

# Schedule of Benefits

(GR-29N 01-01 01)

**Employer:** Metal Lathers Local 46 Trust

**Group Policy Number:** GP-619383

**Issue Date:** February 22, 2010

**Effective Date:** February 1, 2010

**Schedule:** 1A

**Cert Base:** 1

For: Open Access Managed Choice (Open Access Gatekeeper PPO Plan)

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

## Gatekeeper PPO Medical Plan (GR-9N 11-005 01 NY)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>		
<b>Individual Deductible*</b>	None	\$1,250
<b>Family Deductible*</b>	None	\$2,500

\*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 **out-of-network** expenses: \$1,500.

### Family Coinsurance Limit:

- For **out-of-network** expenses: \$3,000.

<b>Lifetime Maximum Benefit per person</b>	Unlimited	\$1,000,000
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(GR-9N 11-010 -01)

**Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, 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, unless specifically stated otherwise.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Wellness Benefit</b>		
<b>Routine Physical Exams</b> Adults and Children.  Includes coverage for immunizations.	\$15 exam <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>
Maximum Exams per 12 consecutive month period		
Adults age 18 to 65	1 exam	1 exam
Maximum Exams per 12 consecutive month period		
Adults age 65 and over	1 exam	1 exam
<b>Preventative Care Services</b>	100% per exam  No <b>deductible</b> applies.	100% per exam  No <b>deductible</b> applies
<b>Hearing Exam</b> (GR-9N 11-010-01)	\$15 exam <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>
Maximum exams per 24 month period	1 exam	1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Routine Cancer Screenings (age and maximum limits do not apply to any person at high risk for the cancer being screened)</b> (GR-9N 11-015-01)		
<b>Routine Mammography</b>	100% per test  No <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>
Maximum tests per Calendar Year	1 test	1 test

<b><i>Diagnostic Screening for Prostatic Cancer</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Bone Mineral Density Measurements or Tests</i></b> (GR-9N S-11-80-01 NY)	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>Routine Gynecological Exams including Pap Smears</i></b>	100% per test  No <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>
Maximum tests per Calendar Year	1 test	1 test
<b><i>Fecal Occult Blood Test</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test	1 test
<b><i>Sigmoidoscopy</i></b> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
<b><i>Double Contrast Barium Enema (DCBE)</i></b> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
<b><i>Colonoscopy</i></b> age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 10 consecutive year period	1 test	1 test

<b>Family Planning Services</b>	100% per visit  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b>Vision Care</b> (GR-9N 11-020-01)		
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<b>Eye Examinations</b> including refraction	\$15 exam <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>
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Maximum Benefit per 12 consecutive month period	1 exam	1 exam
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Maximum Benefit for All Vision Care Supplies per 12 consecutive month period. (Does not apply toward the plan's lifetime maximum)	\$125	
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b>Physician Services</b> (GR-9N S 11-25 01)		
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<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	\$15 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
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<b>Specialist Office Visits</b>	\$15 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
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<b>Physician Office Visits-Surgery</b>		
<b>Physician</b>	\$15 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b>Specialist</b>	\$15 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	100% per visit No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b><i>Administration of Anesthesia</i></b>	100% per procedure No <b>deductible</b> applies	70% per procedure after Calendar Year <b>deductible</b>
<b><i>Allergy Testing and Treatment</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Allergy Injections</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Immunizations (when not part of the physical exam)</i></b>	\$15 visit <b>copay</b> then the plan pays 100% No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<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.
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Emergency Medical Services</i></b> (GR-9N 11-030 -01)		
<b><i>Hospital Emergency Facility</i></b>	\$150 <b>copay</b> per visit then the plan pays 100% No <b>deductible</b> applies	\$150 <b>deductible</b> per visit then the plan pays 100% No <b>deductible</b> applies
<b><i>Non-Emergency Care in a Hospital Emergency Room</i></b>	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 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>Urgent Care Services</b>		
<b>Urgent Medical Care</b> (at a non-hospital free standing facility)	\$15 <b>copay</b> per visit then the plan pays 100%	70% after Calendar Year <b>deductible</b>
	No <b>deductible</b> applies	

<b>Urgent Medical Care</b> (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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**Important Notice:**  
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.  
  
Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Outpatient Diagnostic Lab and Radiologic Services and Preoperative Testing</b> (GR-9N S-11-35-01 NY)		
<b>Outpatient Diagnostic Lab and Radiologic Services and Preoperative Testing</b>	\$5 per procedure <b>copay</b> then the plan pays 100%	70% per procedure after Calendar Year <b>deductible</b>
	No <b>deductible</b> applies	

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Outpatient Surgery</b>		
<b>Outpatient Surgery</b>	100% per visit/surgical procedure	70% per visit/surgical procedure after Calendar Year <b>deductible</b>
	No <b>deductible</b> applies	

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Facility Expenses</b> (GR-9N 11-045 01 NY)		
<b>Birthing Center</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<b>Hospital Expenses</b>		
Room and Board (including maternity)	100% per admission	70% per admission after Calendar Year <b>deductible</b>
	No <b>deductible</b> applies	
Other than Room and Board	100% per admission	70% per admission after Calendar Year <b>deductible</b>
	No <b>deductible</b> applies	

<b><i>Skilled Nursing Facility</i></b>	100% per admission No <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>
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Maximum Days per Calendar Year	60 days	60 days
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<b><i>Ambulatory Care Cancer</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
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<b><i>Specialty Benefits</i></b> (GR-9N 10-050-01) (GR-9N 11-050-01)		
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<b><i>Home Health Care (Outpatient)</i></b>	100% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
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Maximum Visits per Calendar Year	120 visits	120 visits
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<b><i>Private Duty Nursing (Outpatient)</i></b>	100% per visit No <b>deductible</b> applies	70% per visit after the Calendar Year <b>deductible</b>
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Maximum Visit Limit per <i>Calendar Year</i>	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.
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<b><i>Hospice Benefits</i></b>		
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<b><i>Hospice Care - Facility Expenses</i></b> (Room & Board)	100% per admission No <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>
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<b><i>Hospice Care - Other Expenses during a stay</i></b>	100% per admission No <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>
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Maximum Benefit per lifetime	210 days	210 days
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<b><i>Hospice Outpatient Visits</i></b>	100% per visit No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>
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Maximum Benefit per lifetime, inpatient and outpatient combined	180 days	180 days
Bereavement Counseling Maximum	5 visits	5 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b><i>Infertility Treatment</i></b> (GR-9N S-11-55-01 NY)		
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<b><i>Basic Infertility Expenses</i></b> Coverage is for the diagnosis and treatment of a correctable medical condition causing the infertility.	Payable on the same basis as any other <b>illness</b> or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other <b>illness</b> or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
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<b><i>Comprehensive Infertility 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.
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<b><i>Advanced Reproductive Technology (ART) 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.
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<p>Maximum per lifetime*</p> <p>Aetna will take into consideration all of the following, whether past or present:</p> <ul style="list-style-type: none"> <li>▪ Services received while covered under a plan of benefits offered by Aetna or one of its affiliated companies;</li> <li>▪ Services received while covered under a plan of benefits, on an individual or group basis, whether insured or self-insured, offered by any other carrier; and</li> <li>▪ Services received while no plan coverage was provided.</li> </ul>	<p>Three courses of treatment in a person's lifetime. (A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.).</p>	<p>Three courses of treatment in a person's lifetime. (A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.).</p>
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\*Does not apply toward the plan coinsurance limit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b><i>Inpatient Treatment of Mental Disorders</i></b> (GR-9N S-11-060-01 NY) (GR-9N 10-060 01)		
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<b><i>Coverage for Biologically-Based Mental Illness and Children with serious Emotional Disturbances</i></b>		
<b><i>Inpatient</i></b>	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.	Payable on the same basis as any other disease or injury, in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.
<b><i>Coverage for other than Biologically-Based Mental Illness and Children with Serious Emotional Disturbances</i></b>		
<b><i>Inpatient</i></b>	100% per admission  No <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>

Maximum Benefit per Calendar Year	30 days	30 days
One inpatient hospitalization day may be exchanged for 2 partial hospitalization visits.		

<b><i>Outpatient Treatment Of Mental Disorders</i></b>		
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<b><i>Coverage for Biologically-Based Mental Illness and Children with serious Emotional Disturbances</i></b>		
<b><i>Outpatient</i></b>	Payable on the same basis as any other disease or <b>injury</b> , in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.	Payable on the same basis as any other disease or <b>injury</b> , in accordance with the type of expense incurred. Refer to the other applicable sections of this Schedule to determine what the plan pays.
<b><i>Coverage for other than Biologically-Based Mental Illness and Children with Serious Emotional Disturbances</i></b>		
<b><i>Outpatient</i></b>	\$5 per visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>

Maximum Visits per Calendar Year	30 visits	30 visits
Crisis Intervention Services	3 visits	3 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Alcoholism and Substance Abuse</i></b> (GR-9N S-11-070-01 NY)		
<b><i>Inpatient Treatment</i></b>	100% per admission No <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>

Maximum Days per Calendar Year	37 days	37 days
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<b><i>Outpatient Treatment of Alcoholism and Substance Abuse</i></b>		
<b><i>Outpatient Treatment</i></b>	\$5 per visit <b>copay</b> then the plan pays 100% No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>

Maximum Visits per Calendar Year	60 visits, at least 20 for family members	60 visits, at least 20 for family members
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Other Covered Health Expenses</i></b> (GR-9N S-11-65-01) (GR-9N S-11-080 01 NY)		

<b><i>Acupuncture</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Emergency Transport (Air, Water, Ground)</i></b>	100% per trip after Calendar Year <b>deductible</b>	70% per trip after Calendar Year <b>deductible</b>
<b><i>Non-Emergency Transportation (ground)</i></b>	100% per trip after Calendar Year <b>deductible</b>	70% per trip after Calendar Year <b>deductible</b>

<b><i>Diabetic Equipment, Supplies and Education</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Durable Medical and Surgical Equipment</i></b>	100% per item	50% per item after the Calendar Year <b>deductible</b>
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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.
<b><i>Prosthetic Devices</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Enteral Formula</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Maternity Expenses</i></b>	Payable on the same basis as any other illness or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other illness or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
<b><i>Reconstructive Surgery and Supplies</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b><i>Reconstructive Breast Surgery</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Outpatient Therapies</i> (GR-9N 11-090-01)</b>		
<b><i>Chemotherapy</i></b>	100% per visit No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b><i>Infusion Therapy</i></b>	100% per visit No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>
<b><i>Radiation Therapy</i></b>	100% per visit No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>

<b><i>End of Life Care</i></b>	Payable on the same basis as any other <b>illness</b> or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.	Payable on the same basis as any other <b>illness</b> or <b>injury</b> , in accordance with type of expense incurred. Refer to the Physician Services other sections of this Summary to determine what the plan pays.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>		
<b><i>Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation</i></b>	\$15 per visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>

Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits
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<b><i>Speech Loss and Impairment</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Early Intervention Services</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Services Provided by a Center for Eating Disorders</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Second Medical Opinions</i></b> (GR-9N S-11-25-01 NY)		
<b><i>Second Medical Opinions (by an appropriate specialist (including, but not limited to a specialist affiliated with a specialty care center for the treatment of cancer) in the event of a positive or negative diagnosis of cancer; or a recurrence of cancer; or a recommendation of a course of treatment for cancer)</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.

**Second Opinions**

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-26-010-01 NY)

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b><i>Preferred Generic Prescription Drugs</i></b>		
For each 30 day supply	\$10	\$10
For more than a 30 day supply but less than a 91 day supply	\$10	Not Applicable
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
For each 30 day supply	\$20	\$20
For more than a 30 day supply but less than a 91 day supply	\$20	Not Applicable
<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
For each 30 day supply	\$10	\$10
For more than a 30 day supply but less than a 91 day supply	\$10	Not Applicable
<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>		
For each 30 day supply	\$30	\$30
For more than a 30 day supply but less than a 91 day supply	\$30	Not Applicable
<b>Coinsurance</b>		
	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drug Plan Coinsurance</b>	100% of the <b>negotiated charge</b>	80% of the <b>reasonable charge</b>

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

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

### 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* is underwritten by Aetna Life Insurance Company, policy form GR-29N.

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

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

### 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.

### 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.

## 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 out-of-network benefits.

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

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

### 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**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*); 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

### Calendar Year Maximum Benefit

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

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

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

### 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 **out-of-network** expenses.

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 reduced coinsurance of 50% will apply separately to the eligible expenses incurred for each type or service.

## 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.