Schedule of Benefits

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

Employer: **Government of the District of Columbia**

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For: PPO Medical Plan

PPO Medical Plan *(GR-9N-S-10-005-02 DC)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
*Individual Deductible**	$750	$1,500	$750
*Family Deductible**	$1,500	$3,000	$1,500

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

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

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $1,500.
- For **out-of-network** expenses: $3,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $3,000.
- For **out-of-network** expenses: $6,000.

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 Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network and other health care, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Wellness Benefits			
Routine Physical Exams Adults and Children. Includes coverage for immunizations.	100% per exam No Calendar Year **deductible** applies.	75% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 1 consecutive months period			
Adults, age 22 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
Well Child Exams Includes coverage for immunizations.	100% per exam No Calendar Year **deductible** applies.	75% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Preventive Health Services Care	100% per exam No Calendar Year **deductible** applies.	75% per exam after Calendar Year **deductible**	80% per exam No Calendar Year **deductible** applies.
Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.	75% per exam No Calendar Year **deductible** applies.	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 12 consecutive month period	1 exam	1 exam	1 exam

Hearing Exam	$30 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Maximum Exams per 24 month period	1 exam	Not Covered	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings *(GR-9N-S-10-015-02 DC)*			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	100% per test No Calendar Year **deductible** applies.	100% per test No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.	100% per visit No Calendar Year **deductible** applies.
Maximum tests per 12 consecutive month period	1 test	1 test	1 test

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Cervical Cytologic Screenings	100% per test No Calendar Year **deductible** applies.	75% per test No Calendar Year **deductible** applies.	80% per test No Calendar Year **deductible** applies.

Maximum Tests per 12 consecutive month period	1 test	1 test	1 test
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 12 consecutive month period	1 test	1 test	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Double Contrast Barium Enema *(DCBE)* Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 10 consecutive year period	1 test	1 test	1 test
Family Planning Services *(GR-9N-S-10-015-01 DC)*			
Family Planning 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.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Vision Care *(GR-9N-S-10-020-01)*			
Eye Examinations (including refraction)	100% per exam No Calendar Year **deductible** applies.	Not Covered	80% per exam No Calendar Year **deductible** applies.
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services *(GR-9N-S-10-25-02)*			
Physician Office Visits (*non-surgical*)	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Alternative to Physician Office Visit *(GR-9N-S-10-25-03 DC)*			
E-visit Online Consultation by a Physician	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits	$30 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Alternative to Specialist Office Visit *(GR-9N-S-10-25-03 DC)*			
E-visit Online Consultation by a Specialist	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered	Not Covered
Physician Office Visits-Surgery	85% per visit after Calendar Year **deductible**	75% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Walk-In Clinic Non-Emergency Visit *(GR-9N-S-10-25-03 DC)*	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Physician Services for Inpatient Facility and Hospital Visits	85% per visit after Calendar Year **deductible**	75% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	85% per procedure after Calendar Year **deductible**	75% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Allergy Testing and Treatment	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Allergy Injections	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies.
Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services *(GR-9N S-10-30-02)*			
Hospital Emergency Facility and Physician	$100 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$100 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies. See Important Note Below	$100 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies. See Important Note Below
Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.			
Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered	Not Covered
Important Notice: A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.			
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible**	$25 **deductible** per visit then the plan pays 80% No Calendar Year **deductible** applies.
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not Covered	Not Covered	Not Covered

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

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

PLAN FEATURES			
Outpatient Diagnostic and Preoperative Testing *(GR-9N-S-10-035-01)*			
Complex Imaging Services			
Complex Imaging	85% per test after Calendar Year **deductible**	75% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	85% per procedure after Calendar Year **deductible**	75% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays			
Diagnostic X-Rays	85% per procedure after Calendar Year **deductible**	75% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery *(GR-9N-S-10-040-01)*			
Outpatient Surgery	100% per visit/surgical procedure after Calendar Year **deductible**	75% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Facility Expenses *(GR-9N S-10-45-01)*			
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (including maternity)	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**

Skilled Nursing Inpatient Facility	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	60 days	60 days	60 days

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Specialty Benefits (GR-9N-10-50-01)			
Home Health Care (Outpatient)	100% per visit after Calendar Year **deductible**	75% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	60	60	60
Private Duty Nursing (Outpatient)	100% per visit after the Calendar Year **deductible**	75% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**
Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	100% per admission after the Calendar Year **deductible**	75% per admission after the Calendar Year **deductible**	80% per admission after the Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	100% per admission after the Calendar Year **deductible**	75% per admission after the Calendar Year **deductible**	80% per admission after the Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
Hospice Outpatient Visits	100% per visit after the Calendar Year **deductible**	75% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Infertility Treatment *(GR-9N-S-10-055-01)*			
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses Expenses for Comprehensive Infertility services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	Not Covered	6 courses of treatment per lifetime
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	Not Covered	6 courses of treatment per lifetime
Advanced Reproductive Technology (ART) Expenses Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum per lifetime	3 attempts	Not Covered	3 attempts
The Advanced Reproductive Technology (ART) Expenses Maximum per lifetime amount shown above will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.			

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Mental Disorders *(GR-9N-S-10-062-01 DC)*			
MENTAL DISORDERS *Hospital Facility Expenses*			
Room and Board	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment			
Facility Expenses	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	100% after Calendar Year **deductible**	75% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Outpatient Treatment Of Mental Disorders			
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Outpatient Services	$15 per visit **copay** then the plan pays 100% for the first 40 visits, 100% for each visit thereafter No Calendar Year **deductible** applies.	75% per visit after the Calendar Year **deductible** for the first 40 visits, 75% for each visit thereafter	80% per visit for the first 40 visits, 80% for each visit thereafter No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Inpatient Residential Treatment			
Facility Expenses	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Physician Services	100% after Calendar Year **deductible**	75% after Calendar Year **deductible**	80% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Treatment of Substance Abuse			
Outpatient Services	$15 per visit **copay** then the plan pays 100% for the first 40 visits, 100% for each visit thereafter No Calendar Year **deductible** applies.	75% per visit after Calendar Year **deductible** for the first 40 visits, 75% for each visit thereafter	80% per visit for the first 40 visits, 80% for each visit thereafter No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Obesity Treatment Non Surgical (GR-9N-S-10-065-01)			
Outpatient Obesity Treatment (non surgical)	100% per visit after Calendar Year **deductible**	Not Covered	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Obesity Treatment Surgical (GR-9N S-11-065-01)			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per admission after Calendar Year **deductible**	Not Covered	80% per admission after Calendar Year **deductible**

Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered		Unlimited

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK	OTHER HEALTH CARE
Transplant Services Facility and Non-Facility Expenses *(GR-9N-S-10-075-01)*				
Transplant Facility Expenses	100% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**	75% per admission after Calendar Year **deductible**
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES			
Other Covered Health Expenses *(GR-9N-S-10-080-01)*			
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Ground, Air or Water Ambulance	100% No Calendar Year **deductible** applies.	75% after Calendar Year **deductible** applies.	80% No Calendar Year **deductible** applies.
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	80% per item after Calendar Year **deductible**	75% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
Jaw Joint Disorder Treatment	100% per visit No Calendar Year **deductible** applies	75% per visit after Calendar Year **deductible**	80% per visit No Calendar Year **deductible** applies

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	80% per item after Calendar Year **deductible**	75% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Therapies *(GR-9N S-10-90-01)*			
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Occupational, and Speech Therapy combined	85% per visit after Calendar Year **deductible**	75% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year *(GR-9N S-10-95-01)*	60	60	60

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Spinal Manipulation			
Spinal Manipulation	85% per visit after Calendar Year **deductible**	75% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

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

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

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$20	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$40	Not Covered
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$20	Not Covered
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$40	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	$80	Not Covered

Coinsurance

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

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

Step therapy for certain **prescription drugs** is required. If the step therapy process is not followed, the **prescription drug** will not be covered.

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

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

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

Keep This Schedule of Benefits With Your Booklet-Certificate.

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

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

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

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

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

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

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

Copayments and Benefit Deductible Provisions *(GR-9N S-09-15 01)*

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 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**.

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 incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction *(GR-9N S-09-30 02 DC)*

The Booklet-Certificate contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A $400 benefit reduction will be applied separately to each type of expense.

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

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.

Schedule of Benefits

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

Employer: **Government of the District of Columbia**

Group Policy Number: **GP-725016**
Control Number: **CN-863743**

Issue Date: March 13, 2014
Effective Date: January 1, 2014
Schedule: 4A
Cert Base: 4

For: Basic Vision Expense Plan

Basic Vision Expense Coverage *(GR-9N-S-24-005-01)*

(GR-9N-S-24-005-01)
Vision Supply Maximum- $100 per 24 month period.

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.

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

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.

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.