

Schedule of Benefits

Employer: **The City of Seattle**
 ASC: 100290
 Issue Date: August 1, 2014
 Effective Date: August 1, 2014
 Schedule: 6A
 Booklet Base: 6

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	None	\$250	None
<i>Family Deductible*</i>	None	\$750	None

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

<i>Common Accident Deductible</i>	None	\$250	None
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Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$500
- For **out-of-network** expenses: \$3,250

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$1,000.
- For **out-of-network** expenses: \$6,750.

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

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Preventive Care Benefits			
Routine Physical Exams Includes coverage for non-travel immunizations.	100% per visit No copay or deductible applies.	Not Covered	100% per visit No deductible applies.

<i>Under age 6:</i> Maximum Visits per Calendar Year*	Unlimited	Not Covered	Unlimited
<i>From age 6 to age 12:</i> Maximum Visits per Calendar Year*	2 visits	Not Covered	2 visits
<i>Age 12 and older:</i> 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.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No copay or deductible applies.	Not Covered	100% per visit No deductible applies.

<i>Obesity</i> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	Not Covered	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

<i>Misuse of Alcohol and/or Drugs</i> Maximum Visits per Calendar Year	5 visits*	Not Covered	5 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

<i>Use of Tobacco Products</i> Maximum Visits per Calendar Year	8 visits*	Not Covered	8 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Well Woman Preventive Visits Office Visits	100% per visit No Calendar Year	70% per visit after Calendar Year deductible	100% per exam No Calendar Year
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	deductible applies.		deductible applies.
Maximum Visits per < Calendar Year	1 visit	1 visit	1 visit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Hearing Exam	\$10 exam copay then the plan pays 100% No Calendar Year deductible applies.	70% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.

Maximum Exams per 12 month period	1 exam	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Routine Cancer Screenings			
Routine Cancer Screenings Outpatient	100% per visit No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.

All Other Routine Exams and Screenings*	100% per visit No Calendar Year deductible applies.	Not Covered	100% per visit No Calendar Year deductible applies.
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* 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Age & Visit Limits per Calendar Year (All Routine Cancer Screenings)	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.* <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Not Covered	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.* <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>

* No age limit applies to routine mammograms.

Prenatal Care			
Office Visits	100% per visit No deductible applies.	70% per visit after Calendar year deductible.	100% per visit No deductible applies.
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			

Comprehensive Lactation Support and Counseling Services			
Lactation Counseling Services - Facility or Office Visits	100% per visit. No deductible applies.	70% per visit after Calendar Year deductible	100% per visit No deductible applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Applicable	6* visits per 12 months
*Important Note: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> ..			

Breast Pumps & Supplies	100% per item. No copay or deductible applies.	70% per item after Calendar Year deductible	100% per item. No deductible applies.
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet-Certificate for limitations on breast pumps and supplies.			

Family Planning Services

<i>Family Planning Services</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Family Planning Services

Female Contraceptive Counseling Services - Office Visits.	100% per visit. No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable	2* visits per 12 months

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Voluntary Sterilization

Inpatient	100% per visit. No copay or deductible applies.	70% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.
Outpatient	100% per visit No copay or deductible applies.	70% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Physician Services

Physician Office Visits <i>(non-surgical)</i>	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
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Specialist Office Visits	\$10 per visit copay then the plan pays 100%	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Office Visits-Surgery	\$10 per visit copay then the plan pays 100%	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Walk-In Clinic Non-Emergency Visit	\$10 visit copay then the plan pays 100%	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies

Physician Services for Inpatient Facility and Hospital Visits	100% per visit	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Administration of Anesthesia	100% per procedure	70% per procedure after Calendar Year deductible	100% per procedure
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Allergy Testing and Treatment	\$10 visit copay then the plan pays 100%	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Allergy Injections	100% per visit	70% per visit after Calendar Year deductible	100% per visit
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

Immunizations (when not part of the physical exam)	100% per visit No Calendar Year deductible applies.	Not Covered	100% per visit No Calendar Year deductible applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Emergency Medical Services			
Hospital Emergency Facility and Physician	\$50 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$50 deductible per visit then the plan pays 100% No Calendar Year deductible applies.	\$50 deductible per visit then the plan pays 100% No Calendar Year deductible applies.
	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	\$50 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$50 deductible per visit then the plan pays 70% No Calendar Year deductible applies.	\$50 deductible per visit then the plan pays 100% No Calendar Year deductible applies.
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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**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Urgent Care Services			
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$35 copay per visit then the plan pays 100% No Calendar Year deductible applies	70% after Calendar Year deductible	\$35 deductible per visit then the plan pays 100% No Calendar Year deductible applies

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

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

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

PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing

Complex Imaging Services

Complex Imaging	100% per test No Calendar Year deductible applies.	70% per test after Calendar Year deductible	100% per test No Calendar Year deductible applies.
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Diagnostic Laboratory Testing

Diagnostic Laboratory Testing	100% per test No Calendar Year deductible applies. (whether or not billed as part of an office visit)	70% per test after Calendar Year deductible	100% per test No Calendar Year deductible applies. (whether or not billed as part of an office visit)
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Diagnostic X-Rays			
Diagnostic X-Rays	100% per procedure No Calendar Year deductible applies. (whether or not billed as part of an office visit)	70% per procedure after Calendar Year deductible	100% per procedure No Calendar Year deductible applies. (whether or not billed as part of an office visit)

Outpatient Surgery			
Outpatient Surgery (performed at a hospital or other outpatient facility)	100% per visit/surgical procedure No Calendar Year deductible applies.	70% per visit/surgical procedure after Calendar Year deductible	100% per visit/surgical procedure No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Facility Expenses			
Birth 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)	100% per admission No Calendar Year deductible applies	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies
Other than Room and Board	100% per admission No Calendar Year deductible applies	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies
Skilled Nursing Inpatient Facility	100% per admission No Calendar Year deductible applies	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Days per Calendar Year	120 days	120 days	120 days

Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialty Benefits			
Home Health Care (Outpatient)	100% per visit No Calendar Year deductible applies	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies
Maximum Visits per Calendar Year	130	130	130

Hospice Benefits			
Hospice Care – Facility Expenses (Room & Board)	100% per admission No Calendar Year deductible applies	Not Covered	100% per admission No Calendar Year deductible applies
Hospice Care – Other Expenses during a stay	100% per admission No Calendar Year deductible applies	Not Covered	100% per admission No Calendar Year deductible applies

Hospice Outpatient Visits	100% per visit No Calendar Year deductible applies	Not Covered	100% per visit No Calendar Year deductible applies
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Benefit per lifetime (inpatient and outpatient combined)	6 months, 6 additional months if authorized	Not Applicable	6 months, 6 additional months if authorized
Respite Care Maximum	10 days in a 6 consecutive month period	Not Applicable	10 days in a 6 consecutive month period

<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> 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.	Not Covered	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infertility Drugs</i> (prescribed by a Network Physician)	80%	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	No Calendar Year deductible applies \$2,000	Not Applicable	Not Applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Mental Disorders</i>			
<i>MENTAL DISORDERS</i>			
<i>Hospital Facility Expenses</i>			
Room and Board	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.
Other than Room and Board	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.
Physician Services	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Outpatient Treatment Of Mental Disorders</i>			
<i>Outpatient Services</i>			
<i>Office Visits</i>	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
<i>Other Than Office Visits</i>	100% No Calendar Year deductible applies.	70% after Calendar Year deductible	100% No Calendar Year deductible applies.

<i>Inpatient Treatment of Substance Abuse</i>			
<i>Hospital Facility Expense</i>			
Room and Board	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.
Other than Room and Board	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.
Physician Services	100% per admission No Calendar Year deductible applies.	70% per admission after Calendar Year deductible	100% per admission No Calendar Year deductible applies.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Treatment of Substance Abuse			
Outpatient Treatment			
Office Visits	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies.	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
Other Than Office Visits	100% No Calendar Year deductible applies.	70% after Calendar Year deductible	100% No Calendar Year deductible applies.

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
Transplant Services Facility and Non-Facility Expenses				
Facility Expenses	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.
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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Acupuncture</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.			
<i>Ambulance(Ground, Air or Water)</i>	100% No Calendar Year deductible applies.	100% No Calendar Year deductible applies.	100% No Calendar Year deductible applies.
<i>Blood Bank Charges</i>	100% No Calendar Year deductible applies.	100% after Calendar Year deductible	100% No Calendar Year deductible applies.
<i>Durable Medical and Surgical Equipment</i>	100% No Calendar Year deductible applies.	70% after Calendar Year deductible	100% No Calendar Year deductible applies.
<i>Hearing Aids</i>	100% No Calendar Year deductible applies.	100% after Calendar Year deductible	100% No Calendar Year deductible applies.
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	100% of billed charges No Calendar Year deductible applies.	100% of billed charges No Calendar Year deductible applies.	100% of billed charges No Calendar Year deductible applies.
All other treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000

Phenylketonuria Formula	100% No Calendar Year deductible applies.	100% after Calendar Year deductible	100% No Calendar Year deductible applies.
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Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500
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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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Short Term Outpatient Rehabilitation Therapies			
<i>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</i>	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Neurodevelopmental Therapy			
Outpatient Neurodevelopmental Therapy	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies
Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)*	\$3,000	\$3,000	\$3,000

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

Spinal Manipulation			
Spinal Manipulation	\$10 per visit copay then the plan pays 100% No Calendar Year deductible applies	70% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies
Spinal Manipulation Maximum visits per Calendar Year	20	20	20

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 31 day supply (retail)	\$10	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$20	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	\$20	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$40	Not Covered

<i>Non-Preferred Generic Prescription Drugs</i>		
For each 31 day supply (retail)	\$10	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$20	Not Covered

<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 31 day supply (retail)	\$40	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$80	Not Covered

Coinsurance

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Plan Coinsurance</i>	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.

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

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Family Deductible Limit

When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

Common Accident Out-of-Network Deductible Limit

This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate **out-of-network** Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar year exceed the common accident **out-of-network deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **out-of-network deductible** limit benefit amount paid for the same **covered expenses**. The added benefit does not count toward your Lifetime Maximum Benefit.

Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's **out-of-network** Calendar Year **deductible** will also count toward the following year's **out-of-network** Calendar Year **deductible**.

Copayments and Benefit Deductible Provisions

Copayment, Copay

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

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit. For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

Maximum Out of Pocket Limit

The **Maximum Out of Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual and family **Maximum Out of Pocket Limit**

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

The **Maximum Out of Pocket Limit** applies to **network provider, out-of-network provider** and **other health care** benefits.

You have a separate **Maximum Out of Pocket Limit** for **network provider and out-of-network provider** benefits. **Covered expenses** applied to the out-of-network **Maximum Out of Pocket Limit** will be applied to satisfy the in-network **Maximum Out of Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out of Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out of Pocket Limit**.

Network Provider and Other Health Care Maximum out of Pocket Limit.

Individual

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

Family

The Family **Maximum Out of Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** and **other health care** expenses paid during the Calendar Year meets this family **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

Out-of-Network Provider Maximum Out of Pocket Limit

Individual

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

Family

The Family **Maximum Out of Pocket Limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the Calendar Year meets this family **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses incurred for infertility drugs;

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

Maximum Benefit Provisions

Calendar Year Maximum Benefit

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

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

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.