# Schedule of Benefits

**Prepared Exclusively for**
**The City of Seattle**

**2018 City Traditional 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:** 5A
**Booklet Base:** 5

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

## PPO Medical Plan

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| **Calendar Year Deductible*** | | | |
| ***Individual Deductible**** | $400 | $1,000 | $400 |
| ***Family Deductible**** | $1,200 | $3,000 | $1,200 |
| **Per Admission Copayment** | $200 per admission | Not applicable | Not applicable |
| **Per Admission Deductible*** | Not applicable | $200 per admission | $200 per admission |
| *Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid. | | | |
| ***Common Accident Deductible*** | $400 | $1,000 | $400 |

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

**Individual Payment Limit**:

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

**Family Payment Limit**:

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

| | | | |
|---|---|---|---|
| ***Lifetime Maximum Benefit Per Person*** | Unlimited | Unlimited | Unlimited |

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

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

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

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

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Routine Cancer Screenings*** | | | |
| ***Routine Mammography*** | 80% per test after Calendar Year **deductible** | 60% per test after Calendar Year **deductible** | 80% per test after Calendar Year **deductible** |
| Maximum tests per Calendar Year | 1 test | 1 test | 1 test |
| **Breast Pumps & Supplies** | 100% per item. No **copay** or **deductible** applies. | 60% per item 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 | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** | 80% per visit after Calendar Year **deductible.** |
| Voluntary Termination of Pregnancy | | | |
| Outpatient | 80% per visit after Calendar Year | 60% per visit after Calendar Year | 80% per visit after Calendar Year |

| | | | |
|---|---|---|---|
| | **deductible.** | **deductible.** | **deductible.** |
| ***Family Planning Services***<br>Female Contraceptive Counseling Services - Office Visits. | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit Calendar Year **deductible** |
| ***Family Planning Services - Female Voluntary Sterilization*** | | | |
| ***Inpatient*** | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** | 80% per visit after Calendar Year **deductible.** |
| ***Outpatient*** | 80% per visit after Calendar Year **deductible.** | 60% per visit after Calendar Year **deductible.** | 80% per visit after Calendar Year **deductible.** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Physician Services*** | | | |
| ***Physician Office Visits*** *(non-surgical)* | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

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

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

| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
|---|---|---|---|
| ***Emergency Medical Services*** | | | |
| ***Hospital Emergency Facility and Physician Services*** | $150 **copay** per visit then the plan pays 80%<br><br>No Calendar Year **deductible** applies. | Paid the same as the Network level of benefits. | Paid the same as the Network level of benefits. |
| | Emergency physician may not be a network provider. See Important Note below | See Important Note Below | 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%<br><br>No Calendar Year **deductible** applies. | $150 **deductible** per visit then the plan pays 60%<br><br>No Calendar Year **deductible** applies. | $150 **deductible** per visit then the plan pays 60%<br><br>No Calendar Year **deductible** applies. |

**Important Notice:**
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

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

| | | | |
|---|---|---|---|
| ***Urgent Care Services*** | | | |
| ***Urgent Medical Care*** *(at a non-hospital free standing facility)* | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Urgent Medical Care*** *(from other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. | Refer to *Emergency Medical Services* and *Physician Services* above. |
| **PLAN FEATURES** | | | |
| ***Outpatient Diagnostic and Preoperative Testing*** | | | |
| ***Complex Imaging Services*** | | | |
| ***Complex Imaging*** | 80% per test after Calendar Year **deductible** | 60% per test after Calendar Year **deductible** | 80% per test after Calendar Year **deductible** |
| ***Diagnostic Laboratory Testing*** | | | |
| ***Diagnostic Laboratory Testing*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |
| ***Diagnostic X-Rays*** | | | |
| ***Diagnostic X-Rays*** | 80% per procedure after Calendar Year **deductible** | 60% per procedure after Calendar Year **deductible** | 80% per procedure after Calendar Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
| ***Outpatient Surgery*** | | | |
| ***Outpatient Surgery*** | 80% per visit/surgical procedure after Calendar Year **deductible** | 60% per visit/surgical procedure after Calendar Year **deductible** | 80% per visit/surgical procedure after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Inpatient Facility Expenses*** | | | |
| ***Birthing Center*** | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Hospital Facility Expenses*** | | | |
| Room and Board (including maternity) | $200 per admission **copay*** then the plan pays 80%<br><br>No Calendar Year **deductible** applies | $200 per admission **deductible*** then the plan pays 60%<br><br>No Calendar Year **deductible** applies | $200 per admission **deductible*** then the plan pays 80%<br><br>No Calendar Year **deductible** applies |
| Other than Room and Board (Inpatient) | 80% per admission<br><br>No Calendar Year **deductible** applies | 60% per admission<br><br>No Calendar Year **deductible** applies | 80% per admission<br><br>No Calendar Year **deductible** applies |
| Other than Room and Board (Outpatient) | 80% per admission after Calendar Year **deductible** | 60% per admission after Calendar Year **deductible** | 80% 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 80%<br><br>No Calendar Year **deductible** applies | $200 per admission **deductible** then the plan pays 60%<br><br>No Calendar Year **deductible** applies | $200 per admission **deductible** then the plan pays 80%<br><br>No Calendar Year **deductible** applies |
| Maximum Days per Calendar Year | 90 days | 90 days | 90 days |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Specialty Benefits*** | | | |
| ***Home Health Care (Outpatient)*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| Maximum Visits per Calendar Year | 130 | 130 | 130 |
| ***Skilled Nursing Care (Outpatient)*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Private Duty Nursing (Outpatient)*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| | | | |
|---|---|---|---|
| ***Hospice Benefits*** | | | |
| ***Hospice Care –Facility Expenses*** (Room & Board) | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** |
| ***Hospice Care – Other Expenses during a stay*** | 80% per admission after the Calendar Year **deductible** | 60% per admission after the Calendar Year **deductible** | 80% per admission after the Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days | Unlimited days | Unlimited days |
| ***Hospice Outpatient Visits*** | 80% per visit after the Calendar Year **deductible** | 60% per visit after the Calendar Year **deductible** | 80% per visit after the Calendar Year **deductible** |

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

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

| | | | |
|---|---|---|---|
| ***Inpatient Residential Treatment*** | | | |
| Facility Expenses | $200 per admission **copay** then the plan pays 80%.<br><br>No Calendar Year **deductible** applies. | $200 per admission **deductible** then the plan pays 60%<br><br>No Calendar Year **deductible** applies. | $200 per admission **deductible** then the plan pays 80%.<br><br>No Calendar Year **deductible** applies. |
| Physician Services | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Outpatient Treatment Of Mental Disorders*** | | | |
| ***Outpatient Services*** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

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

| | | | |
|---|---|---|---|
| ***Outpatient Treatment of Substance Abuse*** | | | |
| ***Outpatient Treatment*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| **PLAN FEATURES** | **NETWORK Institute of Quality (IOQ) Facility** | **NETWORK Non-IOQ Facility** | **OUT-OF-NETWORK** |
|---|---|---|---|
| ***Obesity Treatment Non Surgical*** | | | |
| ***Outpatient Obesity Treatment (non surgical)*** | 80% per visit after Calendar Year **deductible** | 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 80%<br><br>No Calendar Year **deductible** applies | Not Covered | Not Covered |
| ***Outpatient Morbid Obesity Surgery*** | 80% per service after Calendar Year **deductible** | Not Covered | Not Covered |
| Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) | Unlimited | Not Covered | Not Covered |

| **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 80% | $200 per admission **deductible** after Calendar Year **deductible** then the plan pays 60% | $200 per admission **deductible** after Calendar Year **deductible** then the plan pays 60% | $200 per admission **deductible** after Calendar Year **deductible** then the plan pays 60% |
| ***Transplant Physician Services*** (including office visits) | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided | Payable in accordance with the type of expense incurred and the place where service is provided |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Other Covered Health Expenses*** | | | |
| ***Acupuncture*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Maximum Visits per Calendar Year*** | 12 visits | 12 visits | 12 visits |
| ***Ground, Air or Water Ambulance*** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| **Blood Bank Charges** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |
| ***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*** | 80% per item after Calendar Year **deductible** | 60% per item after Calendar Year **deductible** | 80% per item after Calendar Year **deductible** |
| **PLAN FEATURES** | **NETWORK** | **OUT-OF-NETWORK** | **OTHER HEALTH CARE** |
| **Hearing Aids** | 80%<br><br>No Calendar Year **deductible** applies. | 80%<br><br>No Calendar Year **deductible** applies. | 80%<br><br>No Calendar Year **deductible** applies. |
| Hearing Supply Maximum per 36 month period | $1,000 per ear | $1,000 per ear | $1,000 per ear |
| ***Jaw Joint Disorder Treatment*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| Non-Surgical Lifetime Maximum Benefit | $5,000 | $5,000 | $5,000 |
| Surgical Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited |

| | | | |
|---|---|---|---|
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | | | |
| Orthodontic treatment directly related to an orthognathic surgical procedure | 80% of billed charges after Calendar Year deductible | 80% of billed charges after Calendar Year deductible | 80% of billed charges after Calendar Year deductible |
| All other treatment | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. |
| Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum | $10,000 | $10,000 | $10,000 |
| Accidental injury treatment Maximum Benefit | $600 per occurrence | $600 per occurrence | $600 per occurrence |

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

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

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

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

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Spinal Manipulation*** | | | |
| ***Spinal Manipulation*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| Spinal Manipulation Maximum visits per Calendar Year | 10 visits | 10 visits | 10 visits |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Autism Spectrum Disorder*** | | | |
| ***Autism - Behavioral therapy*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |
| ***Autism - Applied Behavior Analysis*** | 80% per visit after Calendar Year **deductible** | 60% per visit after Calendar Year **deductible** | 80% per visit after Calendar Year **deductible** |

| PLAN FEATURES | NETWORK | OUT-OF-NETWORK | OTHER HEALTH CARE |
|---|---|---|---|
| ***Habilitative Services*** | | | |
| Therapy for Children with Developmental Delays | 80% after Calendar Year **deductible** | 60% after Calendar Year **deductible** | 80% after Calendar Year **deductible** |

# Pharmacy Benefit

**Copays/Deductibles**

| 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<br>$3,600 Family | Not Covered<br>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 Out-of-Network Deductible Limit**
This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **network** or **out-of-network providers** and for **other health care**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **network** or **out-of-network deductible** limit benefit amount paid for the same **covered expenses**. This added benefit does not count toward any Lifetime Maximum Benefit for you and your covered dependents.

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

## Copayments and Benefit Deductible Provisions

**Copayment, Copay**
This is a specified dollar amount or percentage, 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 short term outpatient rehabilitation therapy and neurodevelopmental therapy expenses;
- 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**

**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.