Schedule of Benefits

Employer:	**The City of Seattle**
ASC:	100290
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Schedule:	2A
Booklet Base:	2

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
*Individual Deductible**	$400	$1,000	$400
*Family Deductible**	$1,200	$3,000	$1,200
Per Admission Copayment	$200 per admission	Not applicable	Not applicable
Per Admission Deductible*	Not applicable	$200 per admission	$200 per admission

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

Common Accident Deductible	$400	$1,000	$400

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

Individual Payment Limit:

- For **network** expenses: $1,000.
- For **out-of-network** expenses: $2,000.

Family Payment Limit:

- For **network** expenses: $3,000.
- For **out-of-network** expenses: $6,000.

Lifetime Maximum Benefit Per Person	Unlimited	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network and other health care, unless specifically stated otherwise.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Preventive Care			
Hearing Exam	80% per exam after Calendar Year **deductible**	60% per exam after Calendar Year **deductible**	80% per exam after Calendar Year **deductible**
Maximum Exams per 12 month period	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Mammography	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test	1 test
Prenatal Care Office Visits	80% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**	80% per visit after Calendar Year **deductible.**
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.			
Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	Not covered	100% per item. No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.			

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.	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit Calendar Year **deductible**

Family Planning Services - Female Voluntary Sterilization			
Inpatient	80% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**	80% per visit after Calendar Year **deductible.**
Outpatient	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**
Physician Services			
Physician Office Visits *(non-surgical)*	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Specialist Office Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable	80% per visit after Calendar Year **deductible**
Non-Designated Network Specialist	70% per visit after Calendar Year **deductible**	Not applicable	70% per visit after Calendar Year **deductible**
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable	80% per visit after Calendar Year **deductible**
Non-Designated Network Specialist	70% per visit after Calendar Year **deductible**	Not applicable	70% per visit after Calendar Year **deductible**
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Walk-In Clinic Non-Emergency Visit	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable	80% per visit after Calendar Year **deductible**
Non-Designated Network Specialist	70% per visit after Calendar Year **deductible**	Not applicable	70% per visit after Calendar Year **deductible**
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Administration of Anesthesia	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services			
Hospital Emergency Facility and Physician	$150 **copay** per visit then the plan pays 80% No Calendar Year **deductible** applies. Emergency physician may not be a network provider. See Important Note below	$150 **deductible** per visit then the plan pays 80% No Calendar Year **deductible** applies. See Important Note below	$150 **deductible** per visit then the plan pays 80% No Calendar Year **deductible** applies. See Important Note below
Important Note: Out-of-network providers do not have a contract with **Aetna**, and may not accept payment of your cost share (your **deductible** and **payment percentage)** as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the emergency room facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.			
Non-Emergency Care in a Hospital Emergency Room	$150 **copay** per visit then the plan pays 60% No Calendar Year **deductible** applies.	$150 **copay** per visit then the plan pays 60% No Calendar Year **deductible** applies.	$150 **copay** per visit then the plan pays 60% No Calendar Year **deductible** applies.
Important Notice: A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived. Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.			
Urgent Care Services			
Urgent Medical Care *(at a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

PLAN FEATURES			
Outpatient Diagnostic and Preoperative Testing			
Complex Imaging Services			
Complex Imaging	80% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**	80% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**
Diagnostic X-Rays			
Diagnostic X-Rays	80% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	80% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery			
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**	80% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Facility Expenses			
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses			
Room and Board (including maternity)	$200 per admission **copayment*,** then the plan pays 80% No Calendar Year **deductible** applies	$200 per admission **deductible***, then the plan 60% No Calendar Year **deductible** applies	$200 per admission **deductible ***, then the plan pays 80% No Calendar Year **deductible** applies
Other than Room and Board (Inpatient)	80% per admission No Calendar Year **deductible** applies	60% per admission No Calendar Year **deductible** applies	80% per admission No Calendar Year **deductible** applies
Other than Room and Board (outpatient)	80% after Calendar Year **deductible**	60% after Calendar Year **deductible**	80% after Calendar Year **deductible**

* Per admission copayment/deductible waived for newborn charges.

Skilled Nursing Inpatient Facility	$200 per admission **copay,** then the plan pays 80% No Calendar Year **deductible** applies	$200 per admission **deductible,** then the plan pays 60% No Calendar Year **deductible** applies	$200 per admission **deductible,** then the plan pays 80% No Calendar Year **deductible** applies
Maximum Days per Calendar Year	90 days	90 days	90 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	130	130	130
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board) ***Hospice Care – Other Expenses during a stay***	80% per admission after the Calendar Year **deductible** 80% per admission after the Calendar Year **deductible**	60% per admission after the Calendar Year **deductible** 60% per admission after the Calendar Year **deductible**	80% per admission after the Calendar Year **deductible** 80% per admission after the Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
Hospice Outpatient Visits	80% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**	80% per visit after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Infertility Treatment			
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Treatment of Substance Abuse			
Hospital Facility Expense			
Room and Board	$200 per admission **copay,** then the plan pays 80% No Calendar Year **deductible** applies.	$200 per admission **deductible**, then the plan pays 60% No Calendar Year **deductible** applies.	$200 per admission **deductible**, then the plan pays Calendar Year No Calendar Year **deductible** applies.
Other than Room and Board	80% per admission No Calendar Year **deductible** applies.	60% per admission No Calendar Year **deductible** applies.	80% per admission No Calendar Year **deductible** applies.
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	$200 per admission **copay**, then the plan pays 80%. No Calendar Year **deductible** applies.	$200 per admission **deductible**, then the plan pays 60% No Calendar Year **deductible** applies.	$200 per admission **deductible**, then the plan pays 80%. No Calendar Year **deductible** applies.
Physician Services	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	80% per admission after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse			
Outpatient Treatment	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK (IOQ Facility)	NETWORK (Non-IOQ Facility)	OUT-OF-NETWORK
Obesity Treatment Non Surgical			
Outpatient Obesity Treatment (non surgical)	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
Obesity Treatment Surgical			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	$200 per admission **copay** then the plan pays 80% No Calendar Year **deductible** applies	Not Covered	Not Covered
Outpatient Morbid Obesity Surgery	80% per service after Calendar Year **deductible**	Not Covered	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Not Covered

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

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
Transplant Services Facility and Non-Facility Expenses				
Transplant Facility Expenses	$200 per admission **copay** after Calendar Year **deductible,** then the plan pays 80%	$200 per admission **deductible** after Calendar Year **deductible,** then the plan pays 60%	$200 per admission **deductible** after Calendar Year **deductible,** then the plan pays 60%	$200 per admission **deductible** after Calendar Year **deductible,** then the plan pays 60%
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES			
Other Covered Health Expenses			
Acupuncture	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	12 visits	12 visits	12 visits
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**
Blood Bank Charges	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**	80% after Calendar Year **deductible**

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

Durable Medical and Surgical Equipment	80% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Hearing Aids	80% No Calendar Year **deductible** applies.	80% No Calendar Year **deductible** applies.	80% No Calendar Year **deductible** applies.
Hearing Supply Maximum per 36 month period	$1,000 per ear	$1,000 per ear	$1,000 per ear
Jaw Joint Disorder Treatment	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Non-Surgical Lifetime Maximum Benefit	$5,000	$5,000	$5,000
Surgical Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)			
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 occurence	$600 per occurence	$600 per occurence

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Phenylketonuria Formula	100% after Calendar Year **deductible**	100% after Calendar Year **deductible**	100% after Calendar Year **deductible**
Prosthetic Devices	80% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	80% per item after Calendar Year **deductible**
Foot Orthotics Lifetime Maximum Benefit	$500	$500	$500
Transgender Reassignment (Sex Change) Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Therapies			
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Short Term Outpatient Rehabilitation Therapies			
Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Only	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Outpatient physical, massage, occupational and speech therapy are covered only for non-chronic conditions and acute illnesses and injuries as described in the Short-Term Rehabiliation 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
Neurodevelopmental Therapy			
*Outpatient Neurodevelopmental Therapy**	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Spinal Manipulation			
Spinal Manipulation	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	80% per visit after Calendar Year **deductible**

Spinal Manipulation Maximum visits per Calendar Year	10 visits	10 visits	10 visits

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

Pharmacy Benefit

Copays/Deductibles

Generic Prescription Drugs		
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 $100	Not Covered

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

Generic Prescription Drugs		
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

PER PRESCRIPTION COPAY/DEDUCTIBLE	**NETWORK**	**OUT-OF-NETWORK**
Brand-Name Prescription Drugs		
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:

Generic Prescription Drugs		
For each 31 day supply (retail)	$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$10	Not Covered

Brand-Name Prescription Drugs		
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

Smoking Cessation Aids or Drugs		
Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply	Not Covered

Proton Pump Inhibitors and Non-Sedating Antihistamines		
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**
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Not Covered

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

Prescription Drug Maximum Out-of-Pocket Limit (Annual Limit)

	NETWORK	OUT-OF-NETWORK
Prescription Drug **Payment Limit**	$1,200 Individual $3,600 Family	Not Covered Not Covered

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

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

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

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

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

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

Expense Provisions

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will 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 network or **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 family **network** or **out-of-network family deductible** limit benefit amount paid for the same **covered expenses**. This added benefit does not count toward any Lifetime Maximum Benefit for you and your covered dependents.

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

Copayments and Benefit Deductible Provisions

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

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

Separate **deductibles** may apply per facility. These **deductibles** are in addition to any other **deductible** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount. Not more than three per admission **deductibles** will apply for each facility type during a Calendar Year.

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**.

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.

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

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

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

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

Payment Provisions

Payment Percentage

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

Payment Limit

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

Certain **covered expenses** do not apply toward the **Payment Limit**. See list below.

Network Provider and Other Health Care Payment 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 **Payment Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Payment 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 Payment Limit,** these expenses will also count toward a family **network provider** and **other health care Payment Limit**.

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

> The family **Payment Limit** is a cumulative **Payment Limit** for all family members. The family **network provider** and **other health care Payment 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 Payment Limit** amount in a Calendar Year.

Out-of Network Provider Payment Limit

Individual

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

Family Payment Limit

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

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

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

The **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 short term outpatient rehabilitation therapy and neurodevelopmental therapy 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.