

# Schedule of Benefits

Employer: The City of Seattle  
 ASC: 100290  
 Issue Date: February 18, 2011  
 Effective Date: January 1, 2011  
 Schedule: 8A  
 Booklet Base: 8

For: Open Choice (PPO Medical) - Most City Preventive Retiree 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      | \$200 per admission |
| <b>Per Admission Deductible*</b>  | Not applicable      | \$200 per admission | Not applicable      |
| *Unless otherwise indicated, any applicable <b>deductible</b> must be met before benefits are paid. |                     |                     |                     |
| <i>Common Accident Deductible</i>   | \$100               | \$450               | \$100               |

**Plan Payment Limit** excludes plan **deductibles** and **copayments**

### Individual Payment Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$3,000.

**Family Payment Limit:**

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$6,000.

|   |           |           |           |
|---|-----------|-----------|-----------|
| <b><i>Lifetime Maximum Benefit Per Person</i></b> | Unlimited | Unlimited | Unlimited |
|---|-----------|-----------|-----------|

*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><i>Wellness Benefits</i></b>  |  |                |   |
| <b><i>Routine Physical Exams</i></b><br>Adults only.<br><br>Includes coverage for immunizations. | 100% per exam<br><br>No <b>deductible</b> applies. | Not Covered    | 90% per exam<br><br>No <b>deductible</b> applies. |
| Maximum Exams per Calendar Year<br><br>Adults, age 18 to 65                                      | 1 exam   | Not Applicable | 1 exam  |
| Maximum Exams per Calendar Year<br><br>Adults, age 65 and over                                   | 1 exam   | Not Applicable | 1 exam  |
| <b><i>Well Child Exams</i></b><br>Includes coverage for immunizations.                           | 100% per exam<br><br>No <b>deductible</b> applies. | Not Covered    | 90% per exam<br><br>No <b>deductible</b> applies. |

| PLAN FEATURES                   | NETWORK   | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---------------------------------|-----------|----------------|-------------------|
| Maximum Exams per Calendar Year |           |                |                   |
| Under age 6                     | Unlimited | Not Applicable | Unlimited         |
| From age 6 to age 12            | 2 exams   | Not Applicable | 2 exams           |
| Age 12 and older                | 1 exam    | Not Applicable | 1 exam            |

|  |  |  |   |
|--|--|--|---|
| <b><i>Routine Gynecological Exam</i></b> | 100% per exam<br>No <b>deductible</b> applies. | 60% per exam after Calendar Year <b>deductible</b> | 90% per exam<br>No <b>deductible</b> applies. |
|--|--|--|---|

|                                 |        |        |        |
|---------------------------------|--------|--------|--------|
| Maximum Exams per Calendar Year | 1 exam | 1 exam | 1 exam |
|---------------------------------|--------|--------|--------|

|                            |   |  |   |
|----------------------------|---|--|---|
| <b><i>Hearing Exam</i></b> | \$15 exam <b>copay</b> then the plan pays 100%<br>No <b>deductible</b> applies. | 60% per exam after Calendar Year <b>deductible</b> | 90% per exam<br>No <b>deductible</b> applies. |
|----------------------------|---|--|---|

|                                   |        |        |        |
|-----------------------------------|--------|--------|--------|
| Maximum Exams per 12 month period | 1 exam | 1 exam | 1 exam |
|-----------------------------------|--------|--------|--------|

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---------------|---------|----------------|-------------------|
|---------------|---------|----------------|-------------------|

***Routine Cancer Screenings***

|                                   |  |  |   |
|-----------------------------------|--|--|---|
| <b><i>Routine Mammography</i></b> | 100% per test<br>No <b>deductible</b> applies. | 60% per test after Calendar Year <b>deductible</b> | 90% per test<br>No <b>deductible</b> applies. |
|-----------------------------------|--|--|---|

|                                 |        |        |        |
|---------------------------------|--------|--------|--------|
| Maximum tests per Calendar Year | 1 test | 1 test | 1 test |
|---------------------------------|--------|--------|--------|

| PLAN FEATURES   | NETWORK  | OUT-OF-NETWORK  | OTHER HEALTH CARE  |
|---|--|---|--|
| <b><i>Prostate Specific Antigen Test</i></b><br>For covered males | 100% per test<br><br>No <b>deductible</b> applies.   | Not Covered   | 90% per test<br><br>No <b>deductible</b> applies.  |
| Maximum tests per Calendar Year                                   | 1 test   | Not Applicable  | 1 test   |
| <b><i>Routine Digital Rectal Exam</i></b><br>For covered males    | 100% per test<br><br>No <b>deductible</b> applies.   | Not Covered   | 90% per test<br><br>No <b>deductible</b> applies.  |
| Maximum tests per Calendar Year                                   | 1 test   | Not Applicable  | 1 test   |
| <b><i>Routine Pap Smears</i></b>                                  | 100 % per test<br><br>No <b>deductible</b> applies.  | 60% per test after Calendar Year<br><b>deductible</b> | 90% per test<br><br>No <b>deductible</b> applies.  |
| Maximum Tests per Calendar Year                                   | 1 test   | 1 test  | 1 test   |
| <b><i>Fecal Occult Blood Test</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. |
| Maximum Tests per 12 consecutive month period                     | 1 test   | Not Applicable  | 1 test   |

| PLAN FEATURES  | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|--|--|--|--|
| <b><i>Sigmoidoscopy</i></b><br>Age 50 and over                       | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered  | Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Tests per 5 consecutive year period                          | 1 test   | Not Applicable   | 1 test   |
| <b><i>Double Contrast Barium Enema (DCBE)</i></b><br>Age 50 and over | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered  | Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum Tests per 5 consecutive year period                          | 1 test   | Not Applicable   | 1 test   |
| <b><i>Colonoscopy</i></b><br>age 50 and over                         | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered  | Payable in accordance with the type of expense incurred and the place where service is provided. |
| Maximum tests per 10 consecutive year period                         | 1 test   | Not Applicable   | 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. |

| PLAN FEATURES  | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE                                 |
|--|--|--|---|
| <b><i>Vision Care</i></b>                                |  |  |   |
| <b><i>Eye Examinations</i></b><br>(including refraction) | 100% per exam<br><br>No <b>deductible</b> applies. | 60% per exam after<br>Calendar Year<br><b>deductible</b> | 90% per exam<br><br>No <b>deductible</b> applies. |
| Maximum Benefit per<br>Calendar Year                     | 1 exam   | 1 exam   | 1 exam  |

| PLAN FEATURES  | NETWORK   | OUT-OF-NETWORK  | OTHER HEALTH CARE                                  |
|--|---|---|--|
| <b><i>Physician Services</i></b>                                 |   |   |  |
| <b><i>Physician Office Visits</i></b><br>( <i>non-surgical</i> ) | \$15 visit <b>copay</b> then the<br>plan pays 100%<br><br>No <b>deductible</b> applies. | 60% per visit after<br>Calendar Year<br><b>deductible</b> | 90% per visit<br><br>No <b>deductible</b> applies. |

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

| PLAN FEATURES  | NETWORK  | OUT-OF-NETWORK  | OTHER HEALTH CARE                                       |
|--|--|---|---|
| <i>Physician Office Visits-Surgery</i>                               | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies. | 60% per visit after Calendar Year <b>deductible</b>     | 90% per visit<br><br>No <b>deductible</b> applies.      |
| <i>Aexcel Designated Network Specialist</i>                          | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies. | Not applicable  | 90% per visit<br><br>No <b>deductible</b> applies.      |
| <i>Non-Designated Network Specialist</i>                             | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies. | Not applicable  | 90% per visit<br><br>No <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<br><br>No <b>deductible</b> applies.      |
| <i>Walk-In Clinic Non-Emergency Visit</i>                            | \$15 visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies.     | 60% per visit after Calendar Year <b>deductible</b>     | 90% per visit<br><br>No <b>deductible</b> applies       |
| <i>Physician Services for Inpatient Facility and Hospital Visits</i> | 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>     |
| <i>Aexcel Designated Network Specialist</i>                          | 90% per visit after Calendar Year <b>deductible</b>                                      | Not applicable  | 90% per visit after Calendar Year <b>deductible</b>     |
| <i>Non-Designated Network Specialist</i>                             | 80% per visit after Calendar Year <b>deductible</b>                                      | Not applicable  | 90% per visit after Calendar Year <b>deductible</b>     |
| <i>Out of Network Provider Specialist</i>                            | Not applicable   | 60% per visit after Calendar Year <b>deductible</b>     | 90% per visit after Calendar Year <b>deductible</b>     |
| <i>Administration of Anesthesia</i>                                  | 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> |

| PLAN FEATURES   | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|---|--|--|--|
| <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>Immunizations (when not part of the physical exam)</i> | 100% per visit<br>No <b>deductible</b> applies.  | Not Covered  | 90% per visit<br>No <b>deductible</b> 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   |
|--|--|---|---|
| <b><i>Emergency Medical Services</i></b> |  |   |   |
| <i>Hospital Emergency Facility</i>       | \$150 <b>copay</b> per visit then the plan pays 90%<br><br>No <b>deductible</b> applies. | \$150 <b>deductible</b> per visit then the plan pays 90%<br><br>No <b>deductible</b> applies. | \$150 <b>deductible</b> per visit then the plan pays 90%<br><br>No <b>deductible</b> applies. |
|  |  | See Important Note Below  | See Important Note Below  |

**Important Note:** Please note that because these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider 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.

| PLAN FEATURES  | NETWORK   | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|--|---|--|--|
| <b>Non-Emergency Care in a Hospital Emergency Room</b> | \$150 <b>copay</b> per visit then the plan pays 60% | \$150 <b>deductible</b> per visit then the plan pays 60% | \$150 <b>deductible</b> per visit then the plan pays 60% |
|  | No <b>deductible</b> applies.                       | No <b>deductible</b> applies.                            | No <b>deductible</b> applies.                            |

**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**.

**Urgent Care Services**

|   |   |  |   |
|---|---|--|---|
| <b>Urgent Medical Care</b><br><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 <b>deductible</b> applies.                       |  | No <b>deductible</b> applies.                           |

|  |   |   |   |
|--|---|---|---|
| <b>Urgent Medical Care</b><br><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. |
|--|---|---|---|

| PLAN FEATURES  | NETWORK  | OUT-OF-NETWORK  | OTHER HEALTH CARE  |
|--|--|---|--|
| <b>Outpatient Diagnostic and Preoperative Testing</b>                                  |  |   |  |
| <b>Diagnostic and Preoperative Testing</b><br><i>(except complex imaging services)</i> | 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) |

| PLAN FEATURES                          | NETWORK  | OUT-OF-NETWORK                                     | OTHER HEALTH CARE                                  |
|--|--|--|--|
| <b><i>Complex Imaging Services</i></b> |  |  |  |
| <b><i>Complex Imaging</i></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> |

|   |  |   |  |
|---|--|---|--|
| <b><i>Diagnostic Laboratory Testing</i></b> |  |   |  |
| <b><i>Diagnostic Laboratory Testing</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>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) |

| PLAN FEATURES   | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|---|--|--|--|
| <b><i>Outpatient Surgery</i></b>  |  |  |  |
| <b><i>Outpatient Surgery</i></b><br>(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>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. |

| PLAN FEATURES                            | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE   |
|--|--|--|---|
| <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 60% | \$200 per admission <b>copayment *</b> , then the plan pays 90% |
|  | No <b>deductible</b> applies                                   | No <b>deductible</b> applies                               | No <b>deductible</b> applies                                    |
| Other than Room and Board (Inpatient)    | 90% per admission  | 60% per admission  | 90% per admission   |
|  | No <b>deductible</b> applies                                   | No <b>deductible</b> applies                               | No <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.

|  |   |   |   |
|--|---|---|---|
| <b><i>Skilled Nursing Inpatient Facility</i></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>copayment</b> , then the plan pays 90% |
|  | No <b>deductible</b> applies                                  | No <b>deductible</b> applies                              | No <b>deductible</b> applies                                  |
| Maximum Days per Calendar Year   | 120 days  | 120 days  | 120 days  |
| 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  |

| 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> | 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   |

| PLAN FEATURES  | NETWORK   | OUT-OF-NETWORK | OTHER HEALTH CARE   |
|--|---|----------------|---|
| <b><i>Hospice Benefits</i></b>                                   |   |                |   |
| <b><i>Hospice Care – Facility Expenses</i></b><br>(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><i>Hospice Care – Other Expenses during a stay</i></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  |
| <b><i>Hospice Outpatient Visits</i></b>                          | 90% per visit after the Calendar Year <b>deductible</b>     | Not Covered    | 90% per visit after the Calendar Year <b>deductible</b>     |

| PLAN FEATURES   | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|---|--|--|--|
| <b><i>Infertility Treatment</i></b>   |  |  |  |
| <b><i>Basic Infertility Expenses</i></b><br>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><i>Infertility Drugs</i></b><br>(prescribed by a <b>Network Physician</b> )  | 80% after the Calendar Year <b>deductible</b>  | Not Covered  | Not Covered  |
| Infertility Drugs<br>Maximum Benefit per Calendar Year  | \$2,000  | Not Applicable   | Not Applicable   |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---------------|---------|----------------|-------------------|
|---------------|---------|----------------|-------------------|

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

|   |   |   |   |
|---|---|---|---|
| <b><i>Inpatient Residential Treatment</i></b> |   |   |   |
| Facility Expenses                             | \$200 per admission <b>copayment</b> , then the plan pays 90%.<br><br>No <b>deductible</b> applies. | \$200 per admission <b>deductible</b> then the plan pays 60%<br><br>No <b>deductible</b> applies. | \$200 per admission <b>copayment</b> , then the plan pays 90%.<br><br>No <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 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%<br><br>No <b>deductible</b> applies. | 60% per visit after Calendar Year <b>deductible</b> | 90% per visit<br><br>No <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><i>Obesity Treatment Surgical</i></b>   |   |                            |                |
| <b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b> | \$200 per admission <b>copay</b> then the plan pays 90%<br><br>No <b>deductible</b> applies | Not Covered                | Not Covered    |
| <b><i>Outpatient Morbid Obesity Surgery</i></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<br>Institutes of Excellence (IOE) Facility   | NETWORK<br>Non-IOE Facility  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|--|--|--|--|--|
| <b><i>Transplant Services Facility and Non-Facility Expenses</i></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. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| <b><i>Physician Services</i></b><br>(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                               | NETWORK  | OUT-OF-NETWORK   | OTHER HEALTH CARE  |
|---|--|--|--|
| <b><i>Other Covered Health Expenses</i></b> |  |  |  |
| <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>Ground, Air or Water Ambulance</i></b>         | 90% after Calendar Year deductible          | 90% after Calendar Year deductible          | 90% after Calendar Year deductible          |
| <b><i>Durable Medical and Surgical Equipment</i></b> | 90% per item after Calendar Year deductible | 60% per item after Calendar Year deductible | 90% per item after Calendar Year deductible |

| <b>PLAN FEATURES</b>  | <b>NETWORK</b>   | <b>OUT-OF-NETWORK</b>  | <b>OTHER HEALTH CARE</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>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) -</i></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>Hearing Aids</b>   | 90%  | 90%  | 90%  |
|   | No <b>deductible</b> applies.  | No <b>deductible</b> applies.  | No <b>deductible</b> applies.  |
| Hearing Supply Maximum per 36 month period  | \$1,000 per ear  | \$1,000 per ear  | \$1,000 per ear  |
| <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>   | 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   | 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>                     | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies | 60% per visit after Calendar Year <b>deductible</b> | 90% per visit<br><br>No <b>deductible</b> applies |
| Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy<br>Maximum visits per Calendar Year | 60 visits   | 60 visits   | 60 visits   |

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><i>Neurodevelopmental Therapy</i></b>  |   |  |   |
| <b><i>Outpatient Neurodevelopmental Therapy</i></b>                               | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies | 60% per visit after Calendar Year<br><b>deductible</b> | 90% per visit<br><br>No <b>deductible</b> applies |
| Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)* | \$5,000   | \$5,000  | \$5,000   |

\* 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>                    |   |  |   |
| <b><i>Spinal Manipulation</i></b>                    | \$15 per visit <b>copay</b> then the plan pays 100%<br><br>No <b>deductible</b> applies | 60% per visit after Calendar Year<br><b>deductible</b> | 90% per visit<br><br>No <b>deductible</b> applies |
| Spinal Manipulation Maximum visits per Calendar Year | 20  | 20   | 20  |

## Pharmacy Benefit

### Copays/Deductibles

| PER PRESCRIPTION COPAY/DEDUCTIBLE  | NETWORK  | OUT-OF-NETWORK |
|--|--|----------------|
| <b><i>Generic Prescription Drugs</i></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<br>COPAY/DEDUCTIBLE                                     | NETWORK  | OUT-OF-NETWORK |
|--|--|----------------|
| <b><i>Brand-Name Prescription Drugs</i></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><i>Generic Prescription Drugs</i></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 |

|  |  |             |
|--|--|-------------|
| <b><i>Brand-Name Prescription Drugs</i></b>                              |  |             |
| 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<br>COPAY/DEDUCTIBLE                                     | NETWORK | OUT-OF-NETWORK |
|--|---------|----------------|
| <b>Generic Prescription Drugs</b>  |         |                |
| 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    |

|  |      |             |
|--|------|-------------|
| <b>Brand-Name Prescription Drugs</b>                                     |      |             |
| 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 |

| <b>Proton Pump Inhibitors and Non-Sedating Antihistamines</b>   |       |
|---|-------|
| Monthly Maximum Benefit paid by plan (applies to covered prescription strength and Over-the-Counter equivalent versions - see your Booklet for details) | \$ 20 |

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<br>\$3,600 Family | Not Applicable<br>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.

#### **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.

There is also a Family **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses incurred for infertility drugs;
- 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** 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.