

# Schedule of Benefits

Employer: The City of Seattle

ASC: 100290

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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>	\$2,000,000	\$2,000,000	\$2,000,000
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*Coinsurance 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.***

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Routine Cancer Screenings</i></b>			
<b><i>Routine Mammography</i></b> For covered females.	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>

Maximum tests per Calendar Year	1 test	1 test	1 test
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<b><i>Family Planning Services</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>Physician Services</i></b>			
<b><i>Physician Office Visits</i></b> <i>(non-surgical)</i>	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>

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Specialist Office Visits</i></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>

<b><i>Physician Office Visits-Surgery</i></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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<i>Walk-In Clinic Non-Emergency Visit</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<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>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>	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>Allergy Injections</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>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.
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility</i>	80% after Calendar Year deductible	80% after Calendar Year deductible.	80% after Calendar Year deductible
<i>Non-Emergency Care in a Hospital Emergency Room</i>	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

### ***Urgent Care Services***

<b><i>Urgent Medical Care</i></b> <i>(at a non-hospital free standing facility)</i>	\$35 <b>copay</b> per visit then the plan pays 100%	60 % after Calendar Year <b>deductible</b>	\$35 <b>deductible</b> per visit then the plan pays 80%
	No <b>deductible</b> applies.		No <b>deductible</b> applies.

<b><i>Urgent Medical Care</i></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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### **PLAN FEATURES**

#### ***Outpatient Diagnostic and Preoperative Testing***

<b><i>Diagnostic and Preoperative Testing</i></b> <i>(except complex imaging services)</i>	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>
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#### ***Complex Imaging Services***

<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>
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#### ***Diagnostic Laboratory Testing***

<b><i>Diagnostic Laboratory Testing</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>
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#### ***Diagnostic X-Rays***

<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>
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b>	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
<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)	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

<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
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Maximum Days per Calendar Year	90 days	90 days	90 days
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Inpatient Rehabilitation Lifetime Maximum per condition (applies to Physical, Occupational, Speech, Cardiac and Pulmonary Therapy - in a hospital or skilled nursing facility)	\$50,000	\$50,000	\$50,000
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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 <b>deductible</b>	90% 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
<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care – Facility Expenses (Room &amp; Board)</i></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><i>Hospice Care – Other Expenses during a stay</i></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><i>Hospice Outpatient Visits</i></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>
Maximum Benefit per lifetime - inpatient	14 days in a 6 consecutive month period	14 days in a 6 consecutive month period	14 days in a 6 consecutive month period
Maximum Benefit per lifetime - outpatient	120 hours	120 hours	120 hours
Maximum Benefit per lifetime (inpatient and outpatient combined)	The greater of 6 months or \$10,000	The greater of 6 months or \$10,000	The greater of 6 months or \$10,000
Respite Care Maximum	240 hours in a 6 consecutive month period	240 hours in a 6 consecutive month period	240 hours in a 6 consecutive month period

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></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>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Mental Disorders</i></b>	50% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible	50% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Treatment of Chemical Dependency</i></b>			
<b><i>Inpatient Treatment</i></b>	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<b><i>Outpatient Treatment of Chemical Dependency</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

Maximum Benefit per 24 consecutive month benefit period (combined inpatient and outpatient - does not apply to detoxification)	\$14,500	\$14,500	\$14,500
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***Transplant Services Facility and Non-Facility Expenses***

<b>PLAN FEATURES</b>	<b>NETWORK Institutes of Excellence(IOE) Facility or Non-IOE Facility</b>	<b>OUT-OF- NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Facility Expenses</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>Physician Services (including office 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.

**PLAN FEATURES**

***Other Covered Health Expenses***

<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.
Maximum visits per Calendar year (excluding treatment of chemical dependency)	12	12	12
<b><i>Ground, Air or Water Ambulance</i></b>	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

<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>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.
<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>Blood Bank Charges</b>	80% after Calendar Year <b>deductible</b>	80% after Calendar Year <b>deductible</b>	80% after Calendar Year <b>deductible</b>

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<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>	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>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
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<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical, Occupational, Speech, Cardiac and Pulmonary Therapy</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Outpatient Neurodevelopmental Therapy</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Combined Physical, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum per Calendar Year	\$2,000	\$2,000	\$2,000

Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)*	\$2,000	\$2,000	\$2,000
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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><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 visits	10 visits	10 visits

## 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*	\$5	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order pharmacy)	\$10	Not Covered
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
For each 34 day supply	\$10	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order pharmacy)	\$20	Not Covered
<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
For each 34 day supply*	\$5	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order pharmacy)	\$10	Not Covered

### ***Non-Preferred Brand-Name Prescription Drugs***

For each 34 day supply	\$25	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order pharmacy)	\$50	Not Covered

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

### **Coinsurance**

	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Prescription Drug Plan Coinsurance</i></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 Out-Of-Pocket Limit**

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

**Individual Prescription Drug 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:

#### **Network Prescription Drug Out-Of-Pocket Limit**

When your share or your covered dependent's share of **network prescription drug covered expenses** reach the **prescription drug network** out-of-pocket limit in a Calendar Year, your plan will pay 100% of that person's **network prescription drug covered expenses** for the rest of the Calendar Year.

**Family Prescription Drug 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:

#### **Network Prescription Drug Out-Of-Pocket Limit**

When your share and your covered dependents share of **network prescription drug covered expenses** combined reach the family **prescription drug** out-of-pocket limit in a Calendar Year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the Calendar Year.

### **Excluded Covered Expenses**

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

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

**Smoking Cessation Aids or  
Drugs Lifetime Maximum  
Benefit**

One 90 day supply (Out-of-  
Network prescription drugs are  
not covered)

## 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**. The added benefit does not count toward your Lifetime Maximum Benefit.

### **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 **network Payment Limit** and **covered expenses** applied to the **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**;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for outpatient **mental disorder** treatment expenses or short term outpatient rehabilitation therapy expenses;
- Non-covered expenses;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), 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** and **out-of-network** expenses combined.

### Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** 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.