Schedule of Benefits

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

Plan Sponsor:	**The Church of Jesus Christ of Latter-Day Saints-Senior Missionaries**
Group Policy Number:	**840232**
Issue Date:	June 3, 2013
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Schedule:	1A
Cert Base:	1

For: PPO Medical and Pharmacy

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

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Plan Year Deductible*			
Individual Deductible*	$2,000	$2,000	$0
Family Deductible*	$4,000	$4,000	$0

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

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

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

Individual Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined: $2,500.
- For outside the United States expenses: $0.

Family Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined: $5,000.
- For outside the United States expenses: $0.

Lifetime Maximum Benefit Per Person	Unlimited	Unlimited	Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Plan 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.

Other Health Care (Out-of-Area): When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Wellness Benefits			
Routine Physical Exams Adults and Children. Includes coverage for immunizations.	100% per exam No Plan Year **deductible** applies.	70% per exam No Plan Year **deductible** applies.	100% per exam No Plan Year **deductible** applies.
Maximum Exams per 12 consecutive months period			
Adults, age 18 to 65	1 exam	1 exam	1 exam
Maximum Exams per 12 consecutive months period			
Adults, age 65 and over	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Wellness Benefits (cont'd)			
Well Child Exams Includes coverage for immunizations and Child Lead Testing.	100% per exam No Plan Year **deductible** applies.	70% per exam No Plan Year **deductible** applies.	100% per exam No Plan Year **deductible** applies.
Maximum Exams			
Under age 3			
first 12 months of life	7 exams	7 exams	7 exams
13th-24th months of life	3 exams	3 exams	3 exams
25th-36th months of life	3 exams	3 exams	3 exams
Maximum Exams per 12 consecutive month period			
From age 3 to age 18	1 exam	1 exam	1 exam
Routine Gynecological Exam	100% per exam No Plan Year **deductible** applies.	70% per exam No Plan Year **deductible** applies.	100% per exam No Plan Year **deductible** applies.
Maximum Exams per plan year	1 exam	1 exam	1 exam
Hearing Exam	100% per exam No Plan Year **deductible** applies.	70% per exam No Plan Year **deductible** applies.	100% per exam No Plan Year **deductible** applies.
Maximum Exams per 24 month period	1 exam	1 exam	1 exam
Hearing Aids for Children Under Age 24 *(GR 9N S-10-080-02 DE)*	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Maximum Benefit *(GR 9N S-10-080-02 DE)*	$1,000 per individual hearing aid, per ear, every three years.	$1,000 per individual hearing aid, per ear, every three years.	$1,000 per individual hearing aid, per ear, every three years.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Routine Cancer Screenings *(GR-9N-S-10-015-01 DE)*			
Routine Mammography	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum tests per plan year	Unlimited test	Unlimited test	Unlimited test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per visit No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Maximum tests per plan year	1 test	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	100% per visit No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Maximum tests per plan year	1 test	1 test	1 test
Routine Pap Smears	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum Tests per plan year	1 test	1 test	1 test
Fecal Occult Blood Test	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum Tests per 12 consecutive month period	1 test	1 test	1 test

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Routine Cancer Screenings (cont'd) *(GR-9N-S-10-015-01 DE)*			
Sigmoidoscopy Age 50 and over	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Colonoscopy age 50 and over	100% per test No Plan Year **deductible** applies.	70% per test No Plan Year **deductible** applies.	100% per test No Plan Year **deductible** applies.
Maximum tests per 10 consecutive year period	1 test	1 test	1 test
Family Planning Services *(GR-9N-S-10-015-01 DE)*			
Family Planning Services	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Vision Care *(GR-9N-S-10-020-01)*			
Eye Examinations (including refraction)	100% per exam No Plan Year **deductible** applies.	70% per exam No Plan Year **deductible** applies.	100% per exam No Plan Year **deductible** applies.
Maximum Benefit per 12 consecutive month period	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Physician Services *(GR-9N-S-10-25-02)*			
Physician Office Visits *(non-surgical)*	$20 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Alternative to Physician Office Visit *(GR-9N-S-10-25-03 DE)*			
E-visit Online Consultation by a Physician	$20 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered	Not Covered
Physician Services *(GR-9N-S-10-25-02)*			
Specialist Office Visits	$20 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Alternative to Specialist Office Visit *(GR-9N-S-10-25-03 DE)*			
E-visit Online Consultation by a Specialist	$20 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered	Not Covered
Physician Services *(GR-9N-S-10-25-02)*			
Physician Office Visits-Surgery			
Physician	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Specialist	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Physician Services (cont'd) *(GR-9N-S-10-25-02)*			
Walk-In Clinic Non-Emergency Visit *(GR-9N-S-10-25-03 DE)*	$20 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Administration of Anesthesia	80% per procedure after Plan Year **deductible**	70% per procedure after Plan Year **deductible**	100% per procedure No Plan Year **deductible** applies.
Allergy Testing and Treatment	$20 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Allergy Injections	80% per visit after Plan Year **deductible**.	70% per visit after Plan Year **deductible**.	100% per visit No Plan Year **deductible** applies.
Immunizations (when not part of the physical exam)	100% per visit No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Prenatal Visits	100% per visit No Plan Year **deductible** applies.	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Emergency Medical Services *(GR-9N 10-030 01)*			
Hospital Emergency Facility	$75 visit **copay** then the plan pays 80% after Plan Year **deductible**	$75 visit **deductible** then the plan pays 80% after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Non-Emergency Care in a Hospital Emergency Room	$75 visit **copay** then the plan pays 80% after Plan Year **deductible**	$75 visit **deductible** then the plan pays 80% after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$30 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan 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)*	$30 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.
Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035-01)*			
Complex Imaging Services			
Complex Imaging	80% per test after Plan Year **deductible**	70% per test after Plan Year **deductible**	100% per test No Plan Year **deductible** applies.
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	100% per procedure after Plan Year **deductible**	70% per procedure after Plan Year **deductible**	100% per procedure No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Diagnostic X-Rays			
Diagnostic X-Rays	80% per procedure after Plan Year **deductible**	70% per procedure after Plan Year **deductible**	100% per procedure No Plan Year **deductible** applies.
Outpatient Surgery *(GR-9N-S-10-040-01)*			
Outpatient Surgery	80% per visit/surgical procedure after Plan Year **deductible**	70% per visit/surgical procedure after Plan Year **deductible**	100% per visit/surgical procedure No Plan Year **deductible** applies.
Inpatient Facility Expenses *(GR-9N S-10-45-01)*			
Birthing Center	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Other than Room and Board	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Skilled Nursing Inpatient Facility	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Maximum Days per Plan Year	120 days	120 days	120 days
Specialty Benefits *(GR-9N-10-50-01)*			
Home Health Care (Outpatient) (Includes Private Duty Nursing)	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Maximum Visits per Plan Year	120 visits	120 visits	120 visits

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	80% per admission after the Plan Year **deductible**	70% per admission after the Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Hospice Care – Other Expenses during a stay	80% per admission after the Plan Year **deductible**	70% per admission after the Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Maximum Benefit per lifetime	30 days	30 days	30 days
Hospice Outpatient Visits	80% per visit after the Plan Year **deductible**	70% per visit after the Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Maximum Benefit per lifetime	Unlimited	Unlimited	Unlimited
Infertility Treatment - **Not Covered***(GR-9N-S-10-055-01)*			

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Inpatient Treatment of Mental Disorders *(GR-9N-S-10-062-01 DE)*			
MENTAL DISORDERS			
Hospital Facility Expenses			
Room and Board	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Other than Room and Board	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Physician Services	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Inpatient Residential Treatment			
Facility Expenses	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Physician Services	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Outpatient Treatment Of Mental Disorders			
Outpatient Services	$20 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Other than Room and Board	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Physician Services	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Inpatient Residential Treatment			
Facility Expenses	80% per admission after Plan Year **deductible**	70% per admission after Plan Year **deductible**	100% per admission No Plan Year **deductible** applies.
Physician Services	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Outpatient Treatment of Substance Abuse			
Outpatient Treatment	$20 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	70% per visit No Plan Year **deductible** applies.	100% per visit No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Other Covered Health Expenses *(GR 9N S-10-080-02 DE)*			
Acupuncture in lieu of anesthesia	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Ground, Air or Water Ambulance	80% per trip after Plan Year **deductible**	70% per trip after Plan Year **deductible**	100% per trip No Plan Year **deductible** applies.
Diabetic Equipment, Supplies and Education	80% per item after Plan Year **deductible**	70% per item after Plan Year **deductible**	100% per item No Plan Year **deductible** applies.
Durable Medical and Surgical Equipment	80% per item after Plan Year **deductible**	70% per item after Plan Year **deductible**	100% per item No Plan Year **deductible** applies.
Maximum Benefit per Plan Year	$2,500	$2,500	$2,500
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Prescription Drugs	Covered Under Pharmacy Benefit	50% per prescription No Plan Year **deductible** applies.	70% per prescription No Plan Year **deductible** applies.
Prosthetic Devices	80% per item after Plan Year **deductible**	70% per item after Plan Year **deductible**	100% per item No Plan Year **deductible** applies.

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Other Covered Health Expenses (cont'd) *(GR 9N S-10-080-02 DE)*			
Scalp Hair Prosthesis *(GR 9N S-10-080-02 DE)*	80% per item after Plan Year **deductible**	70% per item after Plan Year **deductible**	100% per item No Plan Year **deductible** applies.
Outpatient Therapies *(GR-9N S-10-90-01)*			
Chemotherapy	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Infusion Therapy	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Outpatient Therapies (cont'd) *(GR-9N S-10-90-01)*			
Radiation Therapy	80% per visit after Plan Year **deductible**	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies.
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Occupational, and Speech Therapy combined	$20 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	70% per visit after Plan Year **deductible**	100% per visit No Plan Year **deductible** applies
Combined Physical, Occupational and Speech Therapy Maximum visits per Plan Year *(GR-9N S-10-95-01)*	60 visits	60 visits	60 visits

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Spinal Manipulation			
Spinal Manipulation	$20 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies	75% per visit No Plan Year **deductible** applies	100% per visit No Plan Year **deductible** applies
Spinal Manipulation Maximum visits per Plan Year	9 visits	9 visits	9 visits
Global Emergency Assistance Program			
$500,000 plan year maximum	100% No Plan Year **deductible** applies	100% No Plan Year **deductible** applies	100% No Plan Year **deductible** applies

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

Coinsurance

PER PRESCRIPTION COPAY	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Generic Prescription Drugs			
The coinsurance percentage applies for each 31 day supply (retail) 365 day maximum supply (12 copay maximum)	35% No Plan Year deductible applies	Covered Under Medical	Covered Under Medical
Formulary - Brand-Name Prescription Drugs			
The coinsurance percentage applies for each 31 day supply (retail) 365 day maximum supply (12 copay maximum)	50% No Plan Year deductible applies	Covered Under Medical	Covered Under Medical

Non-Preferred-Brand-Name Prescription Drugs			
The coinsurance percentage applies for each 31 day supply (retail) 365 day maximum supply (12 copay maximum)	50% No Plan Year deductible applies	Covered Under Medical	Covered Under Medical

Mail Order - Generic Prescription Drugs			
Three times retail coinsurance for 90 day supply (mail order) 365 day maximum supply (12 copay maximum)	35% No Plan Year deductible applies	Not Covered	Not Covered

Mail Order -Formulary - Brand-Name Prescription Drugs			
Three times retail coinsurance for 90 day supply (mail order) 365 day maximum supply (12 copay maximum)	50% No Plan Year deductible applies	Not Covered	Not Covered

Mail Order- Non-Preferred Brand-Name Prescription Drugs			
Three times retail coinsurance for 90 day supply (mail order) 365 day maximum supply (12 copay maximum)	50% No Plan Year deductible applies	Not Covered	Not Covered

Coinsurance

PLAN FEATURES	NETWORK (In the U.S.)	OUT-OF-NETWORK (In the U.S.)	OUTSIDE THE U.S.
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Covered Under Medical	Covered Under Medical

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. Mail order only mails to locations in the United States.

Expense Provisions *(GR-9N-S-09-05-01 DE)*

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 DE)*

Network Plan Year Deductible

This is an amount of **network covered expenses** incurred each Plan Year for which no benefits will be paid. The **network** Plan Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **network** Plan Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Plan Year.

Out-of-Network Plan Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Plan Year for which no benefits will be paid. The **out-of-network** Plan Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Plan Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Plan 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** Plan Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Plan Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Plan Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Plan Year.

Out-of-Network Family Deductible Limit

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

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.

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 Plan 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 Plan 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 Plan Year meets the individual **Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Plan 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 Plan Year meets two times the individual **Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Plan 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**.

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**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- 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**. (Applies in the United States)

Precertification Benefit Reduction (Applies in the United States) *(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 $200 benefit reduction will be applied separately to each type of expense.

General *(GR-9N-28-01-01-DE)*

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.