical Equipment</i></b>	70% per item after Calendar Year <b>deductible</b>	50% per item after Calendar Year <b>deductible</b>	70% per item after Calendar Year <b>deductible</b>
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Maximum Benefit per Calendar Year	\$5,000	\$5,000	\$5,000
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<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.	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>	70% per item after Calendar Year <b>deductible</b>	50% per item after Calendar Year <b>deductible</b>	70% per item after Calendar Year <b>deductible</b>
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
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<b><i>Outpatient Therapies (GR-9N S-10-90-01)</i></b>			
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<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.	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.	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.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
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<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>			
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<b><i>Outpatient Physical, Occupational, and Speech Therapy combined</i></b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year <i>(GR-9N S-10-95-01)</i>	60 visits	60 visits	60 visits
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
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<b><i>Spinal Manipulation</i></b>			
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<b><i>Spinal Manipulation</i></b>	70% per visit after Calendar Year <b>deductible</b>	50% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits
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# Pharmacy Benefit (GR-9N-S-26-005-01)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prescription Drug Calendar Year Deductible	\$200 Individual	\$200 Individual

## Prescription Drug Calendar Year Deductible

The individual **prescription drug** calendar year **deductible** applies separately to you. After **prescription drug covered expenses** reach the **prescription drug** calendar year **deductible**, the plan will begin to pay benefits for **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug** calendar year **deductible** applies to **network** and **out-of-network prescription drug covered expenses** combined.

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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<i>Preferred Generic Prescription Drugs</i>		
For each 30 day supply (retail)	30% of the <b>negotiated charge</b>	30% of the <b>recognized charge</b>
For more than a 30 day supply but less than a 91 day supply (mail order)	30% of the <b>negotiated charge</b>	Not Applicable

<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply (retail)	30% of the <b>negotiated charge</b>	30% of the <b>recognized charge</b>
For more than a 30 day supply but less than a 91 day supply (mail order)	30% of the <b>negotiated charge</b>	Not Applicable

<i>Non-Preferred Generic Prescription Drugs</i>		
For each 30 day supply (retail)	30% of the <b>negotiated charge</b>	30% of the <b>recognized charge</b>
For more than a 30 day supply but less than a 91 day supply (mail order)	30% of the <b>negotiated charge</b>	Not Applicable

<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply (retail)	50% of the <b>negotiated charge</b>	50% of the <b>recognized charge</b>
For more than a 30 day supply but less than a 91 day supply (mail order)	50% of the <b>negotiated charge</b>	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug**

equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

### Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the <b>negotiated charge</b>	60% 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.

**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 not be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will not be applied to satisfy the **out-of-network deductible**.

### 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 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.

The **Coinsurance Limit** applies to both network and out-of-network benefits. You have separate **Coinsurance Limits** for in-network and out-of-network benefits. **Coinsurance Limit** amounts paid by you for in-network and out-of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one 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**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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

### Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

The Lifetime Maximum Benefit will not deny benefits for certain covered expenses.

### 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.