Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure

The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers

We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a 'Discounted Fee For Service' arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.

Schedule of Benefits

(GR-29N-01-001-01 CA)

Employer: **California Lutheran University**

Group Policy Number: **GP-231825**

Issue Date: May 3, 2018
Effective Date: June 1, 2018
Schedule: 1A
Cert Base: 1

For: OA Managed Choice POS HDHP

Employee and Dependents 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 S-11-005-01 CA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$2,700	$2,700
Family Deductible*	$3,000	$3,000

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

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

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

Individual Maximum Out of Pocket Limit:

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

Family Maximum Out of Pocket Limit:

- For **network** expenses: $10,000.
- For **out-of-network** expenses: $20,000.

Lifetime Maximum Benefit per person	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, 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
Preventive Care		
Routine Physical Exams ***Office Visits***	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive month period	1 visit	1 visit
Covered Persons age 65 and over: Maximum Visits per 12 consecutive month period	1 visit	1 visit

(GR-9N S-10-016 05 NG CA)

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*	60% per visit after Calendar Year **deductible** Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.*

Screening & Counseling Services ***Office Visits*** ***-Obesity and/or Healthy Diet*** ***-Misuse of Alcohol and/or Drugs*** ***-Use of Tobacco Products*** ***-Sexually Transmitted Infections*** ***-Genetic Risk for Breast and Ovarian Cancer*** *(GR-9N S-10-016 05 NG CA)*	100% per visit No **copay** or **deductible** applies.	60% per visits after Calendar Year **deductible**

Obesity and/or Healthy Diet Benefit Maximums Maximum Visits per 12 consecutive month period *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *****
Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit. *(GR-9N S-10-016 05 NG CA)*		

Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive month period	5 visits*	5 visits*
Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit. *(GR-9N S-10-016 05 NG CA)*		

Use of Tobacco Products Maximum Visits per 12 consecutive month period	8 visits *****	8 visits *****

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.
(GR-9N S-10-016 05 NG CA)

Well Woman Preventive Visits ***Office Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administration	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit

Routine Cancer Screening ***Outpatient*** *(GR-9N S-10-016 05 NG CA)*	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N S-10-016 05 NG CA)

Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age; family history; and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*
Lung Cancer Screening Maximum	One screening every 12 months*.	One screening every 12 months*.
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing of your Schedule of Benefits.		

Prenatal Care		
Office Visits *(GR-9N S-10-016 05 NG CA)*	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible.**
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		

Comprehensive Lactation Support and Counseling Services *(GR-9N S-10-016 05 NG CA)*		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N S-10-016 05 NG CA)

Lactation Counseling Services Maximum Visits per 12 consecutive month period either in a group or individual setting	6* visits	Not Applicable
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		

(GR-9N S-10-016 05 NG CA)

Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	60% per item after Calendar Year **deductible**
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		

(GR-9N S-10-016 05 NG CA)

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**

(GR-9N S-10-016 05 NG CA)

Contraceptive Counseling Services - Maximum Visits per 12 months either in a group or individual setting	2* visits	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.*		

Family Planning Services - Female Contraceptives *(GR-9N S-10-016 05 NG CA)*		
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item. No **copay** or **deductible** applies.	60% per item after Calendar Year **deductible**

Family Planning Services - Female Voluntary Sterilization *(GR-9N S-10-016 05 NG CA)*		
Inpatient	100% per admission. No **copay** or **deductible** applies.	60% per admission after Calendar Year **deductible**
Outpatient	100% per visit/surgical procedure. No **copay** or **deductible** applies.	60% per visit/surgical procedure after Calendar Year **deductible**
Family Planning – Other *(GR-9N S-10-16-02 CA)*		
Voluntary Termination of Pregnancy Outpatient	80% per visit/surgical procedure after Calendar Year **deductible.**	60% per visit/surgical procedure after Calendar Year **deductible.**
Voluntary Sterilization for Males Outpatient	80% per visit/surgical procedure after Calendar Year **deductible.**	60% per visit/surgical procedure after Calendar Year **deductible.**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care *(GR-9N-S-11-020-01)*		
Eye Examinations including refraction	100% per exam No Calendar Year **deductible** applies.	Not Covered
Maximum Benefit per 24 consecutive month period	1 exam	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services *(GR-9N-S-11-025-03)*		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Specialist Office Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Walk-in Clinics Non-Emergency Visit	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services *(GR-9N S-10-030 09 CA)*		
Hospital Emergency Facility and Physician	80% per visit after the Calendar Year **deductible**	Paid the same as the Network level of benefits. See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
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.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not covered	Not covered

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing *(GR-9N S-10-035 06 CA)*		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery *(GR-9N 10-006 04 PA)*		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses *(GR-9N S-10-045 08 CA)*		
Birthing Center	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospital Facility Expenses		
Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	100 days	100 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits *(GR-9N 10-006 05 PA)*		
Home Health Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits

Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment *(GR-9N-S-10-055-01)*		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Mental Disorders and Substance Abuse *(GR-9N S-11-062 01 CA)*		
MENTAL DISORDERS (including Severe Emotional Disturbances of a Child)		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**

Outpatient Treatment Of Mental Disorders		
Outpatient Services	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	80% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical *(GR-9N S-11-065-01)*		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after the Calendar Year **deductible**	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna	$10,000 per lifetime	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses *(GR-9N S-10-075 06 CA)*			
Transplant Facility Expenses	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses *(GR-9N S-10-080 06 CA)*		
Acupuncture	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Maximum visits per Calendar Year	20 visits	20 visits
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Diabetes Benefits - Services, Supplies, Equipment and Training	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.
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Orthotic and Prosthetic Devices	Payment will be subject to the same **deductible**, **copay**, percentage and Maximums that apply to any other illness.	Payment will be subject to the same **deductible**, **copay**, percentage and Maximums that apply to any other illness.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies *(GR-9N S-10-090 05 CA)*		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Infusion Therapy	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

Radiation Therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies *(GR-9N S-10-095 07 CA)*		
Outpatient Physical and Occupational Therapy only	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies *(GR-9N S-10-095 07 CA)*		
Speech Therapy only	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder and Pervasive Developmental Disorder Treatment *(GR-9N S-10-061 05 CA)*		
Autism Spectrum Disorder and Pervasive Developmental Disorder behavioral health treatment, including Applied Behavior Analysis	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.
Autism Spectrum Disorder and Pervasive Developmental Disorder Diagnosis and Testing		
Autism Spectrum Disorder and Pervasive Developmental Disorder Diagnosis and Testing	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Phenylketonuria Services		
Phenylketonuria Services	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
Osteoporosis Services *(GR-9N S-11-16-01 CA)*		
	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
Anesthesia and Associated Charges for Certain Dental Care Services *(GR-9N S-11-81-01 CA)*		
	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
Second Medical Opinion Services *(GR-9N S-11-82-01 CA)*		
	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
AIDS Vaccine Services *(GR-9N S-11-83-01 CA)*		
	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
Expanded Alpha Feto Protein Services ***(GR-9N S-11-84-01 CA)***		
	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-26-011 01) (GR-9N S-26-013 01) (GR-9N S-26-016 01)*

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	None
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$25	None
For more than a 30 day supply but less than a 91 day supply (mail order)	$50	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$40	None
For more than a 30 day supply but less than a 91 day supply (mail order)	$80	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$40	None
For more than a 30 day supply but less than a 91 day supply (mail order)	$80	Not Applicable
Specialty Care Prescription Drugs		
For each 30 day supply	30% of the **negotiated charge** not to exceed $200	Not Covered
Orally administered anti-cancer prescription drugs including specialty drugs (GR-9N S-26-025 02 CA)		
For each 30 day supply filled at a retail or **specialty pharmacy**	Orally administered anti-cancer prescription drugs will be no more than $200 for a 30 day supply	Orally administered anti-cancer prescription drugs will be no more than $200 for a 30 day supply

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

Waiver for Prescription Drug Contraceptives

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

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

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

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

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	75% of the **recognized charge** (member cost-share will not exceed $250 for each 30 day supply of a prescription drug)

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

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

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

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

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

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

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

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

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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

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

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

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

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

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

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

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

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

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

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

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses 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**.

Penalty for Failure to Request Precertification *(GR-9N S-09-030 03 CA)*

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 the following penalty:

- A $400 penalty will be applied separately to each type of expense. However, the penalty will not exceed the cost of the 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.