

Schedule of Benefits

Employer: The City of Seattle

ASC: 100290

Issue Date: May 13, 2015

Effective Date: January 1, 2015

Schedule: 8B

Booklet Base: 8

For: Open Choice (PPO Medical) - Most City Preventive Retiree Plan

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$150	\$450	\$150
<i>Family Deductible*</i>	\$450	\$1,350	\$450
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>	\$150	\$450	\$150

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

Individual Payment Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$3,000.

Family Payment Limit:

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$6,000.

<i>Lifetime Maximum Benefit Per Person</i>	Unlimited	Unlimited	Unlimited
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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</i>			
<i>Routine Physical Exams</i>	100% per exam	Not Covered	100% per exam
Includes coverage for immunizations.	No deductible applies.		No deductible applies.
<i>Under age 6: Maximum Visits per Calendar Year*</i>	Unlimited	Not Covered	Unlimited
<i>From age 6 to age 12 : Maximum Visits per Calendar Year</i>	1 visit	Not Covered	1 visit
* The age and visit limits shown above will apply to your plan unless the age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration result in greater benefits.			
<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>Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products</i>	100% per visit	Not Covered	100% per visit
	No copay or deductible applies.		No deductible applies.

<i>Obesity</i>			
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.**

<i>Misuse of Alcohol and/or Drugs</i>			
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.**

<i>Use of Tobacco Products</i>			
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.**

Well Woman Preventive Visits			
Office Visits	100% per visit No Calendar Year deductible applies.	60% 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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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Routine Cancer Screenings			
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Routine Gynecological Exam (including Routine Pap Smears)	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.
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Maximum exam per Calendar Year	1 exam	1 exam	1 exam
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Hearing Exam	\$15 exam copay then the plan pays 100% No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	90% per exam No Calendar Year deductible applies.
Maximum Exams per 12 month period	1 exam	1 exam	1 exam
All Other Routine Exams and Screenings*	100% per visit No Calendar Year deductible applies.	Not Covered	100% per visit No Calendar Year deductible applies.

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

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>

* No age limit applies to routine mammograms.

Breast Pumps & Supplies	100% per item. No copay or deductible applies.	Not Covered	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	90% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	90% per visit after Calendar Year deductible.
Voluntary Termination of Pregnancy			
Outpatient	90% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	90% per visit after Calendar Year deductible.

Family Planning Services			
Female Contraceptive Counseling Services - Office Visits.	90% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible.

Family Planning Services - Female Voluntary Sterilization			
Inpatient	90% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	90% per visit after Calendar Year deductible.
Outpatient	90% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	90% per visit after Calendar Year deductible.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Vision Care			
Eye Examinations (including refraction)	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	90% per exam No Calendar Year deductible applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
Physician Office Visits (non-surgical)	\$15 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialist Office Visits</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.
<i>Aexcel Designated Network Specialist</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	Not applicable	90% per visit No Calendar Year deductible applies.
<i>Non-Designated Network Specialist</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	Not applicable	90% per visit No Calendar Year deductible applies.
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.
<i>Physician Office Visits-Surgery</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	90% per visit after Calendar Year deductible	Not applicable	90% 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	90% per visit after Calendar Year deductible
<i>Walk-In Clinic Non-Emergency Visit</i>	\$15 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.

<i>Physician Services for Inpatient Facility and Hospital Visits</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	90% per visit after Calendar Year deductible	Not applicable	90% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	90% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

<i>Administration of Anesthesia</i>	90% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible
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<i>Allergy Injections</i>	90% per visit No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.
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<i>Immunizations (when not part of the physical exam)</i>	100% per visit No Calendar Year deductible applies.	Not Covered	90% per visit No Calendar Year deductible applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Prenatal Visits</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
Emergency Medical Services			
Hospital Emergency Facility and Physician Services	\$150 copay per visit then the plan pays 90% 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
<p>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.</p>			
Non-Emergency Care in a Hospital Emergency Room	\$150 copay per visit then the plan pays 60% No Calendar Year deductible applies.	\$150 deductible per visit then the plan pays 60% No Calendar Year deductible applies.	\$150 deductible per visit then the plan pays 60% No Calendar Year deductible applies.
<p>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.</p> <p>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.</p>			
Urgent Care Services			
Urgent Medical Care (at a non-hospital free standing facility)	\$35 copay per visit then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.
Urgent Medical Care (from other than a non-hospital free standing facility)	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.

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>	90% per test after Calendar Year deductible	60% per test after Calendar Year deductible	90% per test after Calendar Year deductible
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Diagnostic Laboratory Testing

<i>Diagnostic Laboratory Testing</i>	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)
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Diagnostic X-Rays

<i>Diagnostic X-Rays</i>	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible (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> (performed at a hospital or other outpatient facility)	90% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible	90% per visit/surgical procedure after Calendar Year deductible
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PLAN FEATURES

NETWORK

OUT-OF-NETWORK

OTHER HEALTH CARE

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.
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<i>Hospital Facility Expenses</i>			
Room and Board (including maternity)	\$200 per admission copay* , then the plan pays 90%	\$200 per admission deductible* , then the plan pays 60%	\$200 per admission deductible* , then the plan pays 90%
	No Calendar Year deductible applies	No Calendar Year deductible applies	No Calendar Year deductible applies
Other than Room and Board (Inpatient)	90% per admission	60% per admission	90% per admission
	No Calendar Year deductible applies	No Calendar Year deductible applies	No Calendar Year deductible applies
Other than Room and Board (outpatient)	90% after Calendar Year deductible	60% after Calendar Year deductible	90% 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 90%	\$200 per admission deductible after Calendar Year deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 90%
	No Calendar Year deductible applies		No Calendar Year deductible applies

Maximum Days per Calendar Year	120 days	120 days	120 days
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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
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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	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

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
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Hospice Benefits

Hospice Care –Facility Expenses (Room & Board)	\$200 per admission copay after Calendar Year deductible , then the plan pays 90%	Not Covered	\$200 per admission deductible after Calendar Year deductible , then the plan pays 90%
Hospice Care – Other Expenses during a stay	90% per admission after Calendar Year deductible	Not Covered	90% per admission after Calendar Year deductible

Maximum Benefit per lifetime	Unlimited days	Not Applicable	Unlimited days
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Hospice Outpatient Visits	90% per visit after the Calendar Year deductible	Not Covered	90% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<i>Infertility Treatment</i>			
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infertility Drugs (prescribed by a Network Physician)	80% after the Calendar Year deductible	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	\$200 per admission copay , then the plan pays 90%	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 90%
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Other than Room and Board	90% per admission	60% per admission	90% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	90% per admission, after Calendar Year deductible	60% per admission, after Calendar Year deductible	90% per admission, after Calendar Year deductible

<i>Inpatient Residential Treatment</i>			
Facility Expenses	\$200 per admission copay , then the plan pays 90%.	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 90%.
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible .	90% per visit after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>			
<i>Office Visits</i>	\$15 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	90% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.
<i>Other Than Office Visits</i>	100% after Calendar Year deductible	60% after Calendar Year deductible	90% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Inpatient Treatment of Substance Abuse

Hospital Facility Expense

Room and Board	\$200 per admission copay , then the plan pays 90%	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 90%
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Other than Room and Board	90% per admission	60% per admission	90% per admission
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	90% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	90% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	\$200 per admission copay , then the plan pays 90%.	\$200 per admission deductible , then the plan pays 60%	\$200 per admission deductible , then the plan pays 90%.
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Physician Services	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible .	90% per visit after Calendar Year deductible

Outpatient Treatment of Substance Abuse

Outpatient Treatment

<i>Office Visits</i>	\$15 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	90% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.
<i>Other Than Office Visits</i>	100% after Calendar Year deductible	60% after Calendar Year deductible	90% 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 90% No Calendar Year deductible applies.	Not Covered	Not Covered

<i>Outpatient Morbid Obesity Surgery</i>	90% per service No Calendar Year deductible applies	Not Covered	Not Covered
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Not Covered
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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 90%	\$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>	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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All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.

<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible	90% after Calendar Year deductible
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Blood Bank Charges	90% after Calendar Year deductible	60% after Calendar Year deductible	90% after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Diabetic Equipment, Supplies and Education</i>		
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>	90% per item after Calendar Year deductible	60% per item after Calendar Year deductible	90% per item after Calendar Year deductible
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Hearing Aids	90% No Calendar Year deductible applies.	90% No Calendar Year deductible applies.	90% 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>Jaw Joint Disorder Treatment</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Non-Surgical Lifetime Maximum Benefit		\$5,000	\$5,000
Surgical Lifetime Maximum Benefit		Unlimited	Unlimited
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>			
Orthodontic treatment directly related to an orthognathic surgical procedure	90% of billed charges after Calendar Year deductible	90% of billed charges after Calendar Year deductible	90% 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
Phenylketonuria Formula	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
<i>Prosthetic Devices</i>	90% per item after Calendar Year deductible	60% per item after Calendar Year deductible	90% 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, Speech, Cardiac and Pulmonary Therapy</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies

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>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies

* 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>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies.
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Autism Spectrum Disorder</i>			
<i>Autism - Behavioral therapy</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% per visit No Calendar Year deductible applies
<i>Autism - Applied Behavior Analysis</i>	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	90% 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	\$15 per visit copay then the plan pays 100% No Calendar Year deductible applies.	60% after Calendar Year deductible	90% per visit No Calendar Year deductible applies.

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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<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 30 day supply (retail)	The greater of \$10 or 40% of the negotiated charge not to exceed \$100	Not Covered
For more than a 30 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 \$5 or 10% 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 \$10 or 10% 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 20% 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 20% of the negotiated charge not to exceed \$200	Not Covered

Diabetic Drugs and Supplies:

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<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>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.

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 Maximum Out-of-Pocket Limit

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

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

Prescription Drug Maximum Out-of-Pocket Limit

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

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

Prescription Drug Maximum Out-of-Pocket Limit

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

Excluded Covered Expenses

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

Expenses above the **recognized charge**.

Non-covered expenses.

Expense Provisions

The following provisions apply to your health expense plan.

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

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 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.

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.

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

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

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

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

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket 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 **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 Maximum Out-of-Pocket Limit

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

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

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

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

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

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

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

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

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

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

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.