

Schedule of Benefits

Employer: The City of Seattle
 ASC: 100290
 Issue Date: May 13, 2015
 Effective Date: January 1, 2015
 Schedule: 6A
 Booklet Base: 6

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
<i>Individual Deductible*</i>	None	\$250	None
<i>Family Deductible*</i>	None	\$750	None
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.			
<i>Common Accident Deductible</i>	None	\$250	None
Plan Maximum Out of Pocket Limit includes copayments.			
Plan Maximum Out of Pocket Limit excludes precertification penalties.			
Individual Maximum Out of Pocket Limit:			
<ul style="list-style-type: none"> For network expenses: \$500 For out-of-network expenses: \$3,250 			
Family Maximum Out of Pocket Limit:			
<ul style="list-style-type: none"> For network expenses: \$1,000 For out-of-network expenses: \$6,750 			
<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.

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 Covered	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 Calendar Year</i>	1 visit	Not Covered	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	Not Covered	1 visit
<i>Preventive Care Immunizations</i>			
<i>Performed in a facility or physician's office</i>	100% per visit No copay or deductible applies.	Not Covered	100% per visit No deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Screening & Counseling Services	100% per visit	Not Covered	100% per visit
Office Visits	No copay or deductible applies.		No deductible applies.
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			

Obesity Maximum Visits per Calendar Year <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 Covered	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 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.			

<i>Sexually Transmitted Infections Benefit Maximums</i>			
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			
Office Visits	100% per visit No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per exam No Calendar Year deductible applies.

Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
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Hearing Exam	\$10 exam copay then the plan pays 100% No Calendar Year deductible applies.	70% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.
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Maximum Exams per 12 month period	1 exam	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Routine Cancer Screenings			
Routine Cancer Screenings Outpatient	100% per visit after Calendar Year deductible	Not Covered	100% per visit 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.
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* 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.* <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 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. <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>
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* No age limit applies to routine mammograms.

<i>Lung Cancer Screening Maximum</i>	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.			

<i>Prenatal Care Office Visits</i>	100% per visit No deductible applies.	70% 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 Lactation Counseling Services - Facility or Office Visits</i>	100% per visit. No deductible applies.	70% per visit after Calendar Year deductible	100% per visit No deductible applies.
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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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> ..			

Breast Pumps & Supplies	100% per item. No copay or deductible applies.	70% per item after Calendar Year deductible	100% per item. No deductible applies.
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet-Certificate for limitations on breast pumps and supplies.			

Family Planning Services - Other

Voluntary Sterilization for Males

Outpatient	100% per visit No deductible applies.	70% per visit after Calendar Year deductible.	100% per visit No deductible applies.
Voluntary Termination of Pregnancy			
Outpatient	100% per visit No deductible applies.	70% per visit after Calendar Year deductible.	100% per visit No deductible applies.

Family Planning ServicesFemale Contraceptive
Counseling Services -
Office Visits.

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

100% per visit. No copay or deductible applies.	70% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.	
Outpatient	100% per visit No copay or deductible applies.	70% 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)	\$10 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
Specialist Office Visits	\$10 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Office Visits-Surgery	\$10 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 Visit (Non-Emergency)			
Preventive Care Services*			
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 Applicable	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 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
*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>	\$10 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.
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies
<i>Administration of Anesthesia</i>	100% per procedure No Calendar Year deductible applies	70% per procedure after Calendar Year deductible	100% per procedure No Calendar Year deductible applies
<i>Allergy Injections</i>	100% per visit No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
<i>Immunizations (when not part of the physical exam)</i>	100% per visit No Calendar Year deductible applies.	Not Covered	100% per visit No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Emergency Medical Services

Hospital Emergency Facility and Physician	\$50 copay per visit then the plan pays 100% 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
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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.
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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>	\$35 copay per visit then the plan pays 100% No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	\$35 deductible per visit then the plan pays 100% No Calendar Year deductible applies.
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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.
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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

<i>Complex Imaging</i>	100% per test No Calendar Year deductible applies	70% per test after Calendar Year deductible	100% per test No Calendar Year deductible applies
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Diagnostic Laboratory Testing

<i>Diagnostic Laboratory Testing</i>	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)
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Diagnostic X-Rays

<i>Diagnostic X-Rays</i>	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)
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PLAN FEATURES

NETWORK

OUT-OF-NETWORK

OTHER HEALTH CARE

Outpatient Surgery

<i>Outpatient Surgery</i>	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
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Facility Expenses</i>			
<i>Birthing Center</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>Hospital Facility Expenses</i>			
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
<i>Skilled Nursing Inpatient Facility</i>	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
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
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	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
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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.	Not Covered	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
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Inpatient Treatment of Mental Disorders

<i>MENTAL DISORDERS</i>			
<i>Hospital Facility Expenses</i>			
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.

<i>Inpatient Residential Treatment</i>			
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

<i>Outpatient Services</i>	\$10 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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Substance Abuse</i>			
<i>Hospital Facility Expense</i>			
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.
<i>Inpatient Residential Treatment</i>			
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.
<i>Outpatient Treatment of Substance Abuse</i>			
<i>Outpatient Treatment</i>	\$10 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.

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>	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission No Calendar Year deductible applies.
<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				
<i>Other Covered Health Expenses</i>				
<i>Acupuncture</i>	\$10 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

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

<i>Ground, Air or Water Ambulance</i>	100% No Calendar Year deductible applies.	100% No Calendar Year deductible applies.		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.
<i>Durable Medical and Surgical Equipment</i>	100% per item No Calendar Year deductible applies	70% per item after Calendar Year deductible		100% per item No Calendar Year deductible applies

Hearing Aids	100%	100% after Calendar Year deductible	100%
	No Calendar Year deductible applies.		No Calendar Year deductible applies.
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear

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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Phenylketonuria Formula	100% No Calendar Year deductible applies.	100% after Calendar Year deductible	100% No Calendar Year deductible applies.
Prosthetic Devices	100% No Calendar Year deductible applies.	70% per item after Calendar Year deductible	100% No Calendar Year deductible applies
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Outpatient Therapies</i>			
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<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.
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<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.
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<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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Short Term Outpatient Rehabilitation Therapies</i>			
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<i>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</i>	\$10 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
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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
<i>Neurodevelopmental Therapy</i>			
<i>Outpatient Neurodevelopmental Therapy*</i>	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.

<i>Spinal Manipulation</i>			
<i>Spinal Manipulation</i>	\$10 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 visits	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Autism Spectrum Disorder</i>			
<i>Autism - Behavioral therapy</i>	\$10 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
<i>Autism - Applied Behavior Analysis</i>	\$10 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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Habilitative Services</i>			
Therapy for Children with Developmental Delays	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies.	70% after Calendar Year deductible	100% per visit No Calendar Year deductible applies.

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
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
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	\$20	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$40	Not Covered
<i>Non-Preferred Generic Prescription Drugs</i>		
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
<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	\$40	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$80	Not Covered

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
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 Covered

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

Covered expenses applied to the **out-of-network provider deductibles** will not be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will not 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**.

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.

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**.

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.