Schedule of Benefits

Prepared Exclusively for
The City of Seattle

2018 City Preventive Plan*

Most Retirees
Fire Chiefs
Police Management
Local 77
Library
Seattle Housing Authority

Open Choice (PPO) Medical

**Please note: In the attached document the effective date is 2017; however, this document represents the benefits for 2018 and minimal changes made to plan documents in 2018.*

To view minor changes for 2018, see the amendment at the end of the "book" with updates to Behavioral Health telemedicine and Precertification. These are only language changes with no material impact to benefits.

Schedule of Benefits

Employer: **The City of Seattle**

ASC: 100290

Issue Date: October 6, 2017
Effective Date: January 1, 2017
Schedule: 8A
Booklet Base: 8

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
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 Payment Limit excludes plan **deductibles and copayments**

Individual Payment Limit:

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

Family Payment Limit:

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

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			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No **deductible** applies.	Not Covered	100% per exam No **deductible** applies.
Under age 6: Maximum Visits per Calendar Year*	Unlimited	Not Covered	Unlimited
From age 6 to age 12: Maximum Visits per Calendar Year*	2 visits	Not Covered	2 visits
Age 12 and older: Maximum Visits per Calendar Year*	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.

*For details, contact your **physician,** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered	100% per visit No **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*
Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	Not Covered	100% per visit No **deductible** applies.

Obesity and/or Healthy Diet			
Maximum Visits per Calendar Year *(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 Calendar Year	5 visits *****	Not Covered	5 visits *****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
Use of Tobacco Products			
Maximum Visits per Calendar Year	8 visits *****	Not Covered	8 visits *****
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
Sexually Transmitted Infections Benefit Maximums			
Maximum Visits per Calendar Year	2 visits*****	Not Covered	2 visits*****
Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.			
Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**	100% per exam No Calendar Year **deductible** applies.
Maximum Exams per Calendar Year	1 exam	1 exam	1 exam

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
Hearing Aids	90% per visit No Calendar Year **deductible** applies.	90% per visit No Calendar Year **deductible** applies.	90% per visit No Calendar Year **deductible** applies.
Hearing Supply Maximum per 36 month period	$1,000	$1,000	$1,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Mammography	100% per test No Calendar Year **deductible** applies.	60% 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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
All Other Routine Exams and Screenings			
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; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*

* No age limit applies to routine mammograms

Lung Cancer Screening Maximum	One screening every 12 months*****	Not Covered	One screening every 12 months*****
Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.			

Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	Not Covered	100% per item. No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.			

Family Planning Services - Other Voluntary Sterilization for Males			
Outpatient	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.	$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.

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

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

Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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	90% 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 Non-Emergency Visit	$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.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**	**OTHER HEALTH CARE**
Emergency Medical Services			
Hospital Emergency Facility and Physician Services	$150 **copay** per visit then the plan pays 90% No Calendar Year **deductible** applies. Emergency physician may not be a network provider. See Important Note below	Paid the same as the Network level of benefits. See Important Note Below	Paid the same as the Network level of benefits. See Important Note Below
Important Note: Out-of-network providers do not have a contract with **Aetna**, and may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the emergency room facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.			
Non-Emergency Care in a Hospital Emergency Room	$150 **copay** per visit then the plan pays 60% No Calendar Year **deductible** applies.	$150 **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 Care Services			
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	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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 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)
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% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**	90% per admission 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
Skilled Nursing Care (Outpatient)	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Private Duty Nursing (Outpatient)	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**	90% per visit after Calendar Year **deductible**
Hospice Benefits			
Hospice Care –Facility Expenses (Room & Board)	$200 per admission **copay** after Calendar Year **deductible** then the plan pays 90%	Not Covered	$200 per admission **deductible** after Calendar Year **deductible** then the plan pays 90%
Hospice Care – Other Expenses during a stay	90% per admission after Calendar Year **deductible**	Not Covered	90% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Not Applicable	Unlimited days
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% 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 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	$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	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 visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**.	90% per visit after Calendar Year **deductible**
Outpatient Treatment of Substance Abuse			
Outpatient Treatment	$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 Institute of Quality (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 Institute of Quality (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

PLAN FEATURES	NETWORK Institute 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 60%
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES			
Other Covered Health Expenses			
Acupuncture	$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.
Maximum Visits per Calendar Year	12 visits	12 visits	12 visits

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**
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**
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**
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.
Prosthetic Devices	90% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**	90% per item after Calendar Year **deductible**
Foot Orthotics Lifetime Maximum Benefit	$500	$500	$500
Transgender Reassignment (Sex Change) Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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	$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 Hospital Facility Services Maximum	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity applies.	First 25 visits per year regardless of medical necessity; thereafter medical necessity 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 32 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 $200	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 32 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.

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

	NETWORK	OUT-OF-NETWORK
***Prescription Drug* Maximum Out-of-Pocket Limit**	$1,200 Individual $3,600 Family	Not Covered Not Covered

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

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

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** and **out-of-network prescription drug covered expenses** combined.

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

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

Expense Provisions

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

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

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

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

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

Network Provider and Other Health Care Calendar Year Deductible

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

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

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

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

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

Out-of-Network Provider Calendar Year Deductible

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

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

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

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

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

Common Accident Deductible Limit
This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **network or out-of-network providers** and for **other health care**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **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 **network or out-of-network** family **deductible** limit benefit amount paid for the same **covered expenses**.

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

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

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.

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

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

Network Provider and Other Health Care Payment Limit

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

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

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

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

Out-of Network Provider Payment Limit

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

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

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

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

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

Expenses That Do Not Apply to Your Payment Limit
Certain covered expenses do not apply toward your plan payment limit. These include:

- Expenses applied toward a **deductible**;
- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses incurred for infertility drugs;
- Non-covered expenses; 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**.

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** expenses.

Lifetime Maximum Benefit
The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** 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.