

Schedule of Benefits

Employer: The City of Seattle
 ASC: 100290
 Issue Date: January 12, 2009
 Effective Date: January 1, 2009
 Schedule: 1A
 Booklet Base: 1

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

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$100	\$450	\$100
<i>Family Deductible*</i>	\$300	\$1,350	\$300
Per Admission Copayment	\$200 per admission	Not applicable	\$200 per admission
Per Admission Deductible*	Not applicable	\$200 per admission	Not applicable
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.			
<i>Common Accident Deductible</i>	\$100	\$450	\$100

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

Individual Payment Limit:

- For **network** expenses: \$2,000.
- For **out-of-network** expenses: \$3,000.

Family Payment Limit:

- For **network** expenses: \$4,000.
- For **out-of-network** expenses: \$6,000.

Lifetime Maximum	\$2,000,000	\$2,000,000	\$2,000,000
Benefit Per Person			

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
Wellness Benefits			
Routine Physical Exams Adults only. Includes coverage for immunizations.	100% per exam No deductible applies.	Not Covered	90% per exam after Calendar Year deductible
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
Well Child Exams Includes coverage for immunizations.	100% per exam No deductible applies.	Not Covered	90% per exam after Calendar Year deductible

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

<i>Routine Gynecological Exam</i>	100% per exam No deductible applies.	60% per exam after Calendar Year deductible	90% per exam after Calendar Year deductible
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Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
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<i>Hearing Exam</i>	\$15 exam copay then the plan pays 100% No deductible applies.	60% per exam after Calendar Year deductible	90% 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
<i>Routine Cancer Screenings</i>			
<i>Routine Mammography</i> For covered females.	100% per test No deductible applies.	60% per test after Calendar Year deductible	90% per test after Calendar Year deductible

Maximum tests per Calendar Year	1 test	1 test	1 test
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<i>Prostate Specific Antigen Test</i> For covered males.	100% per test No deductible applies.	Not Covered	90% per test after Calendar Year deductible.
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Maximum tests per Calendar Year	1 test	Not Applicable	1 test
<i>Routine Digital Rectal Exam</i> For covered males.	100% per test No deductible applies.	Not Covered	90% per test after Calendar Year deductible .
Maximum tests per Calendar Year	1 test	Not Applicable	1 test
<i>Routine Pap Smears</i>	100 % per test No deductible applies.	60% per test after Calendar Year deductible	90% per test after Calendar Year deductible
Maximum Tests per Calendar Year	1 test	1 test	1 test
<i>Fecal Occult Blood Test</i>	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
<i>Sigmoidoscopy</i> 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

<i>Double Contrast Barium Enema (DCBE)</i> 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
<i>Colonoscopy</i> 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
<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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Physician Services</i>			
<i>Physician Office Visits</i> <i>(non-surgical)</i>	\$15 visit copay then the plan pays 100% No deductible applies.	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialist Office Visits</i>	\$15 visit copay then the plan pays 100% No deductible applies.	60% after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% after Calendar Year deductible	90% per visit after Calendar Year deductible

<i>Physician Office Visits-Surgery</i>	\$15 visit copay then the plan pays 100% No deductible applies.	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	\$15 visit copay then the plan pays 100% No deductible applies.	Not applicable	90% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Walk-In Clinic Non-Emergency Visit</i>	\$15 visit copay then the plan pays 100% No deductible applies.	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Aexcel Designated Network Specialist</i>	90% per visit after Calendar Year deductible	Not applicable	90% per visit after Calendar Year deductible
<i>Non-Designated Network Specialist</i>	80% per visit after Calendar Year deductible	Not applicable	90% per visit after Calendar Year deductible
<i>Out of Network Provider Specialist</i>	Not applicable	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	90% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible

<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 deductible applies	Not Covered	90% per visit after Calendar Year deductible
<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
<i>Emergency Medical Services</i>			
<i>Hospital Emergency Facility</i>	\$150 copay per visit then the plan pays 90% No deductible applies.	\$150 deductible per visit then the plan pays 90% No deductible applies.	\$150 deductible per visit then the plan pays 90% No deductible applies.
<i>Non-Emergency Care in a Hospital Emergency Room</i>	\$150 copay per visit then the plan pays 60% No deductible applies.	\$150 deductible per visit then the plan pays 60% No deductible applies.	\$150 deductible per visit then the plan pays 60% No deductible applies.

Important Notice:

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

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

Urgent Care Services

Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$15 copay per visit then the plan pays 100% No deductible applies.	60 % after Calendar Year deductible	90% 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

Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)
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Complex Imaging Services

Complex Imaging	90% per test after Calendar Year deductible	60% per test after Calendar Year deductible	90% per test after Calendar Year deductible
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Diagnostic Laboratory Testing

Diagnostic Laboratory Testing	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)
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Diagnostic X-Rays			
Diagnostic X-Rays	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)	60% per procedure after Calendar Year deductible	90% per procedure after Calendar Year deductible (whether or not billed as part of an office visit)

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Outpatient Surgery			
Outpatient Surgery (performed at a hospital or other outpatient facility)	90% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible	90% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Inpatient Facility Expenses			
Birth Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Hospital Facility Expenses Room and Board (including maternity)	\$200 per admission copayment* then the plan pays 90% No deductible applies.	\$200 per admission deductible* then the plan pays 60% No deductible applies.	\$200 per admission copayment* then the plan pays 90% No deductible applies.
Other than Room and Board (inpatient)	90% per admission No deductible applies.	60% per admission No deductible applies.	90% per admission No deductible applies.
Other than Room and Board (outpatient)	90% after Calendar Year deductible	60% after Calendar Year deductible	90% after Calendar Year deductible

* Per admission copayment/deductible waived for newborn charges.

<i>Skilled Nursing Inpatient Facility</i>	\$200 per admission copayment then the plan pays 90%	\$200 per admission deductible then the plan pays 60%	\$200 per admission copayment then the plan pays 90%
	No deductible applies.	No deductible applies.	No deductible applies.

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
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<i>Specialty Benefits</i>			
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<i>Home Health Care (Outpatient)</i>	90% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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Maximum Visits per Calendar Year	130	130	130
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<i>Hospice Benefits</i>			
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<i>Hospice Care – Facility Expenses (Room & Board)</i>	90% per admission after the Calendar Year deductible	Not Covered	90% per admission after the Calendar Year deductible
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<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after the Calendar Year deductible	Not Covered	90% per admission after the Calendar Year deductible
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<i>Hospice Outpatient Visits</i>	90% per visit after the Calendar Year deductible	Not Covered	90% per visit after the Calendar Year deductible
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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
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	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>Infertility Drugs</i> (prescribed by a Network Physician)	80% after the Calendar Year deductible	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
<i>Inpatient Treatment of Mental Disorders</i>			
<i>Mental Disorders</i>	\$200 per admission copayment then the plan pays 90%	\$200 per admission deductible then the plan pays 60%	\$200 per admission copayment then the plan pays 90%
	No deductible applies.	No deductible applies.	No deductible applies.

<i>Outpatient Treatment Of Mental Disorders</i>			
<i>Mental Disorders</i>	\$15 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
	No deductible applies.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Chemical Dependency</i>			
<i>Inpatient Treatment</i>	\$200 per admission copayment then the plan pays 90%	\$200 per admission deductible then the plan pays 60%	\$200 per admission copayment then the plan pays 90%
	No deductible applies.	No deductible applies	No deductible applies.
<i>Outpatient Treatment of Chemical Dependency</i>			
<i>Outpatient Treatment</i>	\$15 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
	No deductible applies.		
Maximum Benefit per 24 consecutive month benefit period (combined inpatient and outpatient - does not apply to detoxification)	\$14,500	\$14,500	\$14,500

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Obesity Treatment Surgical and Non Surgical</i>			
<i>Outpatient Obesity Treatment (non surgical)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Inpatient Morbid Obesity Surgery (Institutes of Quality Bariatric Surgery Facility only)</i>	\$200 per admission copayment then the plan pays 90%	Not Covered	Not Covered
	No deductible applies.		
<i>Related Outpatient Morbid Obesity Surgery Services (Institutes of Quality Bariatric Surgery Facility only)</i>	90% per service after Calendar Year deductible	Not Covered	Not Covered

Transplant Services Facility and Non-Facility Expenses

PLAN FEATURES	NETWORK Institutes of Excellence (IOE) Facility or Non-IOE Facility	OUT-OF- NETWORK	OTHER HEALTH CARE
<i>Facility Expenses</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.
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.

PLAN FEATURES

Other Covered Health Expenses

<i>Acupuncture</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible	90% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	90% per item after Calendar Year deductible	60% per item after Calendar Year deductible	90% per item after Calendar Year deductible
<i>Prosthetic Devices</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.
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) -</i>			
Orthodontic treatment directly related to an orthognathic surgical procedure	90% of billed charges after Calendar Year deductible	90% of billed charges after Calendar Year deductible	90% 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
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
Phenylketonuria Formula			
	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
Blood Bank Charges			
	90% after Calendar Year deductible	90% after Calendar Year deductible	90% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Outpatient Therapies

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

<i>Outpatient Physical, Occupational, Speech, Cardiac, Pulmonary and Neurodevelopmental Therapy</i>	\$15 visit copay then the plan pays 100% No deductible applies.	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
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Maximum visits per Calendar Year			
Physical 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)*	\$5,000	\$5,000	\$5,000
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* Benefits for rehabilitation therapy may not be duplicated for the same conditions and services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Spinal Manipulation</i>			
	\$15 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
	No deductible 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
<i>Generic Prescription Drugs</i>		
For each 31 day supply	The greater of \$10 or 30 % of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	The greater of \$20 or 30% of the negotiated charge not to exceed \$200	Not Covered
<i>Brand-Name Prescription Drugs</i>		
For each 31 day supply	The greater of \$10 or 40 % of the negotiated charge not to exceed \$100	Not Covered
For more than a 31 day supply but less than a 91 day supply (mail order pharmacy)	The greater of \$20 or 40% of the negotiated charge not to exceed \$200	Not Covered

A \$5 copay applies to diabetic drugs and supplies if you are enrolled in **Aetna's** diabetic disease management program.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	Not Covered

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Prescription Drug Out-Of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug Out-of-Pocket Limits	\$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**.

Monthly Maximum Benefit (applies only to covered Over-the-Counter equivalents for certain prescription drugs - see your Booklet for details)	\$ 20
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The above maximum applies separately to you and each of your covered dependents. Unused amounts do not roll over from month to month.

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**. 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 **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.

Per Admission Deductible

A Per Admission **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent have a **stay** in an inpatient facility.

Per Admission Copayment

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Separate **deductibles/copayments** may apply per facility. These **deductibles/copayments** are in addition to any other **deductibles/copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **deductible/copayment** cannot be applied to any other or **deductible/copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **deductibles/copayments** cannot be applied to meet the per admission **deductible/copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **deductible/copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment Limit

The **Payment Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. 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. **Covered expenses** applied to the **out-of-network Payment Limit** will be applied to satisfy the **network Payment Limit** and **covered expenses** applied to the **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**;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- 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.