# Schedule of Benefits

**Prepared Exclusively for**
**The City of Seattle**

**2018 City Traditional Plan***

**Local 77 Employees**

**Open Choice (PPO) Medical**

**Please note: In the attached document the effective date is 2017; however, this document represents the benefits for 2018 and minimal changes made to plan documents in 2018.*

*To view minor changes for 2018, see the amendment at the end of the "book" with updates to Behavioral Health telemedicine and Precertification. These are only language changes with no material impact to benefits.*

# Schedule of Benefits

**Employer:** **The City of Seattle**

**ASC:** 100290

**Issue Date:** January 26, 2017
**Effective Date:** January 1, 2017
**Schedule:** 7A
**Booklet Base:** 7

For: Open Choice (PPO Medical) - Local 77 Traditional Plan

## PPO Medical Plan

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | Other Health Care |
|---|---|---|---|
| **Calendar Year Deductible*** | | | |
| ***Individual Deductible**** | $100 | $150 | $100 |
| ***Family Deductible**** | $300 | $450 | $300 |

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

| | | | |
|---|---|---|---|
| ***Common Accident Deductible*** | $100 | $150 | $100 |

**Plan Maximum Out of Pocket Limit** includes plan **deductible** and **copayments**.

**Plan Maximum Out of Pocket Limit** excludes **precertification** penalties.

**Individual Maximum Out of Pocket Limit**:

- For **network** expenses: $300.
- For **out-of-network** expenses: $1,350.

**Family Maximum Out of Pocket Limit**:

- For **network** expenses: $900.
- For **out-of-network** expenses: $4,050.

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|---|---|---|---|
| ***Lifetime Maximum Benefit Per Person*** | Unlimited | Unlimited | Unlimited |

***Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.***

***All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.***

***Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network and other health care, unless specifically stated otherwise.***

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Preventive Care Benefits*** | | | |
| ***Routine Physical Exams*** | | | |
| ***Office Visits*** | 100% per visit<br><br>No **copay** or **deductible** applies. | Not Covered | 100% per visit<br><br>No **deductible** applies. |
| *Covered Persons through age 21*:<br>Maximum Age & Visit Limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.<br><br>*For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of 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 Guidelines for Children and Adolescents.<br><br>*For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* |
| *Covered Persons ages 22 but less than 65*:<br>Maximum Visits per 12 consecutive months | 1 visit | Not Covered | 1 visit |
| *Covered Persons age 65 and over*:<br>Maximum Visits per 12 consecutive months | 1 visit | Not Covered | 1 visit |

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|---|---|---|---|
| ***Preventive Care Immunizations***<br>*Performed in a facility or* ***physician's*** *office* | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.<br><br>*For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* | Not Covered | 100% per visit<br><br>No **deductible** applies.<br><br>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.<br><br>*For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.* |
| ***Screening & Counseling Services***<br><br>***Office Visits***<br>***Obesity and/or Healthy Diet***<br><br>***Misuse of Alcohol and/or Drugs & Use of Tobacco Products***<br><br>***Sexually Transmitted Infections***<br><br>***Genetic Risk for Breast and Ovarian Cancer*** | 100% per visit<br><br>No **copay** or **deductible** applies. | Not Covered | 100% per visit<br><br>No **deductible** applies. |
| *Obesity and/or Healthy Diet*<br>Maximum Visits per 12 consecutive months<br>*(This maximum applies only to Covered Persons ages 22 & 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-related chronic disease)* | 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-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*<br>Maximum Visits per 12 consecutive 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.***

| | | | |
|---|---|---|---|
| *Use of Tobacco Products*<br>Maximum Visits per 12 consecutive 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.***

| | | | |
|---|---|---|---|
| *Sexually Transmitted Infections Benefit Maximums*<br>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.***

| | | | |
|---|---|---|---|
| ***Well Woman Preventive Visits***<br>***Office Visits***<br><br>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations | 100% per visit<br><br>No Calendar Year **deductible** applies. | Not Covered | 100% per exam<br><br>No Calendar Year **deductible** applies. |
| Maximum Visits per Calendar Year | 1 visit | Not Covered | 1 visit |
| ***Hearing Exam*** | 80% per exam after Calendar Year **deductible** | 80% per exam after Calendar Year **deductible** | 80% per exam after Calendar Year **deductible** |
| Maximum Exams per 12 month period | 1 exam | 1 exam | 1 exam |
| **Hearing Aids**<br><br>Hearing Supply Maximum per 36 month period | 100% after Calendar Year **deductible**<br><br>$1,000 per ear | 100% after Calendar Year **deductible**<br><br>$1,000 per ear | 100% after Calendar Year **deductible**<br><br>$1,000 per ear |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Routine Cancer Screenings*** | | | |
| ***Routine Mammography*** | 100% per visit<br><br>No Calendar Year **deductible** applies. | 60% per visit<br><br>No Calendar Year **deductible** applies. | 100% per visit<br><br>No Calendar Year **deductible** applies. |
| Maximum tests per Calendar Year | 1 test | 1 test | 1 test |
| ***All Other Routine Exams and Screenings* (including Routine Gynecological Exam & Routine Pap Smears)*** | 100% per visit<br><br>No Calendar Year **deductible** applies. | Not Covered | 100% per visit<br><br>No Calendar Year **deductible** applies. |

*Including but not limited to: fecal occult blood tests, digital rectal exams, prostate specific antigen (PSA) tests, sigmoidoscopies, double contrast barium enemas (DCBE) and colonoscopies.

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|---|---|---|---|
| Maximums | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• 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<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br>*For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.* | Not Covered | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• 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<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br>*For details, contact your* ***physician*** *or Member Services by logging onto the* ***Aetna*** *website www.aetna.com, or calling the number on the back of your ID card.* |
| *Lung Cancer Screening Maximum* | One screening every 12 months***** | Not Covered | One screening every 12 months***** |

***Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.***

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|---|---|---|---|
| ***Prenatal Care Office Visits*** | 100% per visit<br><br>No **deductible** applies. | 60% per visit after Calendar Year **deductible** | 100% per visit<br><br>No **deductible** applies. |
| Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits. | | | |
| ***Comprehensive Lactation Support and Counseling Services*** | | | |
| ***Lactation Counseling Services -*** Facility or Office Visits | 100% per visit.<br><br>No **deductible** applies. | 80% per visit after Calendar Year **deductible** | 100% per visit<br><br>No **deductible** applies. |
| Lactation Counseling Services Maximum Visits either in a group or individual setting | 6* visits per 12 months | Not Applicable | 6* visits per 12 months |
| ***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.. | | | |
| **Breast Pumps & Supplies** | 100% per item.<br>No **copay** or **deductible** applies. | 80% per item after Calendar Year **deductible** | 100% per item.<br><br>No **deductible** applies. |
| Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies. | | | |
| ***Family Planning Services - Other*** | | | |
| Voluntary Sterilization for Males | | | |
| Outpatient | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** | 80% per visit after Calendar Year **deductible.** |
| Voluntary Termination of Pregnancy | | | |
| Outpatient | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** | 80% per visit after Calendar Year **deductible.** |
| ***Family Planning Services*** | | | |
| Female Contraceptive Counseling Services - Office Visits. | 100% per visit.<br><br>No **copay** or Calendar Year **deductible** applies. | 60% per visit after Calendar Year **deductible** | 100% per visit<br><br>No Calendar Year **deductible** applies. |
| Contraceptive Counseling Services - Maximum Visits either in a group or individual setting | 2* visits per 12 months | Not Applicable | 2* visits per 12 months |
| *Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.* | | | |

| | | | |
|---|---|---|---|
| Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits. | 100% per item<br><br>No **copay** or **deductible** applies. | 80% per item after Calendar Year **deductible** | 100% per item<br><br>No **copay** or **deductible** applies. |

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|---|---|---|---|
| ***Family Planning Services - Female Voluntary Sterilization*** | | | |
| ***Inpatient*** | 100% per visit.<br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** | 100% per visit<br><br>No **copay** or **deductible** applies. |
| ***Outpatient*** | 100% per visit<br><br>No **copay** or **deductible** applies. | 60% per visit after Calendar Year **deductible** | 100% per visit<br><br>No **copay** or **deductible** applies. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Physician Services*** | | | |
| ***Physician Office Visits*** *(non-surgical)* | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Specialist Office Visits*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Aexcel Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Non-Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Out of Network Provider Specialist*** | Not applicable | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

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|---|---|---|---|
| ***Physician Office Visits-Surgery*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Aexcel Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Non-Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Out of Network Provider Specialist*** | Not applicable | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| ***Walk-In Clinic Visit (Non-Emergency)*** | | | |
| ***Preventive Care Services**** | | | |
| Immunizations | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card. | Not Covered | 100% per visit<br><br>No **deductible** applies.<br><br>For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card. |
| Individual Screening and Counseling Services for Tobacco Use | 100% per visit<br><br>No **copay** or **deductible** applies. | Not Covered | 100% per visit<br><br>No **deductible** applies. |
| Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Not Covered | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
| Individual Screening and Counseling Services for Obesity | 100% per visit<br><br>No **copay** or **deductible** applies. | Not Covered | 100% per visit<br><br>No **deductible** applies. |
| Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services | Not Covered | Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services |
| ***Important Note**:<br>Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**. | | | |
| ***All Other Services*** | 80% after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible**. |

| | | | |
|---|---|---|---|
| ***Physician Services for Inpatient Facility and Hospital Visits*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Aexcel Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Non-Designated Network Specialist*** | 80% per visit after Calendar Year **deductible** | Not applicable | 80% per visit after Calendar Year **deductible** |
| ***Out of Network Provider Specialist*** | Not applicable | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Administration of Anesthesia*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Emergency Medical Services*** | | | |
| ***Hospital Emergency Facility and Physician Services*** | 80% after Calendar Year **deductible** | Paid the same as the Network level of benefits. | Paid the same as the Network level of benefits. |
| | Emergency physician may not be a network provider. See Important Note below | See Important Note Below | See Important Note Below |

**Important Note:** Out-of-network providers do not have a contract with **Aetna**, and may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the emergency room facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

| | | | |
|---|---|---|---|
| ***Non-Emergency Care in a Hospital Emergency Room*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Urgent Care Services*** | | | |
| ***Urgent Medical Care*** *(at a non-hospital free standing facility)* | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Urgent Medical Care*** *(from other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. |

| PLAN FEATURES | | | |
|---|---|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** | | | |
| ***Preoperative Testing (except complex imaging services) Performed at a Hospital Outpatient Facility*** | 100% per procedure<br><br>No Calendar Year **deductible** applies. | 100% per procedure<br><br>No Calendar Year **deductible** applies. | 100% per procedure<br><br>No Calendar Year **deductible** applies. |
| ***Complex Imaging Services*** | | | |
| ***Complex Imaging*** | 80% per test after Calendar Year **deductible** | 60% per test after Calendar Year **deductible** | 80% per test after Calendar Year **deductible** |
| ***Diagnostic Laboratory Testing*** | | | |
| ***Diagnostic Laboratory Testing*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |
| ***Diagnostic X-Rays*** | | | |
| ***Diagnostic X-Rays*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Outpatient Surgery*** | | | |
| ***Outpatient Surgery*** | 80% per visit/surgical procedure after Calendar Year **deductible** | 60% per visit/surgical procedure after Calendar Year **deductible** | 80% per visit/surgical procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Inpatient Facility Expenses*** | | | |
| ***Birthing Center*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Hospital Facility Expenses*** | | | |
| Room and Board (including maternity) | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| ***Skilled Nursing Inpatient Facility*** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Maximum Days per Calendar Year | 90 days | 90 days | 90 days |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
| ***Specialty Benefits*** | | | |
| ***Home Health Care (Outpatient)*** | 90% per visit after Calendar Year **deductible** | 90% per visit after Calendar Year **deductible** | 90% per visit after Calendar Year **deductible** |
| Maximum Visits per Calendar Year | 130 | 130 | 130 |
| ***Skilled Nursing Care (Outpatient)*** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** |
| ***Private Duty Nursing (Outpatient)*** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** |
| ***Hospice Benefits*** | | | |
| ***Hospice Care –Facility Expenses*** (Room & Board) | 90% per admission after the Calendar Year **deductible** | 90% per admission after the Calendar Year **deductible** | 90% per admission after the Calendar Year **deductible** |
| ***Hospice Care – Other Expenses during a stay*** | 90% per admission after the Calendar Year **deductible** | 90% per admission after the Calendar Year **deductible** | 90% per admission after the Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** | 90% per visit after the Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Infertility Treatment*** | | | |
| ***Basic Infertility Expenses*** Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Inpatient Treatment of Mental Disorders*** | | | |
| ***MENTAL DISORDERS*** | | | |
| ***Hospital Facility Expenses*** | | | |
| Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Physician Services | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment*** | | | |
| Facility Expenses | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Physician Services | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| ***Outpatient Treatment Of Mental Disorders*** | | | |
| ***Outpatient Services*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Inpatient Treatment of Substance Abuse*** | | | |
| ***Hospital Facility Expense*** | | | |
| Room and Board | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Other than Room and Board | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Physician Services | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment*** | | | |
| Facility Expenses | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** | 80% per admission after Calendar Year **deductible** |
| Physician Services | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| ***Outpatient Treatment of Substance Abuse*** | | | |
| ***Outpatient Treatment*** (including acupuncture) | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK Institute of Excellence (IOE) Facility | NETWORK Non-IOE Facility | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|---|
| ***Transplant Services Facility and Non-Facility Expenses*** | | | | |
| ***Transplant Facility Expenses*** | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** |
| ***Transplant Physician Services*** (including office visits) | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided |

| PLAN FEATURES | | | |
|---|---|---|---|
| ***Other Covered Health Expenses*** | | | |
| ***Acupuncture*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| Maximum visits per Calendar Year | 12 | 12 | 12 |
| ***Ground, Air or Water Ambulance*** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| **Blood Bank Charges** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| ***Durable Medical and Surgical Equipment*** | 80% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** |
| ***Clinical Trial Therapies*** (Experimental or Investigational Treatment) | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Routine Patient Costs*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | 80% of billed charges after Calendar Year **deductible** | 80% of billed charges after Calendar Year **deductible** | 80% of billed charges after Calendar Year **deductible** |
| Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum | $10,000 | $10,000 | $10,000 |
| Accidental injury treatment Maximum Benefit | $600 per occurrence | $600 per occurrence | $600 per occurrence |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| **Phenylketonuria Formula** | 100% after Calendar Year **deductible** | 100% after Calendar Year **deductible** | 100% after Calendar Year **deductible** |
| ***Prosthetic Devices*** | | | |
| Foot Orthotics | 80% per item after Calendar Year **deductible** | 60% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** |
| Other Prosthetic Devices | 80% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** |
| Foot Orthotics Lifetime Maximum Benefit | $500 | $500 | $500 |
| **Transgender Reassignment (Sex Change) Surgery** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Outpatient Therapies*** | | | |
| ***Chemotherapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Infusion Therapy*** | 90% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Radiation Therapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** | | | |
| ***Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy*** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum visits per Year | 30 visits | 30 visits | 30 visits |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Neurodevelopmental Therapy*** | | | |
| ***Outpatient Neurodevelopmental Therapy**** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Spinal Manipulation*** | | | |
| ***Spinal Manipulation*** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| Spinal Manipulation Maximum visits per Calendar Year | 10 visits | 10 visits | 10 visits |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Autism Spectrum Disorder*** | | | |
| ***Autism - Behavioral therapy*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Autism - Applied Behavior Analysis*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Habilitative Services*** | | | |
| Therapy for Children with Developmental Delays | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |

# Pharmacy Benefit

**Copays/Deductibles**

| PER PRESCRIPTION COPAY/DEDUCTIBLE | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Generic Prescription Drugs*** | | |
| Maximum supply per prescription: the greater of 34 day supply or 100 unit doses | | |
| Retail Pharmacy | $15 | Not Covered |
| Mail order Pharmacy | $30 | Not Covered |
| ***Brand-Name Prescription Drugs*** | | |
| Maximum supply per prescription: the greater of 34 day supply or 100 unit doses | | |
| Retail Pharmacy | $15 | Not Covered |
| Mail order Pharmacy | $30 | Not Covered |

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

| | | |
|---|---|---|
| ***Smoking Cessation Aids or Drugs*** | | |
| **Smoking Cessation Aids or Drugs Lifetime Maximum Benefit** | One 90 day supply | Not Covered |

**Copay and Deductible Waiver**

**Waiver for Risk-Reducing Breast Cancer Prescription Drugs**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

**Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs**

The **prescription drug deductible** and the per **prescription copayment/coinsurance** 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 **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

**Waiver for Prescription Drug Contraceptives**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **FDA-Approved Female Generic Over-the-Counter Contraceptives**<br><br>For each 30 day supply filled at a retail **pharmacy** | 100% per supply<br><br>No **copay** or **deductible** applies. | Not covered. |
| **FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives** | 100% per supply<br><br>No **copay** or **deductible** applies. | Not covered. |

**Important Note:**
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

| | | |
|---|---|---|
| ***Preventive Care Drugs and Supplements*** | | |
| Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**:<br><br>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 your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card. | 100% per item.<br><br>No **copay** or **deductible** applies. | Not Covered. |
| **Important Note:**<br>**Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.** | | |
| ***Tobacco Cessation Prescription and Over-the-Counter Drugs*** | | |
| Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply.<br><br>Maximums:<br>Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.<br><br>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 prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card. | 100% per supply<br><br>No **copay** or **deductible** applies. | Not covered. |

**Coinsurance**

| | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Prescription Drug Plan Coinsurance*** | 100% of the **negotiated charge** | Not Covered |

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

**Prescription Drug Payment Limit**

| | NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Prescription Drug Payment Limit*** | $1,200 Individual<br>$3,600 Family | Not Covered<br>Not Covered |

**Individual Prescription Drug Payment Limit**: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

**Prescription Drug Payment Limit**
When your share or each of your covered dependent's share of **prescription drug covered expenses** reach the **prescription drug Payment Limit** in a Calendar Year, your plan will pay 100% of that person's **prescription drug covered expenses** for the rest of the Calendar Year. The **prescription drug Payment Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

**Family Prescription Drug Payment Limit**. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

**Prescription Drug Payment Limit**
When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Payment Limit** in a Calendar Year, your plan will pay 100% of the family's **covered expenses** for the rest of the Calendar Year. The family **prescription drug Payment Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

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

Expenses applied toward a **deductible** or **copay** amount.
Expenses above the **recognized charge**.
Non-**covered expenses**.

## Expense Provisions

**The following provisions apply to your health expense plan.**
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## Deductible Provisions

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

**Network Provider and Other Health Care Calendar Year Deductible**

**Individual**
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** and for **other health care** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** and for **other health care** for the rest of the Calendar Year.

**Family Deductible Limit**
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

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

> The combined **covered expenses** 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.

**Out-of-Network Provider Calendar Year Deductible**

**Individual**
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

**Family Deductible Limit**
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

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

> The combined **covered expenses** 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.

**Common Accident Out-of-Network Deductible Limit**
This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **out-of-network providers** and for **other health care**. 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 **out-of-network family deductible** limit benefit amount paid for the same **covered expenses**. This added benefit does not count toward any Lifetime Maximum Benefit for you and your covered dependents.

**Deductible Carryover**
Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers**, **out-of-network** providers and **other health care** will also count toward the following year's **network providers**, **out-of-network** providers and **other health care deductibles**.

## Copayments and Benefit Deductible Provisions

**Copayment, Copay**
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

## Payment Provisions

**Payment Percentage**
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

**Maximum Out of Pocket Limit**
The **Maximum Out of pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual and family **Maximum out of Pocket Limit**.

Certain **covered expenses** do not apply toward the **Maximum Out of Pocket Limit.** See list below.

The **Maximum Out of Pocket Limit** applies to **network provider**, **out-of-network provider** and **other health care** benefits.

You have a separate **Maximum Out of Pocket Limit** for **network provider and out-of-network provider** benefits. **Covered expenses** 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 **covered expenses** applied to the in-network **Maximum Out of Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out of Pocket Limit.**

**Network Provider and Other Health Care Maximum Out of Pocket Limit**

**Individual**
Once the amount of eligible **network provider** and **other health care** expenses you have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

**Family**
The Family **Maximum Out of Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** and **other health care** expenses paid during the Calendar Year meets this family **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

**Out-of Network Provider Maximum Out of Pocket Limit**

**Individual**
Once the amount of eligible **out-of-network provider** expenses you have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

**Family**
The Family **Maximum Out of Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the Calendar Year meets this family **Maximum Out of Pocket Limit** this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

**Expenses That Do Not Apply to Your Out-of-Pocket Limit**
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses incurred for short term outpatient rehabilitation therapy and neurodevelopmental therapy expenses; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

**Maximum Benefit Provisions**

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

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

# General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.