

# **Schedule of Benefits**

**Prepared Exclusively for  
The City of Seattle**

**2021 City Traditional Plan\***

**Local 77 - Most Employees**

**Open Choice (PPO) Medical**

*\*Please note: In the attached document the effective date is 2020; however, this document represents the benefits for 2021 and minimal changes made to plan documents in 2021.*

*To view minor changes for 2021, see the amendment at the end of the "book".*

## **Aexcel Plus Open Choice (PPO Medical) - Local 77 Most City Traditional Plan Schedule of Benefits**

**Prepared exclusively for:**

<b>Employer:</b>	The City of Seattle
<b>Contract number:</b>	ASC-100290
	Schedule of Benefits 11A
<b>Plan effective date:</b>	January 1, 2020
<b>Plan issue date:</b>	March 30, 2020

**These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.**

## Schedule of benefits

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This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

### How to read your schedule of benefits

- When we say:
  - “In-network coverage”, we mean you get care from **network providers**.
  - “Out-of-network coverage”, we mean you can get care from **out-of-network providers**.
  - “Other health care coverage”, we mean you can get care from an **out-of-network provider** when you could not reasonably get the services and supplies needed from a **network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

#### **Important note:**

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

## Schedule of Benefits

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This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

### Important Information about Your Cost Share as it Applies to Aexcel Designated Network Specialists, Non-Designated Network Specialists and All Other Network Providers

This plan provides access to covered services and supplies through a network of health care providers. The plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your cost-sharing will generally be lower when you use **network providers**.

*In addition to the **network providers** described above, this plan provides access to **covered expenses** through designated network of specialty **physicians** that are unique to your plan. These **network providers** are shown as **Aexcel designated specialists and non-designated specialists** and all other network providers. Your cost sharing will be lower when you use the **Aexcel designated network specialists**. The **Aexcel designated network specialists, non-designated network specialists**, and "all other network provider groups" are identified in the printed **directory** and the on-line version of the **directory** via provider search at [www.aetna.com](http://www.aetna.com). Please be sure to look at the appropriate **directory** that applies to your plan, since different **Aetna** plans use different networks of providers. Your plan includes different benefit levels based upon the type of **network provider** that you use (designated, non-designated or all other network provider) or if you choose to see an **out-of-network** provider. The Aexcel designated specialists include 12 medical specialties which are listed below.*

The *Aexcel* medical specialties include:

- Cardiology
- Cardiothoracic surgery
- Gastroenterology
- General surgery
- Neurology
- Neurosurgery
- Obstetrics and Gynecology
- Orthopedics
- Otolaryngology/ENT
- Plastic surgery
- Urology
- Vascular surgery

#### Important Notes:

1. **Aexcel Designated Network Specialists** can be found in the paper **directory** with an asterisk and on the on-line version of the **directory** via provider search with a blue star.
2. If you obtain covered services and supplies from an **Aexcel designated network specialist**, separate cost sharing applies to these types of providers. If your **PCP** is also an **Aexcel designated network specialist** or a **non-designated network specialist**, in this situation, you will be subject to the applicable **specialist copay** (if any) that applies to these types of providers and *not* the **copay** that applies to **PCP's** under this Plan. The cost sharing amounts are described later in this *Schedule of Benefits*.

#### Important Note:

**If you live in an area with an "Aexcel" network, for maximum savings, you must select an Aexcel designated network specialist for specialty care in these Aexcel specialties. If you select a non-designated network specialist for your specialty care, your out-of-pocket expenses will be higher than if you selected an Aexcel designated network specialist in that same specialty or certain benefits may not be covered under this Plan. Carefully read the details on cost-sharing provided later in this Schedule of Benefits.**

	IN-NETWORK COVERAGE			OUT-OF-NETWORK COVERAGE
Eligible health services	Aexcel Designated Network Specialists	Non-Designated Network Specialists	All Other Network Providers	Out-of-Network Providers
Services performed by a specialist listed in one of the Aexcel medical specialty categories listed above	80% per visit	70% per visit	80% per visit	60% per visit

Plan features	Deductible/Maximums		
	In-network coverage*	Out-of-network coverage*	Other health care*
<b>Deductible</b>			
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.			
Individual	\$400 per Calendar Year	\$1,000 per Calendar Year	\$400 per Calendar Year
Family	\$1,200 per Calendar Year	\$3,000 per Calendar Year	\$1,200 per Calendar Year
<b>Common Accident Deductible</b>			
Common Accident Deductible	\$400	\$1,000	\$400

<b>Deductible waiver</b>			
The Calendar Year in-network <b>deductible</b> is waived for all of the following <b>eligible health services</b> :			
<ul style="list-style-type: none"> <li>• Preventive care and wellness</li> <li>• Family planning services - female contraceptives</li> </ul>			
<b>Maximum out-of-pocket limit</b>			
<b>Maximum out-of-pocket limit</b> per Calendar Year.			
Individual	\$1,400 per Calendar Year	\$3,000 per Calendar Year	\$1,400 per Calendar Year
Family	\$4,200 per Calendar Year	\$9,000 per Calendar Year	\$4,200 per Calendar Year

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<b>Preventive care and wellness</b>			

<b>Routine physical exams</b>			
Performed at a <b>physician's</b> office	100% per visit No <b>deductible</b> applies.	Not Covered	100% per visit No <b>deductible</b> applies.
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Not Covered	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit	Not Covered	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	Not Covered	1 visit

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<b>Preventive care immunizations</b>			
Performed in a facility or at a <b>physician's</b> office	100% per visit  No <b>deductible</b> applies	Not Covered	100% per visit  No <b>deductible</b> applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna's secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Not Covered	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna's secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>			
Performed at a <b>physician's</b> , obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit  No <b>deductible</b> applies	Not Covered	100% per visit  No <b>deductible</b> applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Not Covered	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit
<b>Obesity and/or healthy diet counseling maximums:</b>			
Maximum visits per 12 months  (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-	Not Covered	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-

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	related chronic disease)*		related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
<b>Misuse of alcohol and/or drugs maximums:</b>			
Maximum visits per 12 months	5 visits*	Not Covered	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
<b>Use of tobacco products maximums:</b>			
Maximum visits per 12 months	8 visits*	Not Covered	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
<b>Sexually transmitted infection counseling maximums:</b>			
Maximum visits per 12 months	2 visits*	Not Covered	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			
<b>Genetic risk counseling for breast and ovarian cancer maximums:</b>			
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not Covered	Not subject to any age or frequency limitations
<b>Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)</b>			
Routine cancer screenings	100% per visit No deductible applies.	Not Covered	100% per visit No deductible applies.

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Maximums	<p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> <p>For details, contact your <b>physician</b> or Member Services by logging onto your Aetna's secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.</p>	Not Applicable	<p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> <p>For details, contact your <b>physician</b> or Member Services by logging onto your Aetna's secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.</p>
Lung cancer screening maximums	1 screening every 12 months*	Not Applicable	1 screening every 12 months*
<p><b>*Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>			
<p><b>Prenatal care</b> <b>Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b></p>			
Preventive care services only	<p>100% per visit</p> <p>No <b>deductible</b> applies</p>	<p>60% (of the <b>recognized charge</b>) per visit</p>	<p>100% per visit</p> <p>No <b>deductible</b> applies</p>
<p><b>Important note:</b> You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.</p>			

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<b>Comprehensive lactation support and counseling services</b>			
Lactation counseling services – facility or office visits	100% per visit No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit	100% per visit No <b>deductible</b> applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>Physician</b> services office visits.			
<b>Breast feeding durable medical equipment</b>			
Breast pump supplies and accessories	100% per item No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per item	100% per item No <b>deductible</b> applies
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.			
<b>Family planning services – female contraceptives</b>			
<b>Counseling services</b>			
Female contraceptive counseling services office visit	100% per visit No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit	100% per visit No <b>deductible</b> applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
<b>*Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under <b>Physician</b> services office visits.			
<b>Devices</b>			
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit	100% per item No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per item	100% per item No <b>deductible</b> applies
<b>Female voluntary sterilization</b>			
Inpatient	100% per admission No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per admission	100% per admission No <b>deductible</b> applies
Outpatient	100% per visit	60% (of the <b>recognized</b>	100% per visit

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	No deductible applies	charge) per visit	No deductible applies
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>
<b>Physicians and other health professionals</b>			
<b>Physicians and specialists</b> office visits (non-surgical)			
<b>Physician services</b>			
Office hours visits (non-surgical) non preventive care	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Immunizations that are not considered preventive care</b>			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Specialist</b>			
<b>Specialist office visits</b>			
Office hours visits (non-surgical)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Physician surgical services</b>			
<b>Physicians and specialists</b> office visits			
Performed at a <b>physician's</b> office	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Performed at a <b>specialist's</b> office	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Alternatives to physician office visits</b>			
<b>Walk-in clinic visits</b>			
<b>Walk-in clinic</b> non-emergency visit <i>(includes coverage for immunizations)</i>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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	<p>For details, contact your <b>physician</b> or Member Services by logging onto your secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.</p>	<p><b>physician</b> or Member Services by logging onto your secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.</p>	<p>For details, contact your <b>physician</b> or Member Services by logging onto your secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.</p>

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<b>Hospital and other facility care</b>			
<b>Hospital care</b>			
Inpatient <b>hospital</b>	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission thereafter	\$200 then the plan pays 80% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
Outpatient <b>hospital</b>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Alternatives to hospital stays</b>			
<b>Outpatient surgery and physician surgical services</b>			
(performed at a hospital or other outpatient facility)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Home health care</b>			
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	130  Limited to: 3 intermittent visits per day provided by a participating <b>home health care agency</b> ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130  Limited to: 3 intermittent visits per day provided by a participating <b>home health care agency</b> ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130  Limited to: 3 intermittent visits per day provided by a participating <b>home health care agency</b> ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge

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<b>Hospice care</b>			
Inpatient facility	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission	80% (of the <b>recognized charge</b> ) per admission
Maximum days per lifetime	Unlimited	Unlimited	Unlimited
<b>Hospice care</b>			
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day
<b>Outpatient private duty nursing</b>			
Outpatient private duty nursing	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Skilled nursing facility</b>			
Inpatient facility	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 80% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
Maximum days per Calendar Year	90	90	90
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>
<b>Emergency services and urgent care</b>			
<b>Emergency services</b>			
Hospital emergency room	\$150 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	Paid the same as in-network coverage.	Paid the same as in-network coverage.

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Non-emergency care in a <b>hospital</b> emergency room	\$150 then the plan pays 60% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	\$150 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies	\$150 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
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**Important Note:**

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment 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. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.

**Urgent care**

Urgent medical care (at a non- <b>hospital</b> free standing facility)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<b>Specific conditions</b>			
<b>Autism spectrum disorder</b>			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other <b>illness</b> under this plan			
<b>Birthing center</b>			
Inpatient	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 80% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<i>The per admission <b>copayment</b> and/or <b>deductible</b> amount for newborns will be waived for nursery charges for the duration of the newborn's initial facility stay. The nursery charges waiver will not apply for non-routine facility stays.</i>			
<b>Family planning services - other</b>			
<b>Voluntary sterilization for males</b>			
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Abortion</b>			
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Jaw joint disorder treatment</b>			
Jaw joint disorder treatment	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Non-Surgical Lifetime Maximum Benefit	\$5,000	\$500	\$5,000
Surgical Lifetime	Unlimited	Unlimited	Unlimited

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Maximum Benefit			
<b>Maternity and related newborn care</b>			
Inpatient	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 80% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<i>The per admission <b>copayment</b> and <b>deductible</b> amount for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.</i>			
<b>Delivery services and postpartum care services</b>			
Performed in a facility or at a <b>physician's</b> office	80% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Mental health treatment - inpatient</b>			
Inpatient mental health treatment  Inpatient <b>residential treatment facility</b>  Coverage is provided under the same terms, conditions as any other <b>illness</b> .	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies	\$200 then the plan pays 80% (of the balance of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<b>Mental health treatment - outpatient</b>			
Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> consultation  Coverage is provided under the same terms, conditions as any other <b>illness</b> .	80% (of the <b>negotiated charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

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Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavior therapy consultation	80% (of the <b>negotiated charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home)  <b>Partial hospitalization treatment</b>  <b>Intensive outpatient program</b>  The cost share doesn't apply to in-network peer counseling support services	80% (of the <b>negotiated charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Substance related disorders treatment - inpatient</b>			
Inpatient <b>substance abuse detoxification</b> during a <b>hospital</b> confinement	\$200 then the plan pays 80% (of the balance of the negotiated charge) per admission	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per admission	\$200 then the plan pays 80% (of the balance of the recognized charge) per admission
Inpatient <b>substance abuse</b> rehabilitation during a <b>hospital</b> confinement	No <b>deductible</b> applies	No <b>deductible</b> applies	No <b>deductible</b> applies
Inpatient <b>residential treatment facility</b> during a <b>hospital</b> confinement  Coverage is provided under the same terms, conditions as any other <b>illness</b> .			
<b>Substance related disorders treatment - outpatient: detoxification and rehabilitation</b>			
Outpatient <b>substance</b>	80% (of the <b>negotiated</b>	80% (of the <b>recognized</b>	80% (of the <b>recognized</b>

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<p><b>abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> (includes <b>telemedicine</b> consultation)</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p><b>charge)</b> per visit</p>	<p><b>charge)</b> per visit</p>	<p><b>charge)</b> per visit</p>
<p>Outpatient <b>substance abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavioral therapy consultations</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	<p>80% (of the <b>negotiated charge)</b> per visit</p>	<p>80% (of the <b>recognized charge)</b> per visit</p>	<p>80% (of the <b>recognized charge)</b> per visit</p>
<p>Other outpatient <b>substance abuse</b> services</p> <p><b>Partial hospitalization treatment</b></p> <p><b>Intensive outpatient program</b></p> <p>The cost share doesn't apply to in-network peer counseling support services.</p>	<p>80% (of the <b>negotiated charge)</b> per visit</p>	<p>80% (of the <b>recognized charge)</b> per visit</p>	<p>80% (of the <b>recognized charge)</b> per visit</p>

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage* Institute of Quality (IOQ) Facility	In-network coverage* Non-IOQ Facility	Out-of-network coverage*
<b>Obesity surgery</b>			
Inpatient <b>hospital</b> (includes surgical procedure and acute <b>hospital</b> services)	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	Not Covered	Not Covered
<b>Outpatient obesity surgery</b>			
	80% (of the <b>negotiated charge</b> ) per visit	Not Covered	80% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
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**Oral and maxillofacial treatment (mouth, jaws and teeth)**

Orthodontic treatment directly related to an orthognathic surgical procedure	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
All other Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Accidental injury treatment Maximum Benefit	\$600 per occurrence	\$600 per occurrence	\$600 per occurrence

**Reconstructive breast surgery**

Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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**Reconstructive surgery and supplies**

Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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Eligible health services	Network Institute of Excellence (IOE) facility	Network Non-IOE facility	Out-of-network coverage*	Other health care
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**Transplant services facility and non-facility**

Inpatient hospital transplant services	\$200 then the plan pays 80% (of the balance of the <b>negotiated charge</b> ) per transplant	\$200 then the plan pays 60% (of the balance of the <b>negotiated charge</b> ) per transplant	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per transplant	\$200 then the plan pays 60% (of the balance of the <b>recognized charge</b> ) per transplant
Physician services including office	Covered according to the type of	Covered according to the type of	Covered according to the type of	Covered according to the type of

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

visits	benefit and the place where the service is received.	benefit and the place where the service is received.	benefit and the place where the service is received.	benefit and the place where the service is received.
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>	
<b>Treatment of infertility</b>				
<b>Basic infertility</b>				
Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>	
<b>Specific therapies and tests</b>				
<b>Outpatient diagnostic testing</b>				
<b>Diagnostic complex imaging services</b>				
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit	
<b>Diagnostic lab work</b>				
	80% (of the <b>negotiated charge</b> ) per visit.	60% (of the <b>recognized charge</b> ) per visit.	80% (of the <b>recognized charge</b> ) per visit.	
<b>Diagnostic radiological services</b>				
	80% (of the <b>negotiated charge</b> ) per visit.	60% (of the <b>recognized charge</b> ) per visit.	80% (of the <b>recognized charge</b> ) per visit.	
<b>Chemotherapy</b>				
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
<b>Outpatient infusion therapy</b>				
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit	
<b>Outpatient radiation therapy</b>				
	Covered according to the type of benefit and the	Covered according to the type of benefit and the	Covered according to the type of benefit and the	

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

	place where the service is received.	place where the service is received.	place where the service is received.

<b>Short-term rehabilitation services</b>			
<b>Outpatient Physical, Massage, Occupational, Cardiac and Pulmonary Therapies</b>			
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
<b>Outpatient Speech Therapy</b>			
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

<b>Habilitation therapy services</b>			
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits



Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<b>Other services</b>			

<b>Acupuncture</b>			
Acupuncture	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

Maximum visits per Calendar Year	12	12	12
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<b>Ambulance service</b>			
Ground, air or water ambulance	80% (of the <b>negotiated charge</b> ) per trip	80% (of the <b>recognized charge</b> ) per trip	80% (of the <b>recognized charge</b> ) per trip

<b>Clinical trial therapies (experimental or investigational)</b>			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Clinical trials (routine patient costs)</b>			
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Durable medical equipment (DME)</b>			
DME	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item	80% (of the <b>recognized charge</b> ) per item

<b>Hearing aids and exams</b>			
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Hearing aids	80% (of the <b>negotiated charge</b> ) per item No <b>deductible</b> applies.	80% (of the <b>recognized charge</b> ) per item No <b>deductible</b> applies	80% (of the <b>recognized charge</b> ) per item No <b>deductible</b> applies

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
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<b>Non-preventive hearing exams</b>			
For adults and children	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

Maximum	One exam in any 12 consecutive month period.
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<b>Nutritional supplements</b>			
Nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

<b>Prosthetic devices</b>			
Prosthetic devices	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item	80% (of the <b>recognized charge</b> ) per item
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

<b>Spinal manipulation</b>			
Spinal manipulation	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	10	10	10

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Outpatient prescription drugs</b>		
<b>Plan features</b>	<b>Deductible/Copayment/Payment Percentage/Maximums</b>	
<b>Deductible waiver</b>		
The Calendar Year <b>deductible</b> is waived for all <b>prescription drugs</b> .		
<b>Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to risk reducing breast cancer <b>prescription drugs</b> when obtained at a <b>network pharmacy</b> . This means that such risk reducing breast cancer <b>prescription drugs</b> will be paid at 100%.		
<b>Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to the first two 90-day treatment regimens for tobacco cessation <b>prescription drugs</b> and OTC drugs when obtained at a <b>network pharmacy</b> . This means that such <b>prescription drugs</b> and OTC drugs will be paid at 100%. Your Calendar Year <b>deductible</b> and any <b>prescription copayment/payment percentage</b> will apply after those two regimens have been exhausted.		
<b>Deductible and copayment/payment percentage waiver for contraceptives</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to female contraceptive methods when obtained at a <b>network pharmacy</b> . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> <li>• Certain over-the-counter (OTC) and generic contraceptive <b>prescription drugs</b> and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a <b>generic prescription drug</b> or device is not available for a certain method, you may obtain certain <b>brand-name prescription drugs</b> for that method paid at 100%.</li> </ul>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> continue to apply to <b>prescription drugs</b> that have a generic equivalent or generic alternative available within the same <b>therapeutic drug class</b> obtained at a <b>network pharmacy</b> unless you are granted a medical exception.		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Generic prescription drugs (including specialty drugs)</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	<p><b>Copayment</b> is the greater of \$10 or 30% (of the <b>negotiated charge</b>) but will be no more than \$100 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p><b>Copayment</b> is the greater of \$20 or 30% (of the <b>negotiated charge</b>) but will be no more than \$200 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
<b>Brand-name prescription drugs (including specialty drugs)</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	<p><b>Copayment</b> is the greater of \$10 or 40% (of the <b>negotiated charge</b>) but will be no more than \$100 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p><b>Copayment</b> is the greater of \$20 or 40% (of the <b>negotiated charge</b>) but will be no more than \$200 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

**Generic prescription drugs for asthma and antihyperlipidemic (including specialty drugs)**

**Per prescription copayment/payment percentage**

For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	<p><b>Copayment</b> is the greater of \$5 or 10% (of the <b>negotiated charge</b>) but will be no more than \$100 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p><b>Copayment</b> is the greater of \$10 or 10% (of the <b>negotiated charge</b>) but will be no more than \$200 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered

**Brand-name prescription drugs for asthma and antihyperlipidemic (including specialty drugs)**

**Per prescription copayment/payment percentage**

For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	<p><b>Copayment</b> is the greater of \$10 or 20% (of the <b>negotiated charge</b>) but will be no more than \$100 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p><b>Copayment</b> is the greater of \$20 or 20% (of the <b>negotiated charge</b>) but will be no more than \$200 per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered

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<b>Generic Diabetic supplies, drugs and insulin</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	\$5 <b>copayment</b> per supply  <b>Payment percentage</b> is 100% (of the <b>negotiated charge</b> )  No Calendar Year <b>deductible</b> applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	\$10 <b>copayment</b> per supply  <b>Payment percentage</b> is 100% (of the <b>negotiated charge</b> )  No Calendar Year <b>deductible</b> applies	Not covered
<b>Brand-name Diabetic supplies, drugs and insulin</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 31 day supply filled at a <b>retail pharmacy</b>	\$15 <b>copayment</b> per supply  <b>Payment percentage</b> is 100% (of the <b>negotiated charge</b> )  No Calendar Year <b>deductible</b> applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	\$30 <b>copayment</b> per supply  <b>Payment percentage</b> is 100% (of the <b>negotiated charge</b> )  No Calendar Year <b>deductible</b> applies	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	Not covered
<b>Preventive care drugs and supplements</b>		
Preventive care drugs and supplements filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	
<b>Risk reducing breast cancer prescription drugs</b>		
Risk reducing breast cancer <b>prescription drugs</b> filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	
<b>Tobacco cessation prescription and over-the-counter drugs</b>		
Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b>	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only.  Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation <b>prescription drugs</b> and OTC	

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	drugs, contact Member Services by logging onto your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	

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## General coverage provisions

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This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

### Deductible provisions

**Eligible health services** applied to the out-of-network **deductibles** will be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will be applied to satisfy the out-of-network **deductibles**.

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

### Individual

This is the amount you owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

### Family

This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

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<b>Common Accident Deductible</b>
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 <b>deductible</b> expenses when covered expenses are applied toward the separate Calendar Year <b>deductibles</b> . 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 <b>payment percentage</b> . The added benefit will be reduced by any family deductible limit benefit amount paid for the same covered expenses.
<b>Deductible carryover</b>
Any amounts that you paid for <b>eligible health services</b> in the last three months of a Calendar Year that apply toward that year's Calendar Year <b>deductibles</b> will also count toward the following year's Calendar Year <b>deductibles</b> .
<b>Per Admission Deductible</b>
Separate <b>deductibles</b> may apply per facility. These <b>deductibles</b> are in addition to any other <b>deductibles</b> applicable under this plan. They may apply to each <b>stay</b> or they may apply on a per day basis up to a per admission maximum amount.
<b>Eligible health services</b> applied to the per admission <b>deductible</b> cannot be applied to any other <b>deductible</b> required in this plan. Likewise, <b>eligible health services</b> applied to this plan's other <b>deductibles</b> cannot be applied to meet the per admission <b>deductible</b> .
<b>Copayments</b>
<b>Copayment</b> As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive <b>eligible health services</b> from a <b>network provider</b> .
<b>Per Admission Copayment</b>
A per admission <b>copayment</b> is an amount you are required to pay when you or a covered dependent have a <b>stay</b> in an inpatient facility.
Separate <b>copayments</b> may apply per facility. These <b>copayments</b> are in addition to any other <b>copayments</b> applicable under this plan. They may apply to each <b>stay</b> or they may apply on a per day basis up to a per admission maximum amount.
The per admission <b>copayment</b> amount is equal to a facility's <b>semi-private room rate</b> for one day.
<b>Payment percentage</b>
The specific percentage the plan pays for a health care service listed in the schedule of benefits.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

## Maximum out-of-pocket limits provisions

**Eligible health services** that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

**Eligible health services** applied to the **out-of-network maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

### Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

### Family

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**
- Out-of-Network expenses incurred for physical, occupational, speech, and neurodevelopmental therapies.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Maximum provisions</b>
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<b>Eligible health services</b> applied to the <b>out-of-network</b> maximum will not be applied to satisfy the network maximum and <b>eligible health services</b> applied to the network maximum will not be applied to satisfy the <b>out-of-network</b> maximum.
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<b>Calculations; determination of recognized charge; determination of benefits provisions</b>
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Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.
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<b>Outpatient prescription drug maximum out-of-pocket limits provisions</b>
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<b>Eligible health services</b> that are subject to the <b>maximum out-of-pocket limit</b> include <b>eligible health services</b> provided under the medical plan and the outpatient <b>prescription drug</b> plan.
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\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits