Schedule of Benefits

Employer:	**The City of Seattle**
ASC:	100290
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Schedule:	12A
Booklet Base:	12

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
Individual Deductible*	$100	$450	$100
Family Deductible*	$300	$1,350	$300
Per Admission Copayment	$200 per admission	Not applicable	Not applicable
Per Admission Deductible*	Not applicable	$200 per admission	$200 per admission

Per Admission copayment/deductible waived for confinements that are not separated by at least 10 days.

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

Common Accident Deductible	$100	$450	$100

Plan In-Network **Maximum Out of Pocket Limit** includes plan **deductible** and **copayments.**

Plan Out-of-Network **Payment Limit** does not include plan **deductible** and **copayments.**

Plan In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit** excludes **precertification** penalties.

Individual In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit**:

- For network expenses: $2,100.
- For out-of-network expenses: $3,450.

Family In-Network **Maximum Out of Pocket Limit** and Out-of-Network **Payment Limit**:

- For network expenses: $4,300.
- For out-of-network expenses: $7,350.

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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Preventive Care Benefits			
Routine Physical Exams			
Office Visits	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	Not Covered	1 visit
Covered Persons age 65 and over: Maximum Visits per 12	1 visit	Not Covered	1 visit

Preventive Care Immunizations			
Performed in a facility or ***physician's*** *office*	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.
Obesity			
Maximum Visits per 12 consecutive months *(This maximum applies only to Covered Persons ages 22 & older.)*	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)****	Not Covered	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)****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
Misuse of Alcohol and/or Drugs			
Maximum Visits per 12 consecutive months	5 visits*	Not Covered	5 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
Use of Tobacco Products			
Maximum Visits per 12 consecutive months	8 visits*	Not Covered	8 visits*
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Cancer Screenings Outpatient	100% per visit No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
*All Other Routine Exams and Screenings**	100% per visit No Calendar Year **deductible** applies.	Not Covered	100% per visit No Calendar Year **deductible** applies.

* 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.* *For details, contact your* ***physician,*** *log onto the* ***Aetna*** *website www.aetna.com, or call the number on the back of your ID card.*	Not Covered	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. *For details, contact your* ***physician,*** *log onto the* ***Aetna*** *website www.aetna.com, or call the number on the back of your ID card.*
Prenatal Care Office Visits	100% per visit No **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			

Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services - Facility or Office Visits	100% per visit. No **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12months	Not Applicable	6* visits per 12 months
***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*..			
Breast Pumps & Supplies	100% per item. No copay or **deductible** applies.	60% per visit after Calendar Year **deductible.**	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	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.	100% per visit. No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No Calendar Year **deductible** applies.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable	2* visits per 12 months
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.			
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item No **copay** or **deductible** applies.	60% per item after Calendar Year **deductible**	100% per item No **copay** or **deductible** applies.
Family Planning Services - Female Voluntary Sterilization			
Inpatient	100% per visit. No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **copay** or **deductible** applies.
Outpatient	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **copay** or **deductible** applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
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
Specialist Office Visits	$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.
Aexcel Designated Network Specialist	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable	100% per visit No Calendar Year **deductible** applies.
Non-Designated Network Specialist	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not applicable	90% per visit No Calendar Year **deductible** applies.
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	90% per visit No Calendar Year **deductible** applies.

Physician Office Visits-Surgery	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	90% per visit after Calendar Year **deductible**	Not applicable	90% per visit after Calendar Year **deductible**
Non-Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable	80% per visit after Calendar Year **deductible**
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**

Walk-In Clinic Visit (Non-Emergency)			
Preventive Care Services*			
Immunizations	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	60% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	60% per visit after Calendar Year **deductible**	100% per visit No **deductible** applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.			
All Other Services	$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.

Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Aexcel Designated Network Specialist	90% per visit after Calendar Year **deductible**	Not applicable	90% per visit after Calendar Year **deductible**
Non-Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not applicable	80% per visit after Calendar Year **deductible**
Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Administration of Anesthesia	90% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**	90% per procedure after Calendar Year **deductible**
Allergy Injections	90% per visit 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
Emergency Medical Services			
Hospital Emergency Facility and Physician Services	$150 **copay** per visit then the plan pays 90% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. See Important Note Below	Paid the same as the Network level of benefits. See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider 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 provider 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 **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.

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 Medical Care *(at a non-hospital free standing facility)*	$15 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**	$15 **copay** per visit then the plan pays 90% No Calendar Year **deductible** applies.
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.

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			
Complex Imaging	90% per test after Calendar Year **deductible**	60% per test after Calendar Year **deductible**	90% per test after Calendar Year **deductible**
Diagnostic Laboratory Testing			
Diagnostic Laboratory Testing	90% per test after Calendar Year **deductible** (whether or not billed as part of an office visit)	60% per test after Calendar Year **deductible**	90% per test after Calendar Year **deductible** (whether or not billed as part of an office visit)

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Diagnostic X-Rays			
Diagnostic X-Rays	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)

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Outpatient Surgery			
Outpatient Surgery (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**

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 **copay*,** then the plan pays 90% 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 90% No Calendar Year **deductible** applies
Other than Room and Board (Inpatient)	90% per admission No Calendar Year **deductible** applies	60% per admission No Calendar Year **deductible** applies	90% per admission 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.

Skilled Nursing Inpatient Facility	$200 per admission **copay,** then the plan pays 90% 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 90% No Calendar Year **deductible** applies
Maximum Days per Calendar Year	120 days	120 days	120 days
Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Maximum Visits per Calendar Year	130	130	130
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	90% per admission after the Calendar Year **deductible**	Not Covered	90% per admission after the Calendar Year **deductible**
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
Hospice Outpatient Visits	90% per visit after the Calendar Year **deductible**	Not Covered	90% 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.
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
Inpatient Treatment of Mental Disorders			
MENTAL DISORDERS			
Hospital Facility Expenses			
Room and Board	$200 per admission **copay**, then the plan pays 90%	$200 per admission , 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 Mental Disorders			
Outpatient Services			
Office Visits	$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**
Other Than Office Visits	100% after Calendar Year **deductible**	60% after Calendar Year **deductible**	90% 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 90% 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 90% No Calendar Year **deductible** applies.
Other than Room and Board	90% per admission No Calendar Year **deductible** applies.	60% per admission No Calendar Year **deductible** applies.	90% per admission 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%. 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 90%. 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**
Outpatient Treatment of Substance Abuse			
Outpatient Treatment			
Office Visits	$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.
Other Than Office Visits	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
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 90% No Calendar Year **deductible** applies	Not Covered	Not Covered
Outpatient Morbid Obesity Surgery	90% 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 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 90%
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	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.

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

Ground, Air or Water Ambulance	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**
Blood Bank Charges	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Effective January 1, 2015 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.

Effective March 1, 2015 Diabetic Equipment, Supplies and 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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	90% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	90% per item after Calendar Year **deductible**

Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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
Jaw Joint Disorder Treatment	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	$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	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**

Prosthetic Devices	90% per item after Calendar Year **deductible**	90% 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
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	$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 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**	$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
Spinal Manipulation			
Spinal Manipulation	$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
Autism Spectrum Disorder			
Autism - Behavioral therapy	$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
Autism - Applied Behavior Analysis	$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
Habilitative Services			
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
Generic Prescription Drugs		
For each initial 31 day supply filled at a retail **pharmacy**	The greater of $10 or 30% of the **negotiated charge** not to exceed $100	Not Covered
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	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 $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.

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Smoking Cessation Drugs, Asthma Drugs and Antihyperlipidemic Drugs		
Generic Prescription Drugs		
For each initial 31 day supply filled at a retail **pharmacy**	The greater of $5 or 10% of the **negotiated charge** not to exceed $100	Not Covered
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order **pharmacy**	The greater of $10 or 10% of the **negotiated charge** not to exceed $200	Not Covered

Smoking Cessation Drugs, Asthma Drugs and Antihyperlipidemic Drugs		
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

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Diabetic prescription drugs, supplies and insulin		
Generic Prescription Drugs		
For each 31 day supply filled at a retail **pharmacy**	$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	$10	Not Covered

Diabetic prescription drugs, supplies and insulin		
Brand-Name Prescription Drugs		
For each 31 day supply filled at a retail **pharmacy**	$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.

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.

Copay and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs;** contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide **out-of-network pharmacy** benefits under the Prescription Drug Plan, the per **prescription copay/deductible** and any applicable **prescription drug** Calendar Year **deductible** continue to apply.

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

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

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

Copayments and Benefit Deductible Provisions

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

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.

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.

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

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

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

Certain **covered expenses** do not apply toward the out-of-network **Payment Limit**. See list below.

Network Provider and Other Health Care Maximum Out of Pocket Limit

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

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

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

> The family in-network **Maximum Out of Pocket Limit** is a cumulative in-network **Maximum Out of Pocket Limit** for all family members. The family **network provider** and **other health care** in-network **Maximum Out of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider** and **other health care** in-network **Maximum Out of Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider Payment Limit

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

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

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

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

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

Covered expenses that are subject to the in-network **Out of Pocket Limit** and the out-of-network **Payment Limit**, include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your In-Network Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan in-network **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Expenses That Do Not Apply to Your Out-of-Network Payment Limit
Certain covered expenses do not apply toward your plan out-of-network **payment limit**. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Calendar Year **Maximum Benefit**
The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

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.