

Schedule of Benefits

Employer: **The City of Seattle**
 ASC: 100290
 Issue Date: December 11, 2013
 Effective Date: January 1, 2014
 Schedule: 7A
 Booklet Base: 7

For: Open Choice (PPO Medical) - Local 77 Traditional Plan

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$100	\$150	\$100
<i>Family Deductible*</i>	\$300	\$450	\$300

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

<i>Common Accident Deductible</i>	\$100	\$150	\$100
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Plan Payment Limit excludes plan **deductibles and copayments**

Individual Payment Limit:

- For **network** expenses: \$200.
- For **out-of-network** expenses: \$1,200.

<i>Lifetime Maximum Benefit Per Person</i>	Unlimited	Unlimited	Unlimited
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Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the 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
Preventive Care			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year deductible applies.
Maximum Exams per 12 consecutive month period Adults, age 18 to 65	1 exam	Not Applicable	1 exam
Maximum Exams per 12 consecutive month period Adults, age 65 and over	1 exam	Not Applicable	1 exam
Well Child Exams Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Exams			
Under age 3			
first 12 months of life	7 exams	Not Applicable	7 exams
13th-24th months of life	3 exams	Not Applicable	3 exams
25th-36th months of life	3 exams	Not Applicable	3 exams
Maximum Exams per 12 consecutive month period			
From age 3 to age 18	1 exam	Not Applicable	1 exam
<i>Routine Gynecological Exam</i>	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year deductible applies.
Maximum Exams per Calendar Year	1 exam	Not Applicable	1 exam
<i>Hearing Exam</i>	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible
Maximum Exams per 12 month period	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Routine Cancer Screenings</i>			
<i>Routine Mammography</i>	80% per test No Calendar Year deductible applies.	60% per test No Calendar Year deductible applies.	80% per test No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	1 test	1 test
<i>Prostate Specific Antigen Test</i> For covered males age 40 and over.	100% per visit No Calendar Year deductible applies.	Not Covered	80% per visit No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	Not Applicable	1 test
<i>Routine Digital Rectal Exam</i> For covered males age 40 and over.	100% per visit No Calendar Year deductible applies.	Not Covered	80% per visit No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	Not Applicable	1 test
<i>Routine Pap Smears</i>	100% per test No Calendar Year deductible applies.	Not Covered	80% per test No Calendar Year deductible applies.
Maximum Tests per Calendar Year	1 test	Not Applicable	1 test
<i>Fecal Occult Blood Test</i>	100% per test No Calendar Year deductible applies.	Not Covered	80% per test No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Tests per 12 consecutive month period	1 test	Not Applicable	1 test
Sigmoidoscopy Age 50 and over	50% per test after Calendar Year deductible	Not Covered	50% per test after Calendar Year deductible
Maximum Tests per 5 consecutive year period	1 test	Not Applicable	1 test
Double Contrast Barium Enema (DCBE) Age 50 and over	100% per test No Calendar Year deductible applies.	Not Covered	80% per test No Calendar Year deductible applies.
Maximum Tests per 5 consecutive year period	1 test	Not Applicable	1 test
Colonoscopy age 50 and over	50% per test after Calendar Year deductible	Not Covered	50% per test after Calendar Year deductible
Maximum tests per 10 consecutive year period	1 test	Not Applicable	1 test
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
Physician Office Visits <i>(non-surgical)</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Specialist Office Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Aexcel Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
Non-Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Physician Office Visits-Surgery	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Aexcel Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
Non-Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Walk-In Clinic Non-Emergency Visit	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Allergy Injections</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Immunizations (when not part of the physical exam)</i>	100% per visit No Calendar Year deductible applies.	Not Covered	80% per visit No Calendar Year deductible applies.
<i>Prenatal Visits</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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services			
Hospital Emergency Facility and Physician	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
	Emergency physician may not be a network provider. See Important Note below	See Important Note below	See Important Note below
<p>Important Note: Out-of-network providers do not have a contract with Aetna, and 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 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.</p>			

Non-Emergency Care in a Hospital Emergency Room	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Urgent Care Services			
Urgent Medical Care (at a non-hospital free standing facility)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Urgent Medical Care (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Diagnostic and Preoperative Testing			
Preoperative Testing (except complex imaging services) Performed at a Hospital Outpatient Facility	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Complex Imaging Services			
Complex Imaging	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Diagnostic X-Rays			
Diagnostic X-Rays	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Outpatient Surgery			
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year deductible	60% 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			
Birth 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	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Room and Board (including maternity)			
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Maximum Days per Calendar Year	90 days	90 days	90 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

Maximum Visits per Calendar Year	130	130	130
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<i>Hospice Benefits</i>			
<i>Hospice Care – Facility Expenses (Room & Board)</i>	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible

<i>Hospice Outpatient Visits</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Mental Disorders</i>			

<i>MENTAL DISORDERS</i>			
<i>Hospital Facility Expenses</i>			
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% 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	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment</i>			
Facility Expenses	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES NETWORK OUT-OF-NETWORK OTHER HEALTH CARE

Inpatient Treatment of Substance Abuse

Hospital Facility Expense

Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i> (including acupuncture)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
Transplant Services Facility and Non-Facility Expenses				
Facility Expenses	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.
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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Acupuncture	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 visits per Calendar year (excluding treatment of substance abuse)	12	12	12
Ambulance (Ground, Air or Water)	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
Blood Bank Charges	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Hearing Aids	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>			
Orthodontic treatment directly related to an orthognathic surgical procedure	80% of billed charges after Calendar Year deductible	80% of billed charges after Calendar Year deductible	80% 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
Accidental injury treatment Maximum Benefit	\$600 per occurrence	\$600 per occurrence	\$600 per occurrence
Phenylketonuria Formula	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Prosthetic Devices</i>			
Foot Orthotics	80% per item after Calendar Year deductible	60% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Other Prosthetic Devices	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Outpatient Therapies</i>			
<i>Chemotherapy</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.
<i>Infusion Therapy</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Radiation Therapy</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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum visits per Calendar Year	30 visits	30 visits	30 visits
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Neurodevelopmental Therapy			
Outpatient Neurodevelopmental Therapy	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

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.

Spinal Manipulation			
Spinal Manipulation	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	10	10	10
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Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic and Brand-Name Prescription Drugs		
Maximum supply per prescription: the greater of 34 day supply or 100 unit doses		
Retail Pharmacy	\$8	Not Covered
Mail Order Pharmacy	\$16	Not Covered

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.

Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply (Out-of-Network prescription drugs are not covered)
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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.

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.

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.

Payment Limit

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

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

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

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses incurred for short term outpatient rehabilitation therapy and neurodevelopmental therapy expenses;
- Non-covered expenses;
- 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.