

# Schedule of Benefits

Employer: The City of Seattle

ASC: 100290

Issue Date: November 1, 2010

Effective Date: January 1, 2010

Schedule: 3A

Booklet Base: 3

For: Open Choice (PPO Medical) - S.P.O.G. Preventive 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 **deductible** must be met before benefits are paid.

<i>Common Accident Deductible</i>	None	\$250	None
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**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>	\$2,000,000	\$2,000,000	\$2,000,000
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*Coinsurance 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>Wellness Benefits</b>			
<b>Routine Physical Exams</b> Adults only. Includes coverage for immunizations.	100% per exam  No <b>deductible</b> applies.	Not Covered	100% per exam  No <b>deductible</b> applies.
Maximum Exams per Calendar Year  Adults, age 18 to 65	1 exam	Not Applicable	1 exam
Maximum Exams per Calendar Year  Adults, age 65 and over	1 exam	Not Applicable	1 exam
<b>Well Child Exams</b> Includes coverage for immunizations.	100% per exam  No <b>deductible</b> applies.	Not Covered	100% per exam  No <b>deductible</b> applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Maximum Exams per Calendar Year			
Under age 6	Unlimited	Not Applicable	Unlimited
From age 6 to age 12	2 exams	Not Applicable	2 exams
Age 12 and older	1 exam	Not Applicable	1 exam
<b><i>Routine Gynecological Exam</i></b>	100% per exam No <b>deductible</b> applies.	70% per exam after Calendar Year <b>deductible</b>	100% per exam No <b>deductible</b> applies.
Maximum Exams per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Routine Cancer Screenings</i></b>			
<b><i>Routine Mammography</i></b> For covered females.	100% per test No <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>	100% per test No <b>deductible</b> applies.
Maximum tests per Calendar Year	1 test	1 test	1 test
<b><i>Prostate Specific Antigen Test</i></b> For covered males.	100% per test No <b>deductible</b> applies.	Not Covered	100% per test No <b>deductible</b> applies.
Maximum tests per Calendar Year	1 test	Not Applicable	1 test

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Routine Digital Rectal Exam</i></b> For covered males.	100% per test  No <b>deductible</b> applies.	Not Covered	100% per test  No <b>deductible</b> applies.
Maximum tests per Calendar Year	1 test	Not Applicable	1 test
<b><i>Routine Pap Smears</i></b>	100 % per test  No <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>	100 % per test  No <b>deductible</b> applies
Maximum Tests per Calendar Year	1 test	1 test	1 test
<b><i>Fecal Occult Blood Test</i></b>	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.
Maximum Tests per 12 consecutive month period	1 test	Not Applicable	1 test
<b><i>Sigmoidoscopy</i></b> Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	Not Applicable	1 test

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Double Contrast Barium Enema (DCBE)</i></b> Age 50 and over	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.
Maximum Tests per 5 consecutive year period	1 test	Not Applicable	1 test
<b><i>Colonoscopy</i></b> age 50 and over	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.
Maximum tests per 10 consecutive year period	1 test	Not Applicable	1 test
<b><i>Family Planning Services</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><i>Physician Services</i></b>			
<b><i>Physician Office Visits (non-surgical)</i></b>	\$5 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
<b><i>Specialist Office Visits</i></b>	\$5 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>	<b>OTHER HEALTH CARE</b>
<i>Physician Office Visits-Surgery</i>	\$5 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
<i>Walk-In Clinic Non-Emergency Visit</i>	\$5 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
<i>Administration of Anesthesia</i>	100% per procedure  No <b>deductible</b> applies.	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure  No <b>deductible</b> applies.
<i>Allergy Testing and Treatment</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>Allergy Injections</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>Immunizations (when not part of the physical exam)</i>	100% per visit  No <b>deductible</b> applies	Not Covered	100% per visit  No <b>deductible</b> applies
<i>Prenatal Visits</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
<b><i>Emergency Medical Services</i></b>			
<b><i>Hospital Emergency Facility</i></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 <b>deductible</b> applies.	No <b>deductible</b> applies.	No <b>deductible</b> applies.
<b><i>Non-Emergency Care in a Hospital Emergency Room</i></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 <b>deductible</b> applies.	No <b>deductible</b> applies.	No <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**.

<b><i>Urgent Care Services</i></b>			
<b><i>Urgent Medical Care</i></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 <b>deductible</b> applies.		No <b>deductible</b> applies
<b><i>Urgent Medical Care</i></b> <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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Outpatient Diagnostic and Preoperative Testing</i></b>			
<b><i>Diagnostic and Preoperative Testing</i></b> <i>(except complex imaging services)</i>	100% per procedure	70% per procedure after Calendar Year <b>deductible</b>	100% per procedure
	No <b>deductible</b> applies. (whether or not billed as part of an office visit)		No <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>Complex Imaging Services</i></b>			
<b><i>Complex Imaging</i></b>	100% per test  No <b>deductible</b> applies.	70% per test after Calendar Year <b>deductible</b>	100% per test  No <b>deductible</b> applies.

<b><i>Diagnostic Laboratory Testing</i></b>			
<b><i>Diagnostic Laboratory Testing</i></b>	100% per procedure  No <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 <b>deductible</b> applies. (whether or not billed as part of an office visit)

<b><i>Diagnostic X-Rays</i></b>			
<b><i>Diagnostic X-Rays</i></b>	100% per procedure  No <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 <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 <b>hospital</b> or other outpatient facility)	100% per visit/surgical procedure  No <b>deductible</b> applies.	70% per visit/surgical procedure after Calendar Year <b>deductible</b>	100% per visit/surgical procedure  No <b>deductible</b> applies.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Inpatient Facility Expenses</i></b>			
<b><i>Birth 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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Hospital Facility Expenses</i></b> Room and Board (including maternity)	100% per admission  No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No <b>deductible</b> applies.
Other than Room and Board	100% per admission  No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No <b>deductible</b> applies.

<b><i>Skilled Nursing Inpatient Facility</i></b>	100% per admission  No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission  No <b>deductible</b> applies.
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Maximum Days per Calendar Year	120 days	120 days	120 days
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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
<b><i>Specialty Benefits</i></b>			
<b><i>Home Health Care (Outpatient)</i></b>	100% per visit  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <b>deductible</b> applies.
Maximum Visits per Calendar Year	130	130	130

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care – Facility Expenses</i></b> (Room & Board)	100% per admission No <b>deductible</b> applies.	Not Covered	100% per admission No <b>deductible</b> applies.
<b><i>Hospice Care – Other Expenses during a stay</i></b>	100% per admission No <b>deductible</b> applies.	Not Covered	100% per admission No <b>deductible</b> applies.
<b><i>Hospice Outpatient Visits</i></b>	100% per visit No <b>deductible</b> applies.	Not Covered	100% per visit No <b>deductible</b> applies.
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

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% No deductible applies	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	\$2,000	Not Applicable	Not Applicable

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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 <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
Other than Room and Board	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
Physician Services	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
<b><i>Inpatient Residential Treatment</i></b>			
Facility Expenses	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible.</b>	100% per admission No <b>deductible</b> applies.
Physician Services	100% per visit No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible.</b>	100% per visit No <b>deductible</b> applies.
<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Mental Disorders</i></b>			
Office Visits	\$5 per visit <b>copay</b> then the plan pays 100% No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit No <b>deductible</b> applies.
Other than Office Visits	100% No <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% No <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 <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
Other than Room and Board	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
Physician Services	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible</b>	100% per admission No <b>deductible</b> applies.
<b><i>Inpatient Residential Treatment</i></b>			
Facility Expenses	100% per admission No <b>deductible</b> applies.	70% per admission after Calendar Year <b>deductible.</b>	100% per admission No <b>deductible</b> applies.
Physician Services	100% per visit No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible.</b>	100% per visit No <b>deductible</b> applies.
<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
Office Visits	\$5 per visit <b>copay</b> then the plan pays 100% No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit No <b>deductible</b> applies.
Other than Office Visits	100% No <b>deductible</b> applies.	70% after Calendar Year <b>deductible</b>	100% No <b>deductible</b> applies.

***Transplant Services Facility and Non-Facility Expenses***

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

All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity. Please contact Aetna to make sure any visits beyond the first 25 visits during a calendar year are approved.

<b><i>Ground, Air or Water Ambulance</i></b>	100%  No <b>deductible</b> applies.	100% after Calendar Year <b>deductible</b>	100%  No <b>deductible</b> applies.
<b><i>Durable Medical and Surgical Equipment</i></b>	100%  No <b>deductible</b> applies.	70% per item after Calendar Year <b>deductible</b>	100%  No <b>deductible</b> applies.
<b><i>Prosthetic Devices</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><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) -</i></b>			
Orthodontic treatment directly related to an orthognathic surgical procedure	100% of billed charges No <b>deductible</b> applies.	100% of billed charges No <b>deductible</b> applies.	100% of billed charges No <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% No <b>deductible</b> applies.	100% after Calendar Year <b>deductible</b>	100% No <b>deductible</b> applies.
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<b>Blood Bank Charges</b>	100% No <b>deductible</b> applies.	100% after Calendar Year <b>deductible</b>	100% No <b>deductible</b> applies.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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***Outpatient Therapies***

<b><i>Chemotherapy</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.
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<b><i>Infusion Therapy</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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<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
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical, Massage, Occupational, Speech, Cardiac, Pulmonary and Neurodevelopmental Therapy</i>	\$5 visit <b>copay</b> then the plan pays 100%  No <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>	100% per visit  No <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
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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<b><i>Spinal Manipulation</i></b>			
	\$5 visit <b>copay</b> then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>	100% per visit No <b>deductible</b> applies.
	No <b>deductible</b> applies.		
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits

## 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	\$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	\$10	Not Covered
<b><i>Preferred Brand-Name Prescription Drugs</i></b>		
For each 31 day supply	\$10	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	\$20	Not Covered
<b><i>Non-Preferred Generic Prescription Drugs</i></b>		
For each 31 day supply	\$5	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	\$10	Not Covered

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>		
For each 31 day supply	\$25	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	\$50	Not Covered

#### Coinsurance

	NETWORK	OUT-OF-NETWORK
<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.

#### Prescription Drug Out-Of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
<b><i>Prescription Drug Out-of- Pocket Limits</i></b>	\$1,200 Individual \$3,600 Family	Not Applicable Not Applicable

**Individual Prescription Drug 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:

#### Network Prescription Drug Out-Of-Pocket Limit

When your share or your covered dependent's share of **network prescription drug covered expenses** reach the **prescription drug network** out-of-pocket limit in a Calendar Year, your plan will pay 100% of that person's **network prescription drug covered expenses** for the rest of the Calendar Year.

**Family Prescription Drug 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:

#### Network Prescription Drug Out-Of-Pocket Limit

When your share and your covered dependents share of **network prescription drug covered expenses** combined reach the family **prescription drug** out-of-pocket limit in a Calendar Year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the Calendar Year.

#### Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** out-of-pocket limit and the family **prescription drug** 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 the Family **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. You have separate **Payment Limits** for in-network and out-of-network benefits. **Payment Limit** amounts paid by you for in-network and out-of-network **covered expenses** apply to each limit separately and may not be combined and applied toward one 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;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*); 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** and **out-of-network** expenses combined.

### **Lifetime Maximum Benefit**

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

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

### **General**

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