

# Schedule of Benefits

Employer: **The City of Seattle**  
 ASC: 100290  
 Issue Date: December 11, 2013  
 Effective Date: January 1, 2014  
 Schedule: 9A  
 Booklet Base: 9

For: Open Choice (PPO Medical) - S.P.O.G. Preventive Retiree Plan

## PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Calendar Year Deductible*</b>			
<i>Individual Deductible*</i>	None	\$250	None
<i>Family Deductible*</i>	None	\$750	None
*Unless otherwise indicated, any applicable <b>deductible</b> must be met before benefits are paid.			
<i>Common Accident Deductible</i>	None	\$250	None

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

### Individual Payment Limit:

- For **network** expenses: \$500.
- For **out-of-network** expenses: \$3,000.

### Family Payment Limit:

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

<b>Lifetime Maximum Benefit Per Person</b>	Unlimited	Unlimited	Unlimited
--	-----------	-----------	-----------

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

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Preventive Care Benefits</b>			
<b>Routine Physical Exams</b> Includes coverage for non-travel immunizations.	100% per visit  No <b>copay</b> or <b>deductible</b> applies.	Not Covered	100% per visit  No <b>deductible</b> 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](http://www.aetna.com), or call the number on the back of your ID card.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Screening &amp; Counseling Services - Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>	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 &amp; 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 Calendar Year	5 visits*	Not Covered	5 visits*
---	-----------	-------------	-----------

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

<i>Use of Tobacco Products</i> Maximum Visits per Calendar Year	8 visits*	Not Covered	8 visits*
--	-----------	-------------	-----------

**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Routine Cancer Screenings</b>			
<b>Routine Gynecological Exam (including Routine Pap Smears)</b>	100% per exam  No Calendar Year <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>	100% per exam  No Calendar Year <b>deductible</b> applies.
<b>Routine Mammography</b>	100% per test  No Calendar Year <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>	100% per test  No Calendar Year <b>deductible</b> applies.
<b>All Other Routine Exams and Screenings*</b>	100% per visit  No Calendar Year <b>deductible</b> applies.	Not Covered	100% per visit  No Calendar Year <b>deductible</b> applies.

\* Including but not limited to: fecal occult blood tests, digital rectal exams, prostate specific antigen (PSA) tests, sigmoidoscopies, double contrast barium enemas (DCBE) and colonoscopies.

Maximum Age & Visit Limits per Calendar Year (All Routine Cancer Screenings)	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.*  <i>For details, contact your <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, 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 <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>
--	--	-------------	--

\* No age limit applies to routine mammograms.

<b>Hearing Aid Supplies</b>	100% per exam  No Calendar Year <b>deductible</b> applies.	100% per exam after Calendar Year <b>deductible</b>
-----------------------------	--	---

Hearing Supply Maximum per 36 month period	\$1,000	\$1,000
--	---------	---------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Family Planning Services</b>			
<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.

<b>Vision Care</b>			
<b>Eye Examinations</b> (including refraction)	100% per exam  No Calendar Year <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>	100% per exam  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Physician Services</b>			
<b>Physician Office Visits</b> ( <i>non-surgical</i> )	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.

<b>Specialist Office Visits</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b>Physician Office Visits-Surgery</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.

<b><i>Walk-In Clinic Non-Emergency Visit</i></b>	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Administration of Anesthesia</i></b>	100% per procedure  No Calendar Year <b>deductible</b> applies.	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure  No Calendar Year <b>deductible</b> applies.
<b><i>Allergy Testing and Treatment</i></b>	\$5 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Allergy Injections</i></b>	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Immunizations (when not part of the physical exam)</i></b>	100% per visit  No Calendar Year <b>deductible</b> applies.	Not Covered	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Prenatal Visits</i></b>	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
<b>Emergency Medical Services</b>			
<b>Hospital Emergency Facility and Physician</b>	\$50 <b>copay</b> per visit then the plan pays 100%	\$50 <b>deductible</b> per visit then the plan pays 100%	\$50 <b>deductible</b> per visit then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
	Emergency physician may not be a network provider. See Important Note below.	See Important Note below	See Important Note below
<p><b>Important Note:</b> Out-of-network providers do not have a contract with <b>Aetna</b>, and may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b>) 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.</p>			

<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$50 <b>copay</b> per visit then the plan pays 100%	\$50 <b>deductible</b> per visit then the plan pays 70%	\$50 <b>deductible</b> per visit then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> 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**.

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Urgent Medical Care</b> (from other than a non-hospital free standing facility)	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.

### 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

<b>Complex Imaging</b>	100% per test  No Calendar Year <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>	100% per test  No Calendar Year <b>deductible</b> applies.
------------------------	--	--	--

##### Diagnostic Laboratory Testing

<b>Diagnostic Laboratory Testing</b>	100% per test  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)	70% per test after Calendar Year <b>deductible</b>	100% per test  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)
--------------------------------------	--	--	--

##### Diagnostic X-Rays

<b>Diagnostic X-Rays</b>	100% per procedure  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure  No Calendar Year <b>deductible</b> applies. (whether or not billed as part of an office visit)
--------------------------	---	---	---

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b> (performed at a hospital or other outpatient facility)	100% per visit/surgical procedure  No Calendar Year <b>deductible</b> applies.	70% per visit/surgical procedure after Calendar Year <b>deductible</b>	100% per visit/surgical procedure  No Calendar Year <b>deductible</b> applies.
<b><i>Inpatient Facility Expenses</i></b>			
<b><i>Birthing Center</i></b>			
	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.
<b><i>Hospital Facility Expenses</i></b>			
Room and Board (including maternity)	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
Other than Room and Board	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
<b><i>Skilled Nursing Inpatient Facility</i></b>			
	100% per admission  No Calendar Year <b>deductible</b> applies	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No Calendar Year <b>deductible</b> applies
Maximum Days per Calendar Year	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Specialty Benefits</b>			
<b>Home Health Care (Outpatient)</b>	100% per visit  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies
Maximum Visits per Calendar Year	130	130	130

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

<b>Hospice Outpatient Visits</b>	100% per visit  No Calendar Year <b>deductible</b> applies	Not Covered	100% per visit  No Calendar Year <b>deductible</b> applies
--------------------------------------	---	-------------	---

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></b> 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.
<b><i>Infertility Drugs</i></b> (prescribed by a <b>Network Physician</b> )	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
<b><i>Inpatient Treatment of Mental Disorders</i></b>			
<b><i>MENTAL DISORDERS</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Residential Treatment</i></b>			
Facility Expenses	100% per admission  No Calendar Year <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b> .	100% per admission  No Calendar Year <b>deductible</b> applies.
Physician Services	100% per visit  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b> .	100% per visit  No Calendar Year <b>deductible</b> applies.

<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Outpatient Services</i></b>			
<b><i>Office Visits</i></b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	100%  No Calendar Year <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100%  No Calendar Year <b>deductible</b> applies.

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

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

<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
<b><i>Office Visits</i></b>	\$5 per visit <b>copay</b> then the plan pays 100% No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	100% No Calendar Year <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	NETWORK (IOQ Facility)	OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility)
<b>Obesity Treatment Surgical</b>		
<b>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</b>	100% per admission  No Calendar Year deductible applies.	Not Covered

<b>Outpatient Morbid Obesity Surgery</b>	100% per service  No Calendar Year deductible applies.	Not Covered
--	--	-------------

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF- NETWORK	OTHER HEALTH CARE
<b>Transplant Services Facility and Non-Facility Expenses</b>				
<b>Facility Expenses</b>	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.
<b>Physician Services</b> (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				
<b>Other Covered Health Expenses</b>				
<b>Acupuncture</b>	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.

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

<b>Ambulance(Ground, Air or Water)</b>	100%	100% after Calendar Year <b>deductible</b>	100%
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.

<b>Blood Bank Charges</b>	100%	100% after Calendar Year <b>deductible</b>	100%
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.

<b>Diabetic Equipment, Supplies and Education</b>	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
<b>Durable Medical and Surgical Equipment</b>	100%	70% after Calendar Year <b>deductible</b>	100%
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.

<b>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</b>			
Orthodontic treatment directly related to an orthognathic surgical procedure	100% of billed charges	100% of billed charges	100% of billed charges
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> 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

<b>Phenylketonuria Formula</b>	100%	100% after Calendar Year <b>deductible</b>	100%
	No Calendar Year <b>deductible</b> applies.		No Calendar Year <b>deductible</b> applies.

Prosthetic Devices	100% per item  No Calendar Year deductible applies	70% per item after Calendar Year deductible
--------------------	--	---

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b>Outpatient Therapies</b>			
<b>Chemotherapy</b>	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.

<b>Infusion Therapy</b>	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.
-------------------------	--	--	--

<b>Radiation Therapy</b>	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
<b>Short Term Outpatient Rehabilitation Therapies</b>			
<b>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> 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
<b>Neurodevelopmental Therapy</b>			
<b>Outpatient Neurodevelopmental Therapy</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> 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.

<b>Spinal Manipulation</b>			
<b>Spinal Manipulation</b>	\$5 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No Calendar Year <b>deductible</b> applies

Spinal Manipulation Maximum visits per Calendar Year	20	20	20
--	----	----	----

## Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
-----------------------------------	---------	----------------

<b><i>Preferred Generic Prescription Drugs</i></b>		
For each 31 day supply (retail)	\$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$10	Not Covered
<b>PER PRESCRIPTION COPAY/DEDUCTIBLE</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
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

<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
For each 31 day supply (retail)	\$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$10	Not Covered

<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>		
For each 31 day supply (retail)	\$25	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order)	\$50	Not Covered

<b>Coinsurance</b>		
	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Prescription Drug Plan Coinsurance</i></b>	100% of the <b>negotiated charge</b>	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.

<b>Prescription Drug Maximum Out-of-Pocket Limit (Annual Limit)</b>		
	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drug Maximum Out-of-Pocket Limit</b>	\$1,200 Individual \$3,600 Family	Not Applicable Not Applicable

**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 prescription drug covered expenses**.

**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 prescription drug covered expenses**.

### **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** 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**

### **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.

#### **Payment Limit**

The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Payment Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Payment Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual **Payment Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

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

### **Expenses That Do Not Apply to Your Payment Limit**

Certain covered expenses do not apply toward your plan payment limit. These include:

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