Schedule of Benefits

Employer: **The City of Seattle**

ASC: 100290

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Schedule: 9A
Booklet Base: 9

For: Open Choice (PPO Medical) - S.P.O.G. Preventive Retiree Plan

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
Individual Deductible*	None	$250	None
Family Deductible*	None	$750	None

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

Common Accident Deductible	None	$250	None

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

Individual Payment Limit:

- For **network** expenses: $500.
- For **out-of-network** expenses: $3,000.

Family Payment Limit:

- For **network** expenses: $1,000.
- For **out-of-network** expenses: $6,000.

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 Includes coverage for non-travel immunizations.	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.
Under age 6: Maximum Visits per Calendar Year*	Unlimited	Not Covered	Unlimited
From age 6 to age 12: Maximum Visits per Calendar Year*	2 visits	Not Covered	2 visits
Age 12 and older: Maximum Visits per Calendar Year*	1 visit	Not Covered	1 visit

* The age and visit limits shown above will apply to your plan unless the age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration result in greater benefits.

For details, contact your **physician,** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.
Obesity Maximum Visits per Calendar Year *(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 10visits 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 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 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.			

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Gynecological Exam (including Routine Pap Smears)	100% per exam No Calendar Year **deductible** applies.	70% per exam after Calendar Year **deductible**	100% per exam No Calendar Year **deductible** applies.
Routine Mammography	100% per test No Calendar Year **deductible** applies.	70% per test after Calendar Year **deductible**	100% per test No Calendar Year **deductible** applies.
All Other Routine Exams and Screenings*	100% per visit No Calendar Year **deductible** applies.	Not Covered	100% per visit 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.

Maximum Age & Visit Limits per Calendar Year (All Routine Cancer Screenings)	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.* *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	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.* *For details, contact your* ***physician,*** *log onto the* ***Aetna*** *website www.aetna.com, or call the number on the back of your ID card.*

* No age limit applies to routine mammograms.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Family Planning Services			
Family Planning Services	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.
Vision Care			
Eye Examinations (including refraction)	100% per exam No Calendar Year **deductible** applies.	70% per exam after Calendar Year **deductible**	100% per exam No Calendar Year **deductible** applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
Physician Office Visits (*non-surgical*)	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Specialist Office Visits	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Physician Office Visits-Surgery	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Walk-In Clinic Non-Emergency Visit	$5 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services for Inpatient Facility and Hospital Visits	100% per visit No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Administration of Anesthesia	100% per procedure No Calendar Year **deductible** applies.	70% per procedure after Calendar Year **deductible**	100% per procedure No Calendar Year **deductible** applies.
Allergy Testing and Treatment	$5 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Allergy Injections	100% per visit No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Immunizations (when not part of the physical exam)	100% per visit No Calendar Year **deductible** applies.	Not Covered	100% per visit No Calendar Year **deductible** applies.
Prenatal 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services			
Hospital Emergency Facility and Physician	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$50 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$50 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies.
	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	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	$50 **deductible** per visit then the plan pays 70% No Calendar Year **deductible** applies.	$50 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies.

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	$35 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies	70% after Calendar Year **deductible**	$35 **deductible** per visit then the plan pays 100% No Calendar Year **deductible** applies

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

Important Notice
A separate **urgent care deductible** or **copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **deductibles** or **copays** cannot be applied to the **urgent care deductible** or **copay**.

PLAN FEATURES			
Outpatient Diagnostic and Preoperative Testing			
Complex Imaging Services			
Complex Imaging	100% per test No Calendar Year **deductible** applies.	70% per test after Calendar Year **deductible**	100% per test No Calendar Year **deductible** applies.
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	100% per test No Calendar Year **deductible** applies. (whether or not billed as part of an office visit)	70% per test after Calendar Year **deductible**	100% per test No Calendar Year **deductible** applies. (whether or not billed as part of an office visit)
Diagnostic X-Rays			
Diagnostic X-Rays	100% per procedure No Calendar Year **deductible** applies. (whether or not billed as part of an office visit)	70% per procedure after Calendar Year **deductible**	100% per procedure No Calendar Year **deductible** applies. (whether or not billed as part of an office visit)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery			
Outpatient Surgery (performed at a **hospital** or other outpatient facility)	100% per visit/surgical procedure No Calendar Year **deductible** applies.	70% per visit/surgical procedure after Calendar Year **deductible**	100% per visit/surgical procedure No Calendar Year **deductible** applies.

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)	100% per admission No Calendar Year **deductible** applies	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies
Other than Room and Board	100% per admission No Calendar Year **deductible** applies	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies
Skilled Nursing Inpatient Facility	100% per admission No Calendar Year **deductible** applies	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies
Maximum Days per Calendar Year	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	100% per visit No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies
Maximum Visits per Calendar Year	130	130	130

Hospice Benefits			
Hospice Care – Facility Expenses (Room & Board)	100% per admission No Calendar Year **deductible** applies	Not Covered	100% per admission No Calendar Year **deductible** applies
Hospice Care – Other Expenses during a stay	100% per admission No Calendar Year **deductible** applies	Not Covered	100% per admission No Calendar Year **deductible** applies
Hospice Outpatient Visits	100% per visit No Calendar Year **deductible** applies	Not Covered	100% per visit No Calendar Year **deductible** applies
Maximum Benefit per lifetime (inpatient and outpatient combined)	6 months, 6 additional months if authorized	Not Applicable	6 months, 6 additional months if authorized
Respite Care Maximum	10 days in a 6 consecutive month period	Not Applicable	10 days in a 6 consecutive month period

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.
Infertility Drugs (prescribed by a **Network Physician**)	80% No Calendar Year deductible applies	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	$2,000	Not Applicable	Not Applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Mental Disorders			
MENTAL DISORDERS ***Hospital Facility Expenses***			
Room and Board	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.
Physician Services	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Residential Treatment			
Facility Expenses	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**.	100% per admission No Calendar Year **deductible** applies.
Physician Services	100% per visit No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**.	100% per visit No Calendar Year **deductible** applies.
Outpatient Treatment Of Mental Disorders			
Outpatient Services			
Office Visits	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Other Than Office Visits	100% No Calendar Year **deductible** applies.	70% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.
Physician Services	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**	100% per admission No Calendar Year **deductible** applies.
Inpatient Residential Treatment			
Facility Expenses	100% per admission No Calendar Year **deductible** applies.	70% per admission after Calendar Year **deductible**.	100% per admission No Calendar Year **deductible** applies.
Physician Services	100% per visit No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**.	100% per visit No Calendar Year **deductible** applies.
Outpatient Treatment of Substance Abuse			
Outpatient Treatment			
Office Visits	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Other Than Office Visits	100% No Calendar Year **deductible** applies.	70% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
Transplant Services Facility and Non-Facility Expenses				
Facility Expenses	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.
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	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.

Ambulance(Ground, Air or Water	100% No Calendar Year **deductible** applies.	100% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.
Blood Bank Charges	100% No Calendar Year **deductible** applies.	100% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Durable Medical and Surgical Equipment	100% No Calendar Year **deductible** applies.	70% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	100% of billed charges No Calendar Year **deductible** applies.	100% of billed charges No Calendar Year **deductible** applies.	100% of billed charges No Calendar Year **deductible** applies.
All other treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	$10,000	$10,000	$10,000
Phenylketonuria Formula	100% No Calendar Year **deductible** applies.	100% after Calendar Year **deductible**	100% No Calendar Year **deductible** applies.
Prosthetic Devices	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	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.
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	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies
Maximum visits per Calendar Year			
Physical/Massage Therapy	20 visits	20 visits	20 visits
Occupational Therapy	20 visits	20 visits	20 visits
Speech Therapy	20 visits	20 visits	20 visits
Cardiac/Pulmonary Therapy	20 visits	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Neurodevelopmental Therapy			
Outpatient Neurodevelopmental Therapy	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies
Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)*	$3,000	$3,000	$3,000

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

Spinal Manipulation			
Spinal Manipulation	$5 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	70% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies
Spinal Manipulation Maximum visits per Calendar Year	20	20	20

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 31 day supply (retail)	$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$10	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Brand-Name Prescription Drugs		
For each 31 day supply (retail)	$10	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$20	Not Covered
Non-Preferred Generic Prescription Drugs		
For each 31 day supply (retail)	$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$10	Not Covered
Non-Preferred Brand-Name Prescription Drugs		
For each 31 day supply (retail)	$25	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$50	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 Maximum Out-of-Pocket Limit (Annual Limit)

	NETWORK	OUT-OF-NETWORK
Prescription Drug Maximum Out-of-Pocket Limit	$1,200 Individual $3,600 Family	Not Applicable Not Applicable

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

Prescription Drug Maximum Out-of-Pocket Limit
When your share or each of your covered dependent's share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network prescription drug covered expenses**.

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

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

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

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

Expense Provisions

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Out-of-Network Calendar Year Deductible
This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Family Deductible Limit
When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

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 **out-of-network** Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar year exceed the common accident **out-of-network 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 **out-of-network deductible** limit benefit amount paid for the same **covered expenses**. The added benefit does not count toward your Lifetime Maximum Benefit.

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

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

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

Payment Limit
The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Payment Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

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

The **Payment Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Payment Limit** will be applied to satisfy the in-network **Payment Limit** and **covered expenses** applied to the in-network **Payment Limit** will be applied to satisfy the out-of-network **Payment Limit**.

Expenses That Do Not Apply to Your Payment Limit
Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses incurred for infertility drugs;
- Non-covered expenses;
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Calendar Year **Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** 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.