

Schedule of Benefits

Employer: **The City of Seattle**
 ASC: 100290
 Issue Date: July 31, 2014
 Effective Date: August 1, 2014
 Schedule: 7A
 Booklet Base: 7

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$100	\$150	\$100
<i>Family Deductible*</i>	\$300	\$450	\$300

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

<i>Common Accident Deductible</i>	\$100	\$150	\$100
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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: \$300.
- For **out-of-network** expenses: \$1,350.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$900.
- For **out-of-network** expenses: \$4,050.

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			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year deductible applies.
Maximum Exams per 12 consecutive month period Adults, age 18 to 65	1 exam	Not Applicable	1 exam
Maximum Exams per 12 consecutive month period Adults, age 65 and over	1 exam	Not Applicable	1 exam
Well Child Exams Includes coverage for immunizations.	100% per exam No Calendar Year deductible applies.	Not Covered	80% per exam No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Exams			
Under age 3			
first 12 months of life	7 exams	Not Applicable	7 exams
13th-24th months of life	3 exams	Not Applicable	3 exams
25th-36th months of life	3 exams	Not Applicable	3 exams
Maximum Exams per 12 consecutive month period			
From age 3 to age 18	1 exam	Not Applicable	1 exam
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 12 months <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>
*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 12 months	5 visits*	Not Covered	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.			
<i>Use of Tobacco Products</i> Maximum Visits per 12 months	12 visits*	Not Covered	12 visits*

months

***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 deductible applies.	Not Covered	100% per exam No Calendar Year deductible applies.
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Maximum Visits per 12 months	1 visit	1 visit	1 visit
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Hearing Exam	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible	80% per exam after Calendar Year deductible
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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
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Routine Cancer Screenings

Routine Cancer Screenings Outpatient	100% per visit No Calendar Year deductible applies.	60%% per visit No Calendar Year deductible applies.	100% per visit No Calendar Year deductible applies.
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Maximums	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</i>	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</i>	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</i>
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<i>number on the back of your ID card.</i>	<i>number on the back of your ID card.</i>	<i>number on the back of your ID card.</i>	<i>number on the back of your ID card.</i>
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Prenatal Care

Office Visits	100% per visit No deductible applies.	60% per visit after Calendar Year deductible.	100% per visit No deductible applies.
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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.	80% per visit after Calendar Year deductible	100% per visit No deductible applies.
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Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Applicable	6* visits per 12 months
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***Important Note:** Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*..

Breast Pumps & Supplies	100% per item. No copay or deductible applies.	80% per item after Calendar Year deductible	100% per item. No deductible applies.
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Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet-Certificate for limitations on breast pumps and supplies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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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.	80% per visit after Calendar Year deductible	100% per visit No Calendar Year deductible applies.
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Contraceptive Counseling Services -	2* visits per 12 months	Not Applicable	2* visits per 12 months
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Maximum Visits either in a group or individual setting

*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.	80% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.
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Outpatient	100% per visit No copay or deductible applies.	80% per visit after Calendar Year deductible	100% per visit No copay or deductible applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Physician Services

Physician Office Visits <i>(non-surgical)</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Specialist Office Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Aexcel Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
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Non-Designated Network Specialist	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
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Out of Network Provider Specialist	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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<i>Physician Office Visits-Surgery</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Walk-In Clinic Non-Emergency Visit</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	80% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
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Allergy Testing and Treatment	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Allergy Injections	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Immunizations (when not part of the physical exam)	100% per visit No Calendar Year deductible applies.	Not Covered	80% per visit No Calendar Year deductible applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Emergency Medical Services			
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Hospital Emergency Facility and Physician	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
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	Emergency physician may not be a network provider. See Important Note below	See Important Note below	See Important Note below
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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	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Urgent Care Services			
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Urgent Medical Care (at a non-hospital free standing facility)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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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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PLAN FEATURES			
Outpatient Diagnostic and Preoperative Testing			
Preoperative Testing (except complex imaging services) Performed at a Hospital Outpatient Facility	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.	100% per procedure No Calendar Year deductible applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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 test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test 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

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
<i>Inpatient Facility Expenses</i>			
<i>Birth Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Hospital Facility Expenses</i> Room and Board (including maternity)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Maximum Days per Calendar Year	90 days	90 days	90 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

Maximum Visits per Calendar Year	130	130	130
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Hospice Benefits			
Hospice Care – Facility Expenses (Room & Board)	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
Hospice Care – Other Expenses during a stay	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
Hospice Outpatient Visits	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Inpatient Treatment of Mental Disorders

<i>MENTAL DISORDERS</i>			
<i>Hospital Facility Expenses</i>			
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment</i>			
Facility Expenses	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Substance Abuse</i>			
<i>Hospital Facility Expense</i>			
Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment</i>			
Facility Expenses	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
<i>Outpatient Treatment of Substance Abuse</i>			
<i>Outpatient Treatment</i> (including acupuncture)	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

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
Acupuncture	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum visits per Calendar year (excluding treatment of substance abuse)	12	12	12
Ambulance (Ground, Air or Water)	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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Hearing Aids	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
Hearing Supply Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>			
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
Phenylketonuria Formula	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Prosthetic Devices</i>			
Foot Orthotics	80% per item after Calendar Year deductible	60% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Other Prosthetic Devices	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Outpatient Therapies</i>			
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<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.

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	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum visits per Calendar Year	30 visits	30 visits	30 visits
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Neurodevelopmental Therapy			
Outpatient Neurodevelopmental Therapy	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Neurodevelopmental Therapy Maximum Benefit per Calendar Year (children to age 7)*	\$5,000	\$5,000	\$5,000
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* Benefits for rehabilitation therapy may not be duplicated for the same conditions and services.

Spinal Manipulation			
Spinal Manipulation	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	10	10	10
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Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Generic and Brand-Name Prescription Drugs		
Maximum supply per prescription: the greater of 34 day supply or 100 unit doses		
Retail Pharmacy	\$15	Not Covered
Mail Order Pharmacy	\$30	Not Covered

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply (Out-of-Network prescription drugs are not covered)
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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.

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

Network Calendar Year Deductible

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

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.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Network Family Deductible Limit

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

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

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 **network** or **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 **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 **network** or **out-of-network** Calendar Year **deductible** will also count toward the following year's **network** or **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 the **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**;
- Expenses incurred for short term outpatient rehabilitation therapy and neurodevelopmental therapy expenses;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.