

Schedule of Benefits

Employer: The City of Seattle
 ASC: 100290
 Issue Date: May 13, 2015
 Effective Date: January 1, 2015
 Schedule: 7A
 Booklet Base: 7

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$100	\$150	\$100
<i>Family Deductible*</i>	\$300	\$450	\$300
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.			
<i>Common Accident Deductible</i>	\$100	\$150	\$100
Plan Maximum Out of Pocket Limit includes plan deductible and copayments .			
Plan Maximum Out of Pocket Limit excludes precertification penalties.			
Individual Maximum Out of Pocket Limit:			
<ul style="list-style-type: none"> ▪ For network expenses: \$300. ▪ For out-of-network expenses: \$1,350. 			
Family Maximum Out of Pocket Limit:			
<ul style="list-style-type: none"> ▪ For network expenses: \$900. ▪ For out-of-network expenses: \$4,050. 			
<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
Preventive Care			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year 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 12 consecutive months</i>	1 visit	Not Covered	1 visit
<i>Covered Persons age 65 and over. Maximum Visits per 12 consecutive months</i>	1 visit	Not Covered	1 visit

Screening & Counseling Services	100% per visit	Not Covered	100% per visit
	No copay or deductible applies.		No deductible applies.
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			

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 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 12 consecutive months	5 visits*	Not Covered*	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			

Use of Tobacco Products			
Maximum Visits per 12 consecutive months	8 visits*	Not Covered*	8 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			

Sexually Transmitted Infections Benefit Maximums			
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	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 Covered	1 visit
Hearing Exam			
	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible
Maximum Exams per 12 month period	1 exam	1 exam	1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Mammography			
	100% per visit	60% per exam	100% per visit
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	1 test	1 test
All Other Routine Exams and Screenings* (including Routine Gynecological Exam & Routine Pap Smears)			
	100% per visit	Not Covered	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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>
<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	Not Applicable	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.			
Prenatal Care Office Visits	100% per visit No Calendar Year 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.			
Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services - Facility or Office Visits	100% per visit. No Calendar Year deductible applies.	80% 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 <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.	80% per item after Calendar Year deductible	100% per item. No copay or 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	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Voluntary Termination of Pregnancy			
Outpatient	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	100% per visit 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.	80% 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.	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			
<i>Physician Office Visits (non-surgical)</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>Specialist Office 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>	80% 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>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>	80% 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

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 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 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>	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>	80% 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
<i>Immunizations (when not part of the physical exam)</i>	100% per visit No Calendar Year deductible applies.	Not Covered	80% per visit No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility and Physician</i>	80% after Calendar Year deductible 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>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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<i>Urgent Care Services</i>			
<i>Urgent Medical Care (at a non-hospital free standing facility)</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Urgent Medical Care (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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<i>Non-Urgent Use of Urgent Care Provider (at an Emergency Room or a non-hospital free standing facility)</i>	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
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PLAN FEATURES			
<i>Outpatient Diagnostic and Preoperative Testing</i>			
<i>Preoperative Testing (except complex imaging services) Performed at a Hospital Outpatient Facility</i>	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.

Complex Imaging Services			
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Complex Imaging</i>	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Diagnostic Laboratory Testing			
<i>Diagnostic Laboratory Testing</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Diagnostic X-Rays			
<i>Diagnostic X-Rays</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
Outpatient Surgery			
<i>Outpatient Surgery</i>	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
Inpatient Facility Expenses			
<i>Birth 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.
Hospital Facility Expenses			
Room and Board (including maternity)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Skilled Nursing Inpatient Facility			
<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Days per Calendar Year	90 days	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Maximum Visits per Calendar Year	130 visits	130 visits	130 visits
<i>Private Duty Nursing (Outpatient)</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
<i>Hospice Benefits</i>			
<i>Hospice Care –Facility Expenses (Room & Board)</i>	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
<i>Hospice Outpatient Visits</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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
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Inpatient Treatment of Mental Disorders

MENTAL DISORDERS

Hospital Facility Expenses

Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Inpatient Treatment of Substance Abuse

Hospital Facility Expense

Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i> (including acupuncture)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Transplant Services Facility and Non-Facility Expenses</i>				
<i>Transplant Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<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
Maximum visits per Calendar Year (excluding treatment of substance abuse)	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
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Blood Bank Charges	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
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<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Hearing Aids	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
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>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
Phenylketonuria Formula	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible

<i>Prosthetic Devices</i>			
Foot Orthotics	80% per item after Calendar Year deductible	60% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Other Prosthetic Devices	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

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>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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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>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum visits per year	30 Visits	30 Visits	30 Visits
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<i>Neurodevelopmental Therapy</i>			
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<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
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* 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	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Spinal Manipulation Maximum visits per Calendar Year	10 visits	10 visits	10 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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 No Calendar Year deductible applies
<i>Autism - Applied Behavior Analysis</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% 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	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

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

<i>Brand-Name Prescription Drugs</i>		
Maximum supply per prescription: the greater of 34 day supply or 100 unit doses		
Retail Pharmacy	\$15	Not Covered
Mail order Pharmacy	\$30	Not Covered

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

<i>Smoking Cessation Aids or Drugs</i>		
Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply	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
<i>Prescription Drug Plan Coinsurance</i>	100% of the negotiated charge	Not Covered

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

Prescription Drug Payment Limit

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Payment Limit</i>	\$1,200 Individual \$3,600 Family	Not Covered Not Covered

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

Prescription Drug Payment Limit

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

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

Prescription Drug Payment Limit

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

Excluded Covered Expenses

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

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

Expense Provisions

The following provisions apply to your health expense plan.

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

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

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

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

Network Provider and Other Health Care Calendar Year Deductible

Individual

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

Family Deductible Limit

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

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

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual

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

Family Deductible Limit

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

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

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Common Accident Deductible Limit

This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate network or Calendar Year **deductibles** for **out-of-network providers** and for **other health care**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any network or **out-of-network family 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.

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

Maximum Out of Pocket Limit

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

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

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

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

Network Provider and Other Health Care Maximum Out of Pocket Limit

Individual

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

Family

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

Out-of-Network Provider Maximum Out of Pocket Limit

Individual

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

Family

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

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

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

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; 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.