

Schedule of Benefits

Employer: The City of Seattle
ASC: 100290
Issue Date: May 13, 2015
Effective Date: January 1, 2015
Schedule: 11A
Booklet Base: 11

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$400	\$1,000	\$400
<i>Family Deductible*</i>	\$1,200	\$3,000	\$1,200
Per Admission Copayment	\$200 per admission	Not applicable	Not applicable
Per Admission Deductible*	Not applicable	\$200 per admission	\$200 per admission
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.			
<i>Common Accident Deductible</i>	\$400	\$1,000	\$400

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

Plan Out-of-Network **Payment Limit** does not include plan **deductible** and **copayments**.

Plan In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit** excludes **precertification** penalties.

Individual In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit**:

- For network expenses: \$1,400.
- For out-of-network expenses: \$3,000.

Family In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit**:

- For network expenses: \$4,200.
- For out-of-network expenses: \$9,000.

<i>Lifetime Maximum Benefit Per Person</i>	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.

Note: Charges incurred for preventive care exams and tests, including routine physical exams, well child exams, routine eye exams and routine cancer screenings are not covered expenses, except as specifically provided below and in the *What the Plan Covers* section of your Booklet.

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

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.
Screening & Counseling Services Office Visits Obesity and/or Healthy Diet Misuse of Alcohol and/or Drugs & Use of Tobacco Products Sexually Transmitted Infections Genetic Risk for Breast and Ovarian Cancer	100% per visit No copay or deductible applies.	Not Covered	100% per visit No deductible applies.
Obesity Maximum Visits per 12 consecutive months <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(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)*</i>	Not Applicable	26 visits <i>(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)*</i>
*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 12 consecutive months	5 visits*	Not Applicable	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 12 consecutive months	8 visits*	Not Applicable	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*

Maximum Visits per Calendar Year	2 visits*	Not Applicable	2 visits*
-------------------------------------	-----------	----------------	-----------

***Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

***Tobacco Cessation
Prescription and Over-
the-Counter Drugs***

Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy for each 90 day supply.	100% per item No copay or deductible applies.	Not Covered	100% per item No copay or deductible applies.
---	---	-------------	---

Maximums:
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.

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.

<i>Well Woman Preventive Visits</i>			
<i>Office Visits</i>	100% per visit	Not Covered	100% per exam
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	No Calendar Year deductible applies.		No Calendar Year deductible applies.
Maximum Visits per Calendar Year	1 visit	Not Applicable	1 visit
<i>Hearing Exam</i>			
	80% per exam after Calendar Year deductible	60% 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
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Routine Cancer Screenings</i>			
<i>Routine Cancer Screenings Outpatient</i>			
	100% per visit	Not Covered	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.
Maximums	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. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Not Applicable	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. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>

<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*	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.			

<i>Prenatal Care Office Visits</i>	100% per visit No deductible applies.	60% per visit after Calendar Year deductible.	100% per visit 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.

<i>Comprehensive Lactation Support and Counseling Services</i>			
<i>Lactation Counseling Services - Facility or Office Visits</i>	100% per visit. No deductible applies.	60% per visit after Calendar Year deductible	100% per visit 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. No copay or deductible applies.	60% per item after Calendar Year deductible	100% per item. 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.

<i>Family Planning Services - Other</i>			
<i>Voluntary Sterilization for Males</i>			
Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
<i>Voluntary Termination of Pregnancy</i>			
Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.

<i>Family Planning Services</i>			
Female Contraceptive Counseling Services - Office Visits.	100% per visit. No copay or Calendar Year deductible applies	60% per visit after Calendar Year deductible	100% per visit 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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .			

Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item No copay or deductible applies.	60% per item after Calendar Year deductible	100% per item No copay or deductible applies.
---	--	--	--

Family Planning Services - Female Voluntary Sterilization			
Inpatient	100% per visit. No copay or deductible applies.	60% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.
Outpatient	100% per visit No copay or deductible applies.	60% per visit after Calendar Year deductible	100% per visit 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	70% 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

<i>Physician Office Visits-Surgery</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	70% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</i>			
Immunizations	100% per visit No copay or deductible applies. 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 No deductible applies. 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 No copay or deductible applies.	Not Covered	100% per visit No deductible applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable	Refer to the <i>Preventive Care Benefit</i> 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 No copay or deductible applies.	Not Covered	100% per visit No deductible applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Covered	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services

***Important Note:**

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**.

<i>All Other Services</i>	80% after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible .
----------------------------------	---	---	---

<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	70% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Administration of Anesthesia</i>	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
---------------	---------	----------------	-------------------

<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility and Physician</i>	\$150 copay per visit then the plan pays 80% No Calendar Year deductible applies. Emergency physician may not be a network provider. See Important Note below	Paid the same as the Network level of benefits. See Important Note below	Paid the same as the Network level of benefits. 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.			

<i>Non-Emergency Care in a Hospital Emergency Room</i>	\$150 copay per visit then the plan pays 60% No Calendar Year deductible applies	\$150 copay per visit then the plan pays 60% No Calendar Year deductible applies	\$150 copay per visit then the plan pays 60% 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**.

Urgent Care Services			
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

PLAN FEATURES
Outpatient Diagnostic and Preoperative Testing

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			
Birth 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.

<i>Hospital Facility Expenses</i>			
Room and Board (including maternity)	\$200 per admission copay* , then the plan pays 80%	\$200 per admission deductible* , then the plan pays 60%	\$200 per admission deductible* , then the plan pays 80%
	No Calendar Year deductible applies	No Calendar Year deductible applies	No Calendar Year deductible applies
Other than Room and Board (Inpatient)	80% per admission No Calendar Year deductible applies	60% per admission No Calendar Year deductible applies.	80% per admission No Calendar Year deductible applies
Other than Room and Board (outpatient)	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

* Per admission copayment/deductible waived for newborn charges.

<i>Skilled Nursing Inpatient Facility</i>			
	\$200 per admission copay , then the plan pays 80%	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 80%
	No Calendar Year deductible applies	No Calendar Year deductible applies	No Calendar Year deductible applies

Maximum Days per Calendar Year	90 days	90 days	90 days
--------------------------------	---------	---------	---------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	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	130	130	130

<i>Hospice Benefits</i>			
<i>Hospice Care –Facility Expenses (Room & Board)</i>	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	80% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	80% per admission after the Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days

<i>Hospice Outpatient Visits</i>	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible	80% per visit after the Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> 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
<i>Inpatient Treatment of Mental Disorders</i>			
MENTAL DISORDERS			
<i>Hospital Facility Expenses</i>			
Room and Board	\$200 per admission copay , then the plan pays 80%	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 80%
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Other than Room and Board	80% per admission	60% per admission	80% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	80% per admission	60% per admission	80% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
<i>Inpatient Residential Treatment</i>			
Facility Expenses	\$200 per admission copay , then the plan pays 80%.	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 80%.
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	80% per visit	60% per visit	80% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	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	\$200 per admission copay , then the plan pays 80%	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 80%
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Other than Room and Board	80% per admission	60% per admission	80% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	80% per admission	60% per admission	80% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.

Inpatient Residential Treatment

Facility Expenses	\$200 per admission copay , then the plan pays 80%.	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 80%.
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	80% per admission	60% per visit	80% per visit
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
-----------------------------	---	---	---

PLAN FEATURES	NETWORK (IOQ Facility)	NETWORK (Non-IOQ Facility)	OUT-OF-NETWORK
<i>Obesity Treatment Non Surgical</i>			
<i>Outpatient Obesity Treatment (non surgical)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility)	NETWORK (Non-IOQ Facility)	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>			
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	\$200 per admission copay then the plan pays 80% No Calendar Year deductible applies	Not Covered	Not Covered

<i>Outpatient Morbid Obesity Surgery</i>	80% per service after Calendar Year deductible	Not Covered	Not Covered
---	---	-------------	-------------

Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Not Covered
---	-----------	-------------	-------------

Important Notice:

If the overall plan Maximum Benefit shown in the Schedule of Benefits is exhausted, no additional **morbid obesity** surgical treatment expenses are covered.

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Transplant Services Facility and Non-Facility Expenses</i>				
<i>Transplant Facility Expenses</i>	\$200 per admission copay after Calendar Year deductible , then the plan pays 80%	\$200 per admission deductible after Calendar Year deductible , then the plan pays 60%	\$200 per admission deductible after Calendar Year deductible , then the plan pays 60%	\$200 per admission deductible after Calendar Year deductible , then the plan pays 60%
<i>Transplant Physician Services</i> (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

<i>Acupuncture</i>	80% per visit after Calendar Year deductible .	60% per visit after Calendar Year deductible .	80% per visit after Calendar Year deductible .
<i>Maximum visits per Calendar year</i>	12	12	12
<i>Ground, Air or Water Ambulance</i>	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

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Diabetic Equipment, Supplies and Education

When Diabetic Equipment and Supplies are obtained from a Durable Medical Equipment provider	100% No Calendar Year deductible applies.	60% after Calendar Year deductible
When Diabetic Equipment and Supplies are not obtained from a Durable Medical Equipment provider	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.
Diabetic Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year deductible	60% per item after Calendar Year deductible	80% per item after Calendar Year deductible
---	--	--	--

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

OTHER HEALTH CARE

Hearing Aids	80% No Calendar Year deductible applies.	80% No Calendar Year deductible applies.	80% No Calendar Year deductible applies.
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear

<i>Clinical Trial Therapies</i> (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.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Jaw Joint Disorder Treatment</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Non-Surgical Lifetime Maximum Benefit	\$5,000	\$5,000	\$5,000
Surgical Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>			
Orthodontic treatment directly related to an orthognathic surgical procedure	80% of billed charges after Calendar Year deductible	80% of billed charges after Calendar Year deductible	80% of billed charges after Calendar Year deductible
All other treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
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
<i>Prosthetic Devices</i>	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
<i>Outpatient Therapies</i>			
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical, Massage, Occupational, Cardiac and Pulmonary Therapy and Spinal Manipulation</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Outpatient physical, massage, occupational and speech therapy are covered only for non-chronic conditions and acute illnesses and injuries as described in the Short-Term Rehabilitation Therapy Services section of your Booklet. All treatment plans are subject to ongoing review and approval by Aetna for medical necessity.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Neurodevelopmental Therapy</i>			
<i>Outpatient Neurodevelopmental Therapy*</i>	80% per visit after Calendar Year deductible	60% 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
<i>Spinal Manipulation</i>			
<i>Spinal Manipulation</i>	80% per visit after Calendar Year deductible	60% 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
<i>Autism Spectrum Disorder</i>			
<i>Autism - Behavioral therapy</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Autism - Applied Behavior Analysis</i>	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
<i>Habilitative Services</i>			
Therapy for Children with Developmental Delays	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Generic Prescription Drugs</i>		
For each 31 day supply (retail)	The greater of \$10 or 30% of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 30% of the negotiated charge not to exceed \$200	Not Covered

<i>Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	The greater of \$10 or 40% of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 40% of the negotiated charge not to exceed \$200	Not Covered

The following reduced copays apply only for the specific drug classifications shown.

Smoking Cessation Drugs, Asthma Drugs and Antihyperlipidemic Drugs:

<i>Generic Prescription Drugs</i>		
For each 31 day supply (retail)	The greater of \$10 or 30% of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 30% of the negotiated charge not to exceed \$200	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	The greater of \$10 or 40% of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	The greater of \$20 or 40% of the negotiated charge not to exceed \$200	Not Covered

Diabetic Drugs and Supplies:

<i>Generic Prescription Drugs</i>		
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

<i>Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	\$15	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$30	Not Covered

<i>Smoking Cessation Aids or Drugs</i>		
Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply	Not Covered

<i>Proton Pump Inhibitors and Non-Sedating Antihistamines</i>		
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

The above maximum applies separately to you and each of your covered dependents. Unused amounts do not roll over from month to month.

An additional benefit may be available for brand name Proton Pump Inhibitors if prescribed by a physician and determined by Aetna to be medically necessary. If approved by Aetna, the additional benefit will be subject to all plan provisions and limitations, including the copays, coinsurance and out-of-pocket limits shown above. Contact Central Benefits at (206) 615-1340 for details.

Copay and Deductible Waiver

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%.

With respect to those plans that provide **out-of-network pharmacy** benefits under the Prescription Drug Plan, the per **prescription copay/deductible** and any applicable **prescription drug** Calendar Year **deductible** continue to apply.

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

- 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** unless you are granted a medical exception.

Coinsurance

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Plan</i>	100% of the negotiated charge	Not Covered
<i>Coinsurance</i>		

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.

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 **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**.

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 of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Per Admission Deductible

A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductible** 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.

Covered expenses applied to the per admission **deductible/ copayment** cannot be applied to any other or **deductible/ copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles copayment** cannot be applied to meet the per admission **deductible/ copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible/ copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Per Admission Copayment

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

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.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Payment Provisions

Payment Percentage

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

Maximum Out of Pocket Limit/Payment Limit

The in-network **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 in-network **Maximum Out of Pocket Limit**. As to the individual in-network **Maximum Out of Pocket Limit**, each of you must meet your in-network **Maximum Out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

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

The out-of-network **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual out-of-network **Payment Limit**. As to the individual out-of-network **Payment Limit**, each of you must meet your out-of-network **Payment Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the out-of-network **Payment Limit**. See list below.

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 or your covered dependents have paid during the Calendar Year meets the individual in-network **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

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider** and **other health care** in-network **Maximum Out of Pocket Limit**, these expenses will also count toward a family **network provider** and **other health care** in-network **Maximum Out of Pocket Limit**.

To satisfy this family **network provider** and **other health care** in-network **Maximum Out of Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family in-network **Maximum Out of Pocket Limit** is a cumulative in-network **Maximum Out of Pocket Limit** for all family members. The family **network provider** and **other health care** in-network **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 **network provider** and **other health care** in-network **Maximum Out of Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider Payment Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual out-of-network **Payment 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

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Payment Limit**, these expenses will also count toward a family **out-of-network provider Payment Limit**.

To satisfy this family **out-of-network provider Payment Limit** for the rest of the Calendar Year, the following must happen:

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

The **Maximum Out of Pocket Limit** applies to in-network benefits and the **Payment Limit** applies to out-of-network benefits. **Covered expenses** applied to the out-of-network **Payment 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 **Payment Limit**.

Covered expenses that are subject to the in-network **Out of Pocket Limit** and the out-of-network **Payment Limit**, include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your In-Network Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan in-network **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; 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**.

Expenses That Do Not Apply to Your Out-of-Network Payment Limit

Certain covered expenses do not apply toward your plan out-of-network **payment limit**. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; 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**.

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.