Schedule of Benefits

Prepared Exclusively for:

The City of Seattle
2021 City Preventive Plan*

Most Employees
Fire Chiefs
Police Management
Library
Seattle Housing Authority
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) - Most City Preventive Plan
Schedule of Benefits

Prepared exclusively for:

Employer:	The City of Seattle
Contract number:	ASC-100290
	Schedule of Benefits 1A
Plan effective date:	January 1, 2020
Plan issue date:	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

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 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

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. 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	90% per visit	80% per visit	90% per visit	60% per visit

Plan features	Deductible/Maximums		
	In-network coverage*	**Out-of-network coverage***	**Other health care***
Deductible			
You have to meet your Calendar Year **deductible** before this plan pays for benefits.			
Individual	$100 per Calendar Year	$450 per Calendar Year	$100 per Calendar Year
Family	$300 per Calendar Year	$1,350 per Calendar Year	$300 per Calendar Year
Common Accident Deductible			
Common Accident Deductible	$100	$450	$100

Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	$2,000 per Calendar Year	$3,000 per Calendar Year	$2,000 per Calendar Year
Family	$4,000 per Calendar Year	$6,000 per Calendar Year	$4,000 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
Preventive care and wellness			
Routine physical exams			
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies.	Not Covered	90% (of the **recognized charge**) per visit No **deductible** 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 **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com 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 **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	Not Covered	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	Not Covered	1 visit
Preventive care immunizations			
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies.	Not Covered	90% (of the **recognized charge**) per visit No **deductible** applies.
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of	Not Covered	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of

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	the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.		the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)			
Performed at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit
Preventive screening and counseling services			
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% (of the **negotiated charge**) per visit No **deductible** applies	Not Covered	90% (of the **recognized charge**) per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per Calendar Year (This maximum applies only to covered persons	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in	Not Covered	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in

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age 22 and older.)	connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*		connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Misuse of alcohol and/or drugs maximums:			
Maximum visits per Calendar Year	5 visits*	Not Covered	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per Calendar Year	8 visits*	Not Covered	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Sexually transmitted infection counseling maximums:			
Maximum visits per Calendar Year	2 visits*	Not Covered	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			
Genetic risk counseling for breast and ovarian cancer maximums:			
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
Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Mammograms	100% (of the **negotiated charge**) per test No **deductible** applies	60% (of the **recognized charge**) per test	100% (of the **recognized charge**) per test No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive

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	guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Prostate specific antigen (PSA) tests	100% (of the **negotiated charge**) per test No **deductible** applies	Not Covered	90% (of the **recognized charge**) per test No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Not Covered	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Digital rectal exams	100% (of the **negotiated charge**) per exam	Not Covered	90% (of the **recognized charge**) per exam

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	No **deductible** applies		No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.	Not Covered	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**			
Performed in a facility or at a **physician's** office	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **deductible** applies	Not Covered	90% (of the **recognized charge**) per item No **deductible** applies

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Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under *Physician services* office visits.			
Devices			
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per item thereafter No **deductible** applies	60% (of the **recognized charge**) per item	90% (of the **recognized charge**) per item No **deductible** applies
Female voluntary sterilization			
Inpatient	90% (of the **negotiated charge**) per admission	60% (of the **recognized charge**) per admission	90% (of the **recognized charge**) per admission
Outpatient	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Physicians and other health professionals			
Physicians and **specialists** office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
***Telemedicine Consultations**			
**The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.*			

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Allergy injections			
Performed at a **physician's** or **specialist** office when you do not see the **physician**	90% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Immunizations that are not considered preventive care			
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.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Physician surgical services			
Physicians and **specialists** office visits			
Performed at a **physician's** office	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Performed at a **specialist's** office	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** 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	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 **physician** or Member	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

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	physician or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	**physician** or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Hospital and other facility care			
Hospital care			
Inpatient **hospital**	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission thereafter	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission No **deductible** applies
Outpatient **hospital**	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
(performed at a hospital or other outpatient facility)	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Home health care			
Outpatient	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	130 Limited to: 3 intermittent visits per day provided by a participating **home health care agency**; 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 **home health care agency**; 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 **home health care agency**; 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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Hospice care			
Inpatient facility	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission	Not Covered	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited	Not Covered	Unlimited
Hospice care			
Outpatient	90% (of the **negotiated charge**) per visit	Not Covered	90% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** 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	Not Covered	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** 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
Outpatient private duty nursing			
Outpatient private duty nursing	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Skilled nursing facility			
Inpatient facility	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission No **deductible** applies
Maximum days per Calendar Year	120	120	120
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
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Emergency services and urgent care			

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Emergency services			
Hospital emergency room	$150 then the plan pays 90% (of the balance of the **negotiated charge**) per visit No **deductible** applies	Paid the same as in-network coverage.	Paid the same as in-network coverage.
Non-emergency care in a **hospital** emergency room	$150 then the plan pays 60% (of the balance of the **negotiated charge**) per visit No **deductible** applies	$150 then the plan pays 60% (of the balance of the **recognized charge**) per visit No **deductible** applies	$150 then the plan pays 60% (of the balance of the **recognized charge**) per visit No **deductible** applies

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-**hospital** free standing facility)	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge)** per visit	$15 then the plan pays 90% (of the balance of the **recognized charge**) per visit thereafter No **deductible** applies

A separate urgent care **deductible** or **copayment/payment percentage** will apply for each visit to an **urgent care provider**.

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific conditions			
Autism spectrum disorder			
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 **illness** under this plan			
Birthing center			
Inpatient	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission No **deductible** applies
*The per admission **copayment** and/or **deductible** 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.*			
Diabetic equipment, supplies and education			
Diabetic equipment, supplies and education	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.
Family planning services - other			
Voluntary sterilization for males			
Outpatient	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Abortion			
Outpatient	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Jaw joint disorder treatment			
Jaw joint disorder	90% (of the **negotiated**	60% (of the **recognized**	90% (of the **recognized**

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treatment	**charge**) per visit	**charge**) per visit	**charge**) per visit
Non-Surgical Lifetime Maximum Benefit	$5,000	$500	$5,000
Surgical Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Maternity and related newborn care			
Inpatient	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission No **deductible** applies
*The per admission **copayment** and **deductible** 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.*			
Delivery services and postpartum care services			
Performed in a facility or at a **physician's** office	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
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.
Mental health treatment - inpatient			
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 90% (of the balance of the **recognized charge**) per admission No **deductible** applies
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies

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Coverage is provided under the same terms, conditions as any other **illness**.			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Substance related disorders treatment - inpatient			
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other	$200 then the plan pays 90% (of the balance of the negotiated charge) per admission No **deductible** applies	$200 then the plan pays 60% (of the balance of the **recognized charge**) per admission No **deductible** applies	$200 then the plan pays 90% (of the balance of the recognized charge) per admission No **deductible** applies

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illness.			
Substance related disorders treatment - outpatient: detoxification and rehabilitation			
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation) Coverage is provided under the same terms, conditions as any other **illness**.	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services.	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies

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Eligible health services	In-network coverage* Institute of Quality (IOQ) Facility	In-network coverage* Non-IOQ Facility	Out-of-network coverage*
Obesity surgery			
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per admission No **deductible** applies	Not Covered	Not Covered
Outpatient obesity surgery			
	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	100% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) 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)	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
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
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
Transplant services facility and non-facility				
Inpatient **hospital** transplant services	$200 then the plan pays 90% (of the balance of the **negotiated charge**) per transplant	$200 then the plan pays 60% (of the balance of the **negotiated charge**) per transplant	$200 then the plan pays 60% (of the balance of the **recognized charge**) per transplant	$200 then the plan pays 60% (of the balance of the **recognized charge**) per transplant
Physician services including office visits	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.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Treatment of infertility			
Basic infertility			
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
Outpatient comprehensive infertility services			
	90% (of the **negotiated charge**) per visit	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit
Maximum per lifetime**	$10,000	$10,000	$10,000
As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by **Aetna or any **Aetna** affiliate, with the same policyholder			

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific therapies and tests			
Outpatient diagnostic testing			

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Diagnostic complex imaging services			
	90% (of the **negotiated** charge) per visit	60% (of the **recognized** charge) per visit	90% (of the **recognized** charge) per visit
Diagnostic lab work			
	90% (of the **negotiated** charge) per visit.	60% (of the **recognized** charge) per visit.	90% (of the **recognized** charge) per visit.

Diagnostic radiological services			
	90% (of the **negotiated charge**) per visit.	60% (of the **recognized charge**) per visit.	90% (of the **recognized charge**) per visit.
Chemotherapy			
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
Outpatient infusion therapy			
	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.
Outpatient radiation therapy			
	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.

Short-term cardiac and pulmonary rehabilitation services			
Cardiac rehabilitation			
Cardiac rehabilitation	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
Pulmonary rehabilitation			
Pulmonary rehabilitation	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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Short-term rehabilitation services			
Outpatient Physical, Massage, Occupational Cardiac and Pulmonary Therapies			
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter. No **deductible** applies	60%(of the **recognized charge**) per visit.	90% (of the **recognized charge**) per visit. No **deductible** applies
Outpatient Speech Therapy			
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter. No **deductible** applies	60%(of the **recognized charge**) per visit.	90% (of the **recognized charge**) per visit. No **deductible** applies
Short-term rehabilitation services maximum	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.

Habilitation therapy services			
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Other services			

Acupuncture			
Acupuncture	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies.

Maximum visits per Calendar Year	20	20	20

Ambulance service			
Ground, air or water **ambulance**	90% (of the **negotiated charge**) per trip	90% (of the **recognized charge**) per trip	90% (of the **recognized charge**) per trip

Clinical trial therapies (experimental or investigational)			
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
Clinical trials (routine patient costs)			
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

Durable medical equipment (DME)			
DME	90% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	90% (of the **recognized charge**) per item

Hearing aids and exams			
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

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Hearing aids	90% per item No **deductible** applies.	90% per item No **deductible** applies	90% per item No **deductible** applies
Maximum per 36 month period	$1,000 per ear	$1,000 per ear	$1,000 per ear

Non-preventive hearing exams			
For adults and children	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies.

Maximum	One exam in any 12 consecutive month period.

Nutritional supplements			
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.

Prosthetic devices			
Prosthetic devices	90% (of the **negotiated charge**) per item	60% (of the **recognized charge**) per item	90% (of the **recognized charge**) per item
Foot Orthotics Lifetime Maximum Benefit	$500	$500	$500

Spinal manipulation			
Spinal manipulation	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies
Maximum visits per Calendar Year	20	20	20

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Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	**Deductible/Copayment/Payment Percentage/Maximums**	
Deductible waiver		
The Calendar Year **deductible** is waived for all **prescription drugs**.		
Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs		
The Calendar Year **deductible** and the per **prescription copayment/payment percentage** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.		
Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year **deductible** and the per **prescription copayment/payment percentage** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your Calendar Year **deductible** and any **prescription copayment/payment percentage** will apply after those two regimens have been exhausted.		
Deductible and copayment/payment percentage waiver for contraceptives		
The Calendar Year **deductible** and the per **prescription copayment/payment percentage** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** 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 **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** for that method paid at 100%. The Calendar Year **deductible** and the per **prescription copayment/payment percentage** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.		
Outpatient prescription drug maximum out-of-pocket limit		
Outpatient **prescription drug maximum out-of-pocket limit** per Calendar Year		
Individual	$1,200 per Calendar Year	
Family	$3,600 per Calendar Year	

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

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Generic prescription drugs for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $5 or 10% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $10 or 10% (of the **negotiated charge**) but will be no more than $200 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
Lifetime Maximum for Smoking Cessation Aids or Drugs	One 90 day supply	Not covered

Brand-name prescription drugs for smoking cessation, asthma and antihyperlipidemic (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	**Copayment** is the greater of $10 or 20% (of the **negotiated charge**) but will be no more than $100 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is the greater of $20 or 20% (of the **negotiated charge**) but will be no more than $200 per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered

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Generic Diabetic supplies, drugs and insulin		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$5 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$10 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
Brand-name Diabetic supplies, drugs and insulin		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$15 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$30 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge** No Calendar Year **deductible** applies	Not covered
Proton Pump Inhibitors and Non-Sedating Antihistamines		
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

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General coverage provisions

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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Common Accident Deductible

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 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 family deductible limit benefit amount paid for the same covered expenses.

Deductible carryover

Any amounts that you paid for **eligible health services** in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year **deductibles**.

Per Admission Deductible

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductibles** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Eligible health services applied to the per admission **deductible** cannot be applied to any other **deductible** required in this plan. Likewise, **eligible health services** applied to this plan's other **deductibles** cannot be applied to meet the per admission **deductible**.

Copayments

Copayment

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 **eligible health services** from a **network provider**.

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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

The per admission **copayment** amount is equal to a facility's **semi-private room rate** for one day.

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

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Maximum out-of-pocket limits provisions

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
- Any out of pocket costs for non-emergency use of the emergency room
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will not be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will not be applied to satisfy the **out-of-network** maximum.

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Calculations; determination of recognized charge; determination of benefits provisions

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.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Outpatient prescription drug maximum out-of-pocket limits provisions

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

Individual

Once the amount of the **copayments** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

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The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug 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

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outpatient **prescription drug maximum out-of-pocket limit** amount.
Certain costs that you incur do not apply toward the outpatient **prescription drug maximum out-of-pocket limit**. These include: • All costs for non-covered services

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Amendment to Plan of Benefits

For Employees of: The City of Seattle
Administrative Services Agreement No.: 100290

Effective January 1, 2021, the following changes have been made to your Booklet.

1) The following section entitled “Habilitation therapy services” replaces the section under the same title in your Schedule of Benefits.

Habilitation therapy services			
	100% (of the **negotiated charge**) per visit No **deductible** applies	60% (of the **recognized charge**) per visit	90% (of the **recognized charge**) per visit No **deductible** applies