

# Schedule of Benefits

Employer: **The City of Seattle**  
 ASC: 100290  
 Issue Date: July 31, 2014  
 Effective Date: August 1, 2014  
 Schedule: 12A  
 Booklet Base: 12

For: Open Choice (PPO Medical) – Local 77 Most City Preventive Plan

## PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Calendar Year Deductible*</b>			
<i>Individual Deductible*</i>	\$100	\$450	\$100
<i>Family Deductible*</i>	\$300	\$1,350	\$300
<b>Per Admission Copayment</b>	\$200 per admission	Not applicable	Not applicable
<b>Per Admission Deductible*</b>	Not applicable	\$200 per admission	\$200 per admission
<i>Common Accident Deductible</i>	\$100	\$450	\$100

Per Admission copayment/deductible waived for confinements that are not separated by at least 10 days.

\*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: \$2,100
- For **out-of-network** expenses: \$3,450

**Family Maximum Out of Pocket Limit:**

- For **network** expenses: \$4,300.
- For **out-of-network** expenses: \$7,350.

<b>Lifetime Maximum Benefit Per Person</b>	Unlimited	Unlimited	Unlimited
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*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.*

*All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.*

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Preventive Care Benefits</b>			
<b>Routine Physical Exams</b> Includes coverage for non-travel immunizations.	100% per visit  No <b>copay</b> or <b>deductible</b> applies.	Not Covered	100% per visit  No <b>deductible</b> applies.

<i>Under age 6:</i> Maximum Visits per Calendar Year*	Unlimited	Not Covered	Unlimited
<i>From age 6 to age 12:</i> Maximum Visits per Calendar Year*	2 visits	Not Covered	2 visits
<i>Age 12 and older:</i> Maximum Visits per Calendar Year*	1 visit	Not Covered	1 visit

\* The age and visit limits shown above will apply to your plan unless the age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration result in greater benefits.

For details, contact your **physician**, log onto the Aetna website [www.aetna.com](http://www.aetna.com), or call the number on the back of your ID card.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Screening &amp; Counseling Services - Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>	100% per visit  No <b>copay</b> or <b>deductible</b> applies.	Not Covered	100% per visit  No <b>deductible</b> applies.

*Obesity*

Maximum Visits per Calendar Year  
*(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)\**

Not Covered

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.**

*Misuse of Alcohol and/or Drugs*

Maximum Visits per Calendar Year

5 visits\*

Not Covered

5 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per Calendar Year

8 visits\*

Not Covered

8 visits\*

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

<b>Well Woman Preventive Visits</b>			
<b>Office Visits</b>	100% per visit	Not Covered	100% per exam
	No Calendar Year deductible applies.		No Calendar Year deductible applies.
Maximum Visits per 12 months	1 visit	1 visit	1 visit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Hearing Exam</b>	\$15 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible	90% per exam
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Maximum Exams per 12 month period	1 exam	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Routine Cancer Screenings</b>			
<b>Routine Cancer Screenings Outpatient</b>	100% per visit	60% per visit after Calendar year deductible.	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

<b>All Other Routine Exams and Screenings*</b>	100% per visit	Not Covered	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

\* Including but not limited to: fecal occult blood tests, digital rectal exams, prostate specific antigen (PSA) tests, sigmoidoscopies, double contrast barium enemas (DCBE) and colonoscopies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Age & Visit Limits per Calendar Year (All Routine Cancer Screenings)	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.*  <i>For details, contact your <b>physician</b>, log onto the <b>Aetna website</b> <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	Not Covered	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.*  <i>For details, contact your <b>physician</b>, log onto the <b>Aetna website</b> <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>

<b>Prenatal Care Office Visits</b>	100% per visit  No <b>deductible</b> applies.	<b>60%</b> per visit after Calendar Year <b>deductible</b> .	100% per visit  No <b>deductible</b> applies.
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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.

<b>Comprehensive Lactation Support and Counseling Services Lactation Counseling Services - Facility or Office Visits</b>	100% per visit.  No <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
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Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per <b>12 months</b>	Not Applicable	6* visits per <b>12 months</b>
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**\*Important Note:** Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*..

<b>Breast Pumps &amp; Supplies</b>	100% per item. No copay or deductible applies.	Not covered	100% per item.  No deductible applies.
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Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.

### Family Planning Services

<i>Family Planning Services</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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### Family Planning Services

Female Contraceptive Counseling Services - Office Visits.	100% per visit. No copay or Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	100% per visit No Calendar Year <b>deductible</b> applies.
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Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable	2* visits per 12 months
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\*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 Voluntary Sterilization

<b>Inpatient</b>	100% per visit. No <b>copay</b> or <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.
<b>Outpatient</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.

### Physician Services

<b>Physician Office Visits</b> ( <i>non-surgical</i> )	\$15 visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit No Calendar Year <b>deductible</b> applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialist Office Visits</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Aexcel Designated Network Specialist</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Non-Designated Network Specialist</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.

<i>Physician Office Visits-Surgery</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Aexcel Designated Network Specialist</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Non-Designated Network Specialist</i>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable	90% per visit  No Calendar Year <b>deductible</b> applies.
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Walk-In Clinic Non-Emergency Visit</b>	\$15 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies
<b>Physician Services for Inpatient Facility and Hospital Visits</b>	90% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>	90% per visit after Calendar Year <b>deductible</b>
<b>Aexcel Designated Network Specialist</b>	90% per visit after Calendar Year <b>deductible</b>	Not applicable	90% per visit after Calendar Year <b>deductible</b>
<b>Non-Designated Network Specialist</b>	80% per visit after Calendar Year <b>deductible</b>	Not applicable	90% per visit after Calendar Year <b>deductible</b>
<b>Out of Network Provider Specialist</b>	Not applicable	60% per visit after Calendar Year <b>deductible</b>	90% per visit after Calendar Year <b>deductible</b>
<b>Administration of Anesthesia</b>	90% per procedure after Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>	90% per procedure after Calendar Year <b>deductible</b>
<b>Allergy Testing and Treatment</b>	\$15 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
<b>Allergy Injections</b>	90% per visit  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
<b>Immunizations (when not part of the physical exam)</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	Not Covered	90% per visit  No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Emergency Medical Services</b>			
<b>Hospital Emergency Facility and Physician</b>	\$150 <b>copay</b> per visit then the plan pays 90%  No Calendar Year <b>deductible</b> applies.	\$150 <b>deductible</b> per visit then the plan pays 90%  No Calendar Year <b>deductible</b> applies.	\$150 <b>deductible</b> per visit then the plan pays 90%  No Calendar Year <b>deductible</b> applies.
	Emergency physician may not be a network provider. See Important Note below.	See Important Note below	See Important Note below
<b>Important Note:</b> Out-of-network providers do not have a contract with <b>Aetna</b> , and may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b> ) 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 the back of 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.			

<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$150 <b>copay</b> per visit then the plan pays 60%  No Calendar Year <b>deductible</b> applies.	\$150 <b>deductible</b> per visit then the plan pays 60%  No Calendar Year <b>deductible</b> applies.	\$150 <b>deductible</b> per visit then the plan pays 60%  No Calendar Year <b>deductible</b> applies.
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**Important Notice:**  
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Urgent Care Services</b>			
<b>Urgent Medical Care</b> <i>(at a non-hospital free standing facility)</i>	\$15 <b>copay</b> per visit then the plan pays 100%	60% after Calendar Year <b>deductible</b>	\$15 <b>deductible</b> per visit then the plan pays 90%
	No Calendar Year <b>deductible</b> applies		No Calendar Year <b>deductible</b> applies

<b>Urgent Medical Care</b> <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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### Important Notice

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

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

### PLAN FEATURES

#### Outpatient Diagnostic and Preoperative Testing

##### Complex Imaging Services

<b>Complex Imaging</b>	90% per test after Calendar Year <b>deductible</b>	60% per test after Calendar Year <b>deductible</b>	90% per test after Calendar Year <b>deductible</b>
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##### Diagnostic Laboratory Testing

<b>Diagnostic Laboratory Testing</b>	90% per test after Calendar Year <b>deductible</b> (whether or not billed as part of an office visit)	60% per test after Calendar Year <b>deductible</b>	90% per test after Calendar Year <b>deductible</b> (whether or not billed as part of an office visit)
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Diagnostic X-Rays</i></b>			
<b><i>Diagnostic X-Rays</i></b>	90% per procedure after Calendar Year <b>deductible</b> (whether or not billed as part of an office visit)	60% per procedure after Calendar Year <b>deductible</b>	90% per procedure after Calendar Year <b>deductible</b> (whether or not billed as part of an office visit)

<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b> (performed at a <b>hospital</b> or other outpatient facility)	90% per visit/surgical procedure after Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>	90% per visit/surgical procedure after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Facility Expenses</i></b>			
<b><i>Birthing Center</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<b><i>Hospital Facility Expenses</i></b>			
Room and Board (including maternity)	\$200 per admission <b>copayment*</b> , then the plan pays 90%	\$200 per admission <b>deductible*</b> , then the plan pays 60%	\$200 per admission <b>deductible *</b> , then the plan pays 90%
	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies
Other than Room and Board (Inpatient)	90% per admission	60% per admission	90% per admission
	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies
Other than Room and Board (outpatient)	90% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>

\* Per admission copayment/deductible waived for newborn charges.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Skilled Nursing Inpatient Facility</b>	\$200 per admission <b>copayment</b> , then the plan pays 90%	\$200 per admission <b>deductible</b> , then the plan 60%	\$200 per admission <b>deductible</b> , then the plan pays 90%
	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies	No Calendar Year <b>deductible</b> applies

Maximum Days per Calendar Year	120 days	120 days	120 days
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Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Specialty Benefits</b>			
<b>Home Health Care (Outpatient)</b>	90% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>	90% per visit after Calendar Year <b>deductible</b>

Maximum Visits per Calendar Year	130	130	130
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<b>Hospice Benefits</b>			
<b>Hospice Care – Facility Expenses</b> (Room & Board)	90% per admission after the Calendar Year <b>deductible</b>	Not Covered	90% per admission after the Calendar Year <b>deductible</b>
<b>Hospice Care – Other Expenses during a stay</b>	90% per admission after the Calendar Year <b>deductible</b>	Not Covered	90% per admission after the Calendar Year <b>deductible</b>

Maximum Benefit per lifetime	Unlimited days	Not Applicable	Unlimited days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Hospice Outpatient Visits</b>	90% per visit after the Calendar Year deductible	Not Covered	90% per visit after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Infertility Treatment</b>			
<b>Basic Infertility Expenses</b> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b>Infertility Drugs</b> (prescribed by a Network Physician)	80% after the Calendar Year deductible	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	\$2,000	Not Applicable	Not Applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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*Inpatient Treatment of Mental Disorders*

**MENTAL DISORDERS**

*Hospital Facility Expenses*

Room and Board	\$200 per admission <b>copayment</b> , then the plan pays 90%	\$200 per admission <b>deductible</b> , then the plan pays 60%	\$200 per admission <b>deductible</b> , then the plan pays 90%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
Other than Room and Board	90% per admission	60% per admission	90% per admission
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
Physician Services	90% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>	90% per admission after Calendar Year <b>deductible</b>

*Inpatient Residential Treatment*

Facility Expenses	\$200 per admission <b>copayment</b> , then the plan pays 90%.	\$200 per admission <b>deductible</b> , then the plan pays 60%	\$200 per admission <b>deductible</b> , then the plan pays 90%.
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
Physician Services	90% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b> .	90% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Outpatient Services</i></b>			
<b><i>Office Visits</i></b>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	100% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Treatment of Substance Abuse</i></b>			
<b><i>Hospital Facility Expense</i></b>			
Room and Board	\$200 per admission <b>copayment</b> , then the plan pays 90%  No Calendar Year <b>deductible</b> applies.	\$200 per admission <b>deductible</b> , then the plan pays 60%  No Calendar Year <b>deductible</b> applies.	\$200 per admission <b>deductible</b> , then the plan pays 90%  No Calendar Year <b>deductible</b> applies.
Other than Room and Board	90% per admission  No Calendar Year <b>deductible</b> applies.	60% per admission  No Calendar Year <b>deductible</b> applies.	90% per admission  No Calendar Year <b>deductible</b> applies.
Physician Services	90% per admission after Calendar Year <b>deductible</b>	60% per admission after Calendar Year <b>deductible</b>	90% per admission after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Residential Treatment</i></b>			
Facility Expenses	\$200 per admission <b>copayment</b> , then the plan pays 90%.	\$200 per admission <b>deductible</b> , then the plan pays 60%	\$200 per admission <b>deductible</b> , then the plan pays 90%.
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
Physician Services	90% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b> .	90% per visit after Calendar Year <b>deductible</b>

<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
<b><i>Office Visits</i></b>	\$15 per visit <b>copay</b> then the plan pays 100%	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies.
	No Calendar Year <b>deductible</b> applies.		
<b><i>Other Than Office Visits</i></b>	100% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Obesity Treatment Non Surgical</i></b>			
<b><i>Outpatient Obesity Treatment (non surgical)</i></b>	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.

PLAN FEATURES	NETWORK (IOQ Facility)	NETWORK (Non-IOQ Facility)	OUT-OF-NETWORK
<b>Obesity Treatment Surgical</b>			
<b>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</b>	\$200 per admission <b>copay</b> then the plan pays 90%  No Calendar Year <b>deductible</b> applies	Not Covered	Not Covered
<b>Outpatient Morbid Obesity Surgery</b>	90% per service after Calendar Year <b>deductible</b>	Not Covered	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Not Covered

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Transplant Services Facility and Non-Facility Expenses</b>				
<b>Facility Expenses</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<b>Physician Services</b> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

**PLAN FEATURES**

***Other Covered Health Expenses***

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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.	Payable in accordance with the type of expense incurred and the place where service is provided.

All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.

<b><i>Ambulance (Ground, Air or Water)</i></b>	90% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>
<b>Blood Bank Charges</b>	90% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Diabetic Equipment, Supplies and Education</i></b>		
When Diabetic Equipment and Supplies <b>are obtained</b> from a Durable Medical Equipment provider	100%  No Calendar Year <b>deductible</b> applies.	60% after Calendar Year <b>deductible</b>
When Diabetic Equipment and Supplies <b>are not obtained</b> from a Durable Medical Equipment provider	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.
Diabetic 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.

<b><i>Durable Medical and Surgical Equipment</i></b>	90% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>
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<b>Hearing Aids</b>	90%	90%	90%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
<b>Jaw Joint Disorder Treatment</b>	90% after Calendar Year <b>deductible</b>	60% after Calendar Year <b>deductible</b>	90% after Calendar Year <b>deductible</b>
Non-Surgical Lifetime Maximum Benefit	\$5,000	\$5,000	\$5,000
Surgical Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</b>			
Orthodontic treatment directly related to an orthognathic surgical procedure	90% of billed charges after Calendar Year deductible	90% of billed charges after Calendar Year deductible	90% of billed charges after Calendar Year deductible
All other treatment	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.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
<b>Phenylketonuria Formula</b>	100% after Calendar Year <b>deductible</b>	100% after Calendar Year <b>deductible</b>	100% after Calendar Year <b>deductible</b>

<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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

<b><i>Transgender Reassignment (Sex Change) 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.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Outpatient Therapies</i></b>			

<b><i>Chemotherapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Infusion Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<b><i>Radiation Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Short Term Outpatient Rehabilitation Therapies</b>			
<b>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</b>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies

Outpatient physical, massage, occupational and speech therapy are covered only for non-chronic conditions and acute illnesses and injuries as described in the Short-Term Rehabilitation Therapy Services section of your Booklet. All treatment plans are subject to ongoing review and approval by Aetna for medical necessity.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Neurodevelopmental Therapy</b>			
<b>Outpatient Neurodevelopmental Therapy</b>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies

Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)*	\$5,000	\$5,000	\$5,000
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\* Benefits for rehabilitation therapy may not be duplicated for the same conditions and services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Spinal Manipulation</b>			
<b>Spinal Manipulation</b>	\$15 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	60% per visit after Calendar Year <b>deductible</b>	90% per visit  No Calendar Year <b>deductible</b> applies

Spinal Manipulation Maximum visits per Calendar Year	20	20	20
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## Pharmacy Benefit

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Generic Prescription Drugs</b>		
For each 31 day supply (retail)	The greater of \$10 or 30% of the <b>negotiated charge</b> not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 30% of the <b>negotiated charge</b> not to exceed \$200	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Brand-Name Prescription Drugs</b>		
For each 31 day supply (retail)	The greater of \$10 or 40% of the <b>negotiated charge</b> not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 40% of the <b>negotiated charge</b> not to exceed \$200	Not Covered

The following reduced copays apply only for the specific drug classifications shown.

### **Smoking Cessation Drugs, Asthma Drugs and Antihyperlipidemic Drugs:**

<b>Generic Prescription Drugs</b>		
For each 31 day supply (retail)	The greater of \$5 or 10% of the <b>negotiated charge</b> not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$10 or 10% of the <b>negotiated charge</b> not to exceed \$200	Not Covered

**Brand-Name Prescription Drugs**

For each 31 day supply (retail)	The greater of \$10 or 20% of the <b>negotiated charge</b> not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 20% of the <b>negotiated charge</b> not to exceed \$200	Not Covered

**Diabetic Drugs and Supplies:**

**PER PRESCRIPTION COPAY/DEDUCTIBLE NETWORK OUT-OF-NETWORK**

**Generic Prescription Drugs**

For each 31 day supply (retail)	\$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$10	Not Covered

**Brand-Name Prescription Drugs**

For each 31 day supply (retail)	\$15	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$30	Not Covered

**Proton Pump Inhibitors and Non-Sedating Antihistamines**

Monthly Maximum Benefit paid by plan (applies to covered prescription strength and Over-the-Counter equivalent versions - see your Booklet for details)	\$ 20
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The above maximum applies separately to you and each of your covered dependents. Unused amounts do not roll over from month to month.

An additional benefit may be available for brand name Proton Pump Inhibitors if prescribed by a physician and determined by Aetna to be medically necessary. If approved by Aetna, the additional benefit will be subject to all plan provisions and limitations, including the copays, coinsurance and out-of-pocket limits shown above. Contact Central Benefits at (206) 615-1340 for details.

## Coinsurance

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

## Prescription Drug Maximum Out-of-Pocket Limit (Annual Limit)

	NETWORK	OUT-OF-NETWORK
<b>Prescription Drug Maximum Out-of-Pocket Limit</b>	\$1,200 Individual \$3,600 Family	Not Applicable Not Applicable

**Individual Prescription Drug Maximum Out-of-Pocket Limit:** Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

### Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent's share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network prescription drug covered expenses**.

**Family Prescription Drug Maximum Out-of-Pocket Limit.** Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

### Prescription Drug Maximum Out-of-Pocket Limit

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network prescription drug covered expenses**.

## Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** maximum out-of-pocket limit and the family **prescription drug** maximum out-of-pocket limit. These include:

Expenses above the **recognized charge**.  
Non-**covered expenses**.

## Expense Provisions

**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*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## **Deductible Provisions**

### **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**.

### **Common Accident Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate **network** or **out-of-network** Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any **network** or **out-of-network** family **deductible** limit benefit amount paid for the same **covered expenses**.

## Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's **network** or **out-of-network** Calendar Year **deductible** will also count toward the following year's **network** or **out-of-network** Calendar Year **deductible**.

## Copayments and Benefit Deductible Provisions

### 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.

### Per Admission Deductible

A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

### Per Admission Copayment

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** 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.

**Covered expenses** applied to the per admission **deductible/copayment** cannot be applied to any other **deductible/copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles/copayments** cannot be applied to meet the per admission **deductible/copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible/copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

## Payment Provisions

### Payment Percentage

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 Payment Percentage". 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 payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage 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. This Plan has an individual **Maximum out of Pocket Limit**. As to the individual **Maximum Out of Pocket Limit**, each of you must meet your **Maximum out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out of Pocket Limit**. See list below.

## **Network Provider and Other Health Care Maximum Out of Pocket Limit.**

### **Individual**

Once the amount of eligible **network provider** and **other health care** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

### **Family Maximum out of Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider** and **other health care Maximum Out of Pocket Limit** these expenses will also count toward a family **network provider** and **other health care Maximum Out of Pocket Limit**.

To satisfy this family **network provider** and **other health care Maximum Out of Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out of Pocket Limit** is a cumulative **Maximum Out of Pocket Limit** for all family members. The family **network provider** and **other health care Maximum Out of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider** and **other health care Maximum Out of Pocket Limit** amount in a Calendar Year.

## **Out-of-Network Provider Maximum Out of Pocket Limit**

### **Individual**

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

### **Family Maximum Out of Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out of Pocket Limit** these expenses will also count toward a family **out-of-network provider Maximum Out of Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out of Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out of Pocket Limit** is a cumulative **Maximum Out of Pocket Limit** for all family members. The family **out-of-network provider Maximum Out of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out of Pocket Limit** amount in a Calendar Year.

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**;
- Expenses incurred for infertility drugs;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

## 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 applies to **network care** and **out-of-network care** expenses combined.

## General

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 and should be kept with your Booklet.