

# Schedule of Benefits

Employer: The City of Seattle

ASC: 100290

Issue Date: May 13, 2015

Effective Date: January 1, 2015

Schedule: 9A

Booklet Base: 9

For: Open Choice (PPO Medical) - S.P.O.G. Preventive Retiree Plan

## PPO Medical Plan

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

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

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Preventive Care</i></b>			
<b><i>Routine Physical Exams</i></b>	100% per exam	Not Covered	100% per exam
Includes coverage for immunizations.	No <b>deductible</b> applies.		No <b>deductible</b> 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>	2 visits	Not Covered	2 visits
<i>Age 12 and older: 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 <b>physician</b>, log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>			

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Screening &amp; Counseling Services - Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</i></b>	100% per visit	Not Covered	100% per visit
	No <b>copay</b> or <b>deductible</b> applies.		No <b>deductible</b> applies.
<i>Obesity Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 &amp; older.)</i>	<i>26 visits (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	<i>26 visits (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>
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>			

*Misuse of Alcohol and/or Drugs*

Maximum Visits per Calendar Year	5 visits*	Not Covered	5 visits*
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per Calendar Year	8 visits*	Not Covered	8 visits*
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Routine Cancer Screenings</i></b>			
<b><i>Routine Gynecological Exam (including Routine Pap Smears)</i></b>	100% per exam  No Calendar Year deductible applies.	70% per exam after Calendar Year deductible	100% per exam  No Calendar Year deductible applies.
Maximum exam per Calendar Year	1 exam	1 exam	1 exam
<b><i>Routine Mammography</i></b>			
	100% per test  No Calendar Year deductible applies.	70% per test after Calendar Year deductible	100% per test  No Calendar Year deductible applies.
Maximum tests per Calendar Year	1 test	1 test	1 test
<b><i>All Other Routine Exams and Screenings*</i></b>	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.

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 <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, 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 <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>
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\* No age limit applies to routine mammograms.

<b>Breast Pumps &amp; Supplies</b>	100% per item. No <b>copay</b> or <b>deductible</b> applies.	70% per item after Calendar Year <b>deductible</b>	100% per item. No <b>deductible</b> 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.			

<b>Family Planning Services - Other</b>			
Voluntary Sterilization for Males			
Outpatient	100% per visit  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
Voluntary Termination of Pregnancy			
Outpatient	100% per visit  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.

<b>Family Planning Services</b>			
Female Contraceptive Counseling Services - Office Visits.	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.

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

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b>Vision Care</b>			
<b>Eye Examinations</b> (including refraction)	100% per exam  No Calendar Year <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>	100% per exam  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b>Physician Services</b>			
<b>Physician Office Visits</b> ( <i>non-surgical</i> )	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b>Specialist Office Visits</b>	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b>Physician Office Visits- Surgery</b>	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100%per visit  No Calendar Year <b>deductible</b> applies.

<i>Walk-In Clinic Non-Emergency Visit</i>	\$5 visit <b>copay</b> then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>	100% per visit
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit	70% per visit after Calendar Year <b>deductible</b>	100% per visit
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies
<i>Administration of Anesthesia</i>	100% per procedure	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure
	No Calendar Year <b>deductible</b> applies		No Calendar Year <b>deductible</b> applies
<i>Immunizations (when not part of the physical exam)</i>	100% per visit	Not Covered	100% per visit
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.
<i>Allergy Injections</i>	100% per visit	70% per visit after Calendar Year <b>deductible</b>	100% per visit
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.
<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
<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility and Physician</i>	\$50 <b>copay</b> per visit then the plan pays 100%	Paid the same as the Network level of benefits.	Paid the same as the Network level of benefits.
	No Calendar Year <b>deductible</b> applies.		
	Emergency physician may not be a network provider. See Important Note below.	See Important Note below	See Important Note below
<b>Important Note:</b> Out-of-network providers do not have a contract with <b>Aetna</b> , and may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b> ) 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.			

<b><i>Non-Emergency Care in a Hospital Emergency Room</i></b>	\$50 <b>copay</b> per visit then the plan pays 100%	\$50 <b>copay</b> per visit then the plan pays 70%	\$50 copay per visit then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	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.

***Urgent Care Services***

<b><i>Urgent Medical Care (at a non-hospital free standing facility)</i></b>	\$35 <b>copay</b> per visit then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>	\$35 <b>deductible</b> per visit then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.

<b><i>Urgent Medical Care (from other than a non-hospital free standing facility)</i></b>	Refer to <i>Emergency Medical Services and Physician Services</i> above.	Refer to <i>Emergency Medical Services and Physician Services</i> above.	Refer to <i>Emergency Medical Services and Physician Services</i> above.
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**Important Notice**

A separate **urgent care deductible** or **copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **deductibles** or **copays** cannot be applied to the **urgent care deductible** or **copay**.

**PLAN FEATURES**

***Outpatient Diagnostic and Preoperative Testing***

***Complex Imaging Services***

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

***Diagnostic Laboratory Testing***

<b><i>Diagnostic Laboratory Testing</i></b>	100% per procedure	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure
	No Calendar Year <b>deductible</b> applies (whether or not billed as part of an office visit)		No Calendar Year <b>deductible</b> applies (whether or not billed as part of an office visit)

<i>Diagnostic X-Rays</i>			
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Diagnostic X-Rays</i>	100% per procedure  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)
<i>Outpatient Surgery</i>			
<i>Outpatient Surgery</i> (performed at a <b>hospital</b> or other outpatient facility)	100% per visit/surgical procedure  No Calendar Year <b>deductible</b> applies	70% per visit/surgical procedure after Calendar Year <b>deductible</b>	100% per visit/surgical procedure  No Calendar Year <b>deductible</b> applies
<i>Inpatient Facility Expenses</i>			
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Hospital Facility Expenses</i>			
Room and Board (including maternity)	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
Other than Room and Board	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
<i>Skilled Nursing Inpatient Facility</i>	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
Maximum Days per Calendar Year	120 days	120 days	120 days

Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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<b><i>Specialty Benefits</i></b>			
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<b><i>Home Health Care (Outpatient)</i></b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
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Maximum Visits per Calendar Year	130	130	130
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<b><i>Hospice Benefits</i></b>			
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<b><i>Hospice Care –Facility Expenses (Room &amp; Board)</i></b>	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after the Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
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<b><i>Hospice Care – Other Expenses during a stay</i></b>	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after the Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
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Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
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<b><i>Hospice Outpatient Visits</i></b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after the Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></b> 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.
<b><i>Infertility Drugs</i></b> (prescribed by a <b>Network Physician</b> )	80%  No Calendar Year deductible applies	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	\$2,000	Not Applicable	Not Applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Treatment of Mental Disorders</i></b>			

<b><i>MENTAL DISORDERS</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
Room and Board	100% per admission  No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies.
Other than Room and Board	100% per admission  No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies.
Physician Services	100% per admission  No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies.

***Inpatient Residential Treatment***

Facility Expenses	100% per admission No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b> .	100% per admission No Calendar Year <b>deductible</b> applies.
Physician Services	100% per visit No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b> .	100% per visit No Calendar Year <b>deductible</b> applies.

***Outpatient Treatment Of Mental Disorders***

***Outpatient Services***

<b><i>Office Visits</i></b>	\$5 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	100% No Calendar Year <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% No Calendar Year <b>deductible</b> applies.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
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***Inpatient Treatment of Substance Abuse***

***Hospital Facility Expense***

Room and Board	100% per admission No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No Calendar Year <b>deductible</b> applies.
Other than Room and Board	100% per admission No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No Calendar Year <b>deductible</b> applies.
Physician Services	100% per admission No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No Calendar Year <b>deductible</b> applies.

<b><i>Inpatient Residential Treatment</i></b>			
Facility Expenses	100% per admission No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b> .	100% per admission No Calendar Year <b>deductible</b> applies.
Physician Services	100% per visit No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b> .	100% per visit No Calendar Year <b>deductible</b> applies.

<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
<i>Office Visits</i>	\$5 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit No Calendar Year <b>deductible</b> applies.
<i>Other Than Office Visits</i>	100% No Calendar Year <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% No Calendar Year <b>deductible</b> applies.

<b>PLAN FEATURES</b>	<b>NETWORK (IOQ Facility)</b>	<b>NETWORK (Non-IOQ Facility)</b>	<b>OUT-OF-NETWORK</b>
<b><i>Obesity Treatment Non Surgical</i></b>			
<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

<b>PLAN FEATURES</b>	<b>NETWORK (IOQ Facility)</b>	<b>NETWORK (Non-IOQ Facility)</b>	<b>OUT-OF-NETWORK</b>
<b><i>Obesity Treatment Surgical</i></b>			
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	100% per admission No Calendar Year <b>deductible</b> applies	Not Covered	Not Covered

<b>Outpatient Morbid Obesity Surgery</b>	100% per service  No Calendar Year <b>deductible</b> applies	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
<b>Transplant Services Facility and Non-Facility Expenses</b>				
<b>Transplant Facility Expenses</b>	100% per admission  No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>	70% per admission  No Calendar Year <b>deductible</b> applies.
<b>Transplant Physician Services</b> (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**

<b>Acupuncture</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
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All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.

<b>Ambulance(Ground, Air or Water)</b>	100%  No Calendar Year <b>deductible</b> applies.	100% after Calendar Year <b>deductible</b>	100%  No Calendar Year <b>deductible</b> applies.
<b>Blood Bank Charges</b>	100%	100% after Calendar Year <b>deductible</b>	100%

	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.
<b><i>Diabetic Equipment, Supplies and Education</i></b>	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.
<b><i>Durable Medical and Surgical Equipment</i></b>	100% per item No Calendar Year <b>deductible</b> applies	70% per item after Calendar Year <b>deductible</b>	100% per item No Calendar Year <b>deductible</b> applies
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b>Hearing Aids</b>	100% No Calendar Year <b>deductible</b> applies.	100% No Calendar Year <b>deductible</b> applies.	100% No Calendar Year <b>deductible</b> applies.
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	100% of billed charges No Calendar Year <b>deductible</b> applies.	100% of billed charges No Calendar Year <b>deductible</b> applies.	100% of billed charges No Calendar Year <b>deductible</b> applies.
All other treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
<b>Phenylketonuria Formula</b>	100% No Calendar Year <b>deductible</b> applies.	100% after Calendar Year <b>deductible</b>	100% No Calendar Year <b>deductible</b> applies.

<i>Prosthetic Devices</i>	100% per item  No Calendar Year <b>deductible</b> applies	70% per item after Calendar Year <b>deductible</b>	100% per item  No Calendar Year <b>deductible</b> applies
<b>Foot Orthotics Lifetime Maximum Benefit</b>	\$500	\$500	\$500

<b>Transgender Reassignment (Sex Change) Surgery</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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.
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<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</i>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies

Maximum visits per Calendar Year			
Physical/Massage Therapy	20 visits	20 visits	20 visits
Occupational Therapy	20 visits	20 visits	20 visits
Speech Therapy	20 visits	20 visits	20 visits
Cardiac/Pulmonary Therapy	20 visits	20 visits	20 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Neurodevelopmental Therapy</i></b>			
<b><i>Outpatient Neurodevelopmental Therapy*</i></b>	80% per visit after Calendar Year <b>deductible</b>	80% per visit after Calendar Year <b>deductible</b>	80% per visit after Calendar Year <b>deductible</b>

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Spinal Manipulation</i></b>			
<b><i>Spinal Manipulation</i></b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies

Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Autism Spectrum Disorder</i></b>			
<b><i>Autism - Behavioral therapy</i></b>	\$5 per visit copay then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies
<b><i>Autism - Applied Behavior Analysis</i></b>	\$5 per visit copay then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Habilitative Services</i>			
Therapy for Children with Developmental Delays	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.

# Pharmacy Benefit

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b><i>Preferred Generic Prescription Drugs</i></b>		
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
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
For each 31 day supply (retail)	\$10	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$20	Not Covered
<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
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
<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>		
For each 31 day supply (retail)	\$25	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$50	Not Covered
<b>Coinsurance</b>		
	NETWORK	OUT-OF-NETWORK
<b><i>Prescription Drug Plan Coinsurance</i></b>	100% of the <b>negotiated charge</b>	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
<b>Prescription Drug Payment Limit</b>	\$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

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

### Out-of-Network Provider Calendar Year Deductible

#### Individual

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

### **Family Deductible Limit**

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

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

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

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

### **Common Accident Out-of-Network Deductible Limit**

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

## **Copayments and Benefit Deductible Provisions**

### **Copayment, Copay**

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

### **Payment Provisions**

#### **Payment Percentage**

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

#### **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. You have separate **Payment Limit** for in-network and out-of-network benefits. **Payment Limit** amounts paid by you for in-network and out -of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one 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.