

# Schedule of Benefits

Employer: **The City of Seattle**  
 ASC: 100290  
 Issue Date: December 11, 2013  
 Effective Date: January 1, 2014  
 Schedule: 4A  
 Booklet Base: 4

For: Open Choice (PPO Medical) - S.P.O.G. Traditional Plan

## PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Calendar Year Deductible*</b>			
<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: \$400.
- For **out-of-network** expenses: \$1,600.

<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 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.**

**Note:** Charges incurred for preventive care exams and tests, including routine physical exams, well child exams, routine eye exams, routine hearing exams and routine cancer screenings are not covered expenses, except as specifically provided below and in the *What the Plan Covers* section of your Booklet.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Routine Cancer Screenings</i></b>			
<b><i>Routine Mammography</i></b>	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Maximum tests per Calendar Year	1 test	1 test	1 test
<b><i>Family Planning Services</i></b>			
<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.
<b><i>Hearing Aid Supplies</i></b>	80%	80% after Calendar Year deductible	
	No Calendar Year deductible applies.		
<b>Hearing Supply Maximum per 36 month period</b>	\$1,000	\$1,000	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Physician Services</b>			
<b>Physician Office Visits</b> <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
<b>Specialist Office Visits</b>	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
<b>Physician Office Visits-Surgery</b>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<b>Walk-In Clinic Non-Emergency Visit</b>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<b>Physician Services for Inpatient Facility and Hospital Visits</b>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<b>Administration of Anesthesia</b>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
<b>Allergy Testing and Treatment</b>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<b>Allergy Injections</b>	80% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>	80% per visit after Calendar Year <b>deductible</b>
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<b>Prenatal Visits</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
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<b>Emergency Medical Services</b>			
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<b>Hospital Emergency Facility and Physician</b>	80% after Calendar Year <b>deductible</b>	80% after Calendar Year <b>deductible</b>	80% after Calendar Year <b>deductible</b>
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	Emergency physician may not be a network provider. See Important Note below	See Important Note below	See Important Note below
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**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.

<b>Non-Emergency Care in a Hospital Emergency Room</b>	80% per visit after Calendar Year <b>deductible</b>	60% per visit after Calendar Year <b>deductible</b>	80% per visit after Calendar Year <b>deductible</b>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b>Urgent Care Services</b>			
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<b>Urgent Medical Care</b> <i>(at a non-hospital free standing facility)</i>	\$35 <b>copay</b> per visit then the plan pays 100%  No <b>deductible</b> applies	60% after Calendar Year <b>deductible</b>	\$35 <b>deductible</b> per visit then the plan pays 80%  No <b>deductible</b> applies
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<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	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Outpatient Diagnostic and Preoperative Testing</i></b>			
<b><i>Complex Imaging Services</i></b>			
<b><i>Complex Imaging</i></b>	80% per test after Calendar Year <b>deductible</b>	60% per test after Calendar Year <b>deductible</b>	80% per test after Calendar Year <b>deductible</b>
<b><i>Diagnostic Laboratory Testing</i></b>			
<b><i>Diagnostic Laboratory Testing</i></b>	80% per test after Calendar Year <b>deductible</b>	60% per test after Calendar Year <b>deductible</b>	80% per test after Calendar Year <b>deductible</b>
<b><i>Diagnostic X-Rays</i></b>			
<b><i>Diagnostic X-Rays</i></b>	80% per procedure after Calendar Year <b>deductible</b>	60% per procedure after Calendar Year <b>deductible</b>	80% per procedure after Calendar Year <b>deductible</b>
<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b>	80% per visit/surgical procedure after Calendar Year <b>deductible</b>	60% per visit/surgical procedure after Calendar Year <b>deductible</b>	80% 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>Birth 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)	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Skilled Nursing Inpatient Facility</i></b>	80% per admission after Calendar Year deductible	60% 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
<b><i>Specialty Benefits</i></b>			
<b><i>Home Health Care (Outpatient)</i></b>	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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<b>Hospice Benefits</b>			
<b>Hospice Care – Facility Expenses</b> (Room & Board)	90% per admission after the Calendar Year <b>deductible</b>	90% per admission after the Calendar Year <b>deductible</b>	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>	90% per admission after the Calendar Year <b>deductible</b>	90% per admission after the Calendar Year <b>deductible</b>
<b>Hospice Outpatient Visits</b>	90% per visit after the Calendar Year <b>deductible</b>	90% per visit after the Calendar Year <b>deductible</b>	90% per visit after the Calendar Year <b>deductible</b>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Treatment of Mental Disorders</i></b>			
<b><i>MENTAL DISORDERS</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
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
<b><i>Inpatient Residential Treatment</i></b>			
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
<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Outpatient Services</i></b>	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
<b><i>Inpatient Treatment of Substance Abuse</i></b>			
<b><i>Hospital Facility Expense</i></b>			
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

<b><i>Inpatient Residential Treatment</i></b>			
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

<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b> (including acupuncture)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Obesity Treatment Surgical</i></b>		
<b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b>	80% per admission	Not Covered
<b><i>Outpatient Morbid Obesity Surgery</i></b>	80% per service after Calendar Year deductible	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>Acupuncture</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.
Maximum visits per Calendar year (excluding treatment of substance abuse)	12	12	12
<b>Ambulance (Ground, Air or Water)</b>	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
<b>Blood Bank Charges</b>	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
<b>Diabetic Equipment, Supplies and Education</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>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Durable Medical and Surgical Equipment</i></b>	80% per item after Calendar Year <b>deductible</b>	80% per item after Calendar Year <b>deductible</b>	80% per item after Calendar Year <b>deductible</b>
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>			
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
<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>Prosthetic Devices</b>	<b>80% per item after Calendar Year deductible up to a \$500 lifetime maximum.</b>	<b>60% per item after Calendar Year deductible up to a \$500 lifetime maximum.</b>	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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.
<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.
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>			
<b><i>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</i></b>	80% per visit after Calendar Year deductible	60% 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	35 visits	35 visits	35 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Neurodevelopmental Therapy</i></b>			
<b><i>Outpatient Neurodevelopmental Therapy</i></b>	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)*	\$2,000	\$2,000	\$2,000

\* Benefits for rehabilitation therapy may not be duplicated for the same conditions and services.

<b><i>Spinal Manipulation</i></b>			
<b><i>Spinal Manipulation</i></b>	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

## Pharmacy Benefit

### Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b><i>Preferred Generic Prescription Drugs</i></b>		
For each 34 day supply*(retail)	\$5	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$10	Not Covered
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
For each 34 day supply* (retail)	\$10	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$20	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b>Non-Preferred Generic Prescription Drugs</b>		
For each 34 day supply* (retail)	\$5	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$10	Not Covered

<b>Non-Preferred Brand-Name Prescription Drugs</b>		
For each 34 day supply* (retail)	\$25	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$50	Not Covered

\* The greater of 34 day supply or 100 unit doses for generic prescription drugs on Aetna's maintenance drug list.

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

## 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.