

# Schedule of Benefits

**Employer:** Houston Independent School District  
**ASA:** 620266  
**Issue Date:** January 13, 2016  
**Effective Date:** January 1, 2016  
**Schedule:** 5B  
**Booklet Base:** 5

For: Open Access Aetna Select - Consumer Limited Basic Plan

This is not an ERISA plan. Please contact your employer for more information.

## Aetna HealthFund (GR-9N-S-06-01)

### Plan Features

<b>Annual HealthFund Amount</b>	\$500 Individual \$750 Employee and Spouse \$750 Employee and Child(ren) \$1,000 Family
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If your coverage terminates and you re-enroll in the Aetna HealthFund in the same Calendar Year, the dollars left in your Aetna HealthFund balance will be reinstated.

#### Schedule of Benefits

The HealthFund benefit will pay 100% of eligible HealthFund expenses (**network** and **out-of-network**). It will also reduce your individual or family **deductible**. Once your maximum HealthFund benefit is paid, you will be responsible for covered expenses until any remaining **deductible** is met. Once your **deductible** has been met, your health expense coverage will begin to pay for **covered expenses**.

When you or your eligible dependents become covered under this plan, you have access to a unique network of providers, the **Limited Network**. You must use **hospitals**, **PCP's**, and **specialists** in the **Limited Network** exclusively for your care. If care is provided by providers that are not in the **Limited Network**, that care is not covered.

Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

## Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>		
Individual Deductible*	\$2,500	Not applicable
Family Deductible*	\$5,000	Not applicable

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

**Plan Maximum Out of Pocket Limit** includes plan **deductible** and **copayments**.

**Individual Maximum Out of Pocket Limit:**

- For **network** expenses: \$6,000

**Family Maximum Out of Pocket Limit:**

- For **network** expenses: \$12,000

<b>Lifetime Maximum Benefit per person</b>	Unlimited	Not applicable
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*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.*

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

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

PLAN FEATURES	NETWORK	OUT OF NETWORK
<b>Preventive Care</b>		
<b>Routine Physical Exams</b>		
<b>Office Visits -</b>	100% per visit. No copay or <b>deductible</b> applies.	Not Covered

<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits per Calendar Year</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> log onto the Aetna 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
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	Not Covered
<i>Covered Persons age 65 and over. Maximum Visits per Calendar Year</i>	1 visit	Not Covered.

<b>Preventive Care Immunizations</b> <i>Performed in a facility or <b>physician's</b> office</i>	100% per visit.  No <b>copay</b> or <b>deductible</b> applies.	Not Covered
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<b>Preventive Care Drugs and Supplements</b>		
Preventive care drugs and supplements filled at a retail <b>pharmacy</b> for each 30 day supply.	100% per item  No <b>copay</b> or <b>deductible</b> applies.	Not Covered.
<p>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</p> <p><b>Important Note:</b> Refer to the Booklet and the <i>Preventive Care</i> section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.</p>		

### Screening & Counseling Services

<b>-Obesity and/or Healthy Diet</b>	100% per visit.	Not Covered
<b>- Misuse of Alcohol and/or Drugs</b>	No copay or deductible applies.	
<b>-Use of Tobacco Products</b>		
<b>-Sexually Transmitted Infections</b>		
<b>-Genetic Risk for Breast and Ovarian Cancer</b>		

#### *Obesity and/or Healthy Diet Benefit Maximums*

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

#### *Misuse of Alcohol and/or Drugs Benefit Maximums*

Maximum Visits per Calendar Year	Unlimited*	Not Covered.
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

#### *Use of Tobacco Products Benefit Maximums*

Maximum Visits per Calendar Year	8 visits*	Not Covered.
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

#### *Sexually Transmitted Infections Benefit Maximums*

Maximum Visits per Calendar Year	2 visits*	Not Covered
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**\*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

### **Tobacco Cessation Prescription and Over-the-Counter Drugs**

Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b> for each 90 day supply.	100% per item No copay or deductible applies.	Not Covered.
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#### Maximums:

Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

**Well Woman Preventive Visits  
Office Visits**

100%

Not Covered

No Calendar Year **deductible** applies

Maximum Visits  
per Calendar Year

1 visit

Not Covered

**Newborn Screening Test for Hearing Loss and Necessary Follow-up Care Related to Test for covered children birth to age 2 years.** (See your Booklet for details.)

100% per test

Not Covered

No **deductible** applies.

**Routine Osteoporosis screening for covered females age 65 and over**

100%

Not Covered

No **deductible** applies.

**Routine Cancer Screening Outpatient**

100% per visit

Not Covered

No Calendar Year **deductible** applies.

Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <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
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<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	Not Covered
<b>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.</b>		

<b>Prenatal Care</b>		
<b>Office Visits</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.	Not Covered
<b>Important Note:</b> Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		

<b>Comprehensive Lactation Support and Counseling Services</b>		
<b>Lactation Counseling Services</b>	100% per visit	Not Covered.
<i>Facility or Office Visits</i>	No <b>copay</b> or <b>deductible</b> applies.	

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

<b>Breast Pumps &amp; Supplies</b>	100% per item. No <b>copay</b> or <b>deductible</b> applies.	Not Covered
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<b>Family Planning - Other</b>		
Voluntary Termination of Pregnancy		
Outpatient	75% per visit after Calendar Year <b>deductible.</b>	Not Covered.
Voluntary Sterilization for Males		
Outpatient	75% per visit after Calendar Year <b>deductible.</b>	Not Covered.

<b>Family Planning Services</b>		
Female Contraceptive Counseling Services -Office Visits.	100% per visit No <b>copay</b> or <b>deductible</b> applies	Not Covered.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Covered.
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Female Contraceptive Generic <b>Prescription Drugs</b> and Devices provided, administered, or removed, by a <b>Physician</b> during an Office Visits.	100% per item  No <b>copay</b> or <b>deductible</b> applies.	Not Covered.

<b>Family Planning - Female Voluntary Sterilization</b> <b>Inpatient</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.	Not Covered
<b>Outpatient</b>	100% per visit No <b>copay</b> or <b>deductible</b> applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Family Planning Services - Female Contraceptives</b>		
<b>Female Contraceptive Generic Prescription Drugs</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per prescription or refill.  No <b>deductible</b> applies.	No coverage.
<b>Female Contraceptive Devices</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per prescription or refill.  No <b>deductible</b> applies.	No coverage.
<b>FDA-Approved Female Generic Emergency Contraceptives</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per prescription or refill.  No <b>deductible</b> applies.	No coverage.
<b>FDA-Approved Female and Male Generic Over-the-Counter Contraceptives</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per prescription or refill.  No <b>deductible</b> applies.	No coverage.
<b>Important Note:</b> Refer to the <i>Outpatient Prescription Drug Expenses</i> section of your <i>Schedule of Benefits</i> for more information on other prescription drug coverage under this Plan		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Physician Services</b>		
<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	75% per visit after Calendar Year deductible	Not Covered
<b>Specialist Office Visits</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</b>		
Immunizations	100% per visit No copay or deductible applies. 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.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No copay or deductible applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
Individual Screening and Counseling Services for Obesity	100% per visit No copay or deductible applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
<b>*Important Note:</b> Not all preventive care services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .		
<b>All Other Services</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Physician Office Visits-Surgery</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Physician Services for Inpatient Facility and Hospital Visits</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Administration of Anesthesia</b>	75% after Calendar Year deductible	Not Covered



PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>		
<b>Hospital Emergency Facility and Physician</b>	\$300 <b>copay</b> per visit then the plan pays 75% after Calendar Year <b>deductible</b> .	Paid same as Network benefits  <i>*See Important note below</i>
<p><b>*Important Note:</b> Please note that as these providers are not Network Providers and do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share 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 <b>physician</b> bills you for an amount above your cost share, you are not responsible for paying that amount. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> 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>	Not Covered	Not Covered
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**Important Notice:**  
A separate **hospital** emergency room **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 **copay** is waived.  
Covered expenses that are applied to the emergency room **copay** cannot be applied to any other **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **copays** cannot be applied to the emergency room **copay**.

<b>Urgent Care Services</b>		
<b>Urgent Medical Care</b> <i>(at a non-hospital free standing facility)</i>	75% after Calendar Year <b>deductible</b>	Not Applicable
<b>Urgent Medical Care</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.
<b>Non-Urgent Use of Urgent Care Provider</b> <i>(at an Emergency Room or a non-hospital free standing facility)</i>	75% per visit after Calendar Year <b>deductible</b>	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Outpatient Diagnostic and Preoperative Testing</b>		
<b>Complex Imaging Services</b>		
<b>Complex Imaging</b>	75% per test after Calendar Year <b>deductible</b>	Not Covered
<b>Diagnostic Laboratory Testing</b>		
	75% per procedure after Calendar Year <b>deductible</b>	Not Covered

<b>Diagnostic X-Rays</b>		
Diagnostic X-Rays (except Complex Imaging Services)	75% per procedure after Calendar Year <b>deductible</b>	Not Covered

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Outpatient Surgery</b>		
<b>Outpatient Surgery</b>	75% per visit/surgical procedure after Calendar Year <b>deductible</b>	Not Covered

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Facility Expenses</b>		
<b>Birth Center</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

<b>Hospital Facility Expenses</b>	75% per admission after Calendar Year <b>deductible</b>	Not Covered
Room and Board (including maternity)		
Other than Room and Board	75% per admission after Calendar Year <b>deductible</b>	Not Covered

<b>Skilled Nursing Inpatient Facility</b>	75% per admission after Calendar Year <b>deductible</b>	Not Covered
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Maximum Days per Calendar Year	60 days	Not Covered
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<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Specialty Benefits</b>		
<b>Home Health Care(Outpatient)</b>	75% per visit after the Calendar Year <b>deductible</b>	Not Covered

Maximum Visits per Calendar Year	100 visits	Not Covered
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<b>Skilled Nursing Care (Outpatient)</b>	75% per visit after the Calendar Year <b>deductible</b>	Not Covered
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<b>Private Duty Nursing (Outpatient)</b>	75% per visit after the Calendar Year <b>deductible</b>	Not Covered
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Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	Not Covered
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**Hospice Benefits**

<b>Hospice Care –Facility Expenses</b> (Room & Board)	75% per admission after Calendar Year <b>deductible</b>	Not Covered
<b>Hospice Care – Other Expenses during a stay</b>	75% per admission after Calendar Year <b>deductible</b>	Not Covered

Maximum Benefit per lifetime	Unlimited days	Not Covered
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<b>Hospice Outpatient Visits</b>	75% per visit after Calendar Year <b>deductible</b>	Not Covered
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**PLAN FEATURES NETWORK OUT-OF-NETWORK**

**Infertility Treatment**

<b>Basic Infertility Expenses</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.	Not Covered
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**PLAN FEATURES NETWORK OUT-OF-NETWORK**

**Inpatient Treatment of Mental Disorders**

**MENTAL DISORDERS**

<b>Hospital Facility Expenses</b>		
Room and Board	75% per admission after Calendar Year <b>deductible</b>	Not Covered
Other than Room and Board	75% per admission after Calendar Year <b>deductible</b>	Not Covered
Physician Services	75% per admission after Calendar Year <b>deductible</b>	Not Covered

<b>Inpatient Residential Treatment Facility Expenses</b>	75% per admission after Calendar Year <b>deductible</b>	Not Covered
<b>Inpatient Residential Treatment Facility Expenses Physician Services</b>	75% after Calendar Year <b>deductible</b>	Not Covered

## Outpatient Treatment Of Mental Disorders

<b>Outpatient Services</b>	75% per visit after the Calendar Year deductible	Not Covered
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### PLAN FEATURES NETWORK OUT-OF-NETWORK

#### *Inpatient Treatment of Substance Abuse*

##### *Hospital Facility Expenses*

Room and Board	75% per admission after Calendar Year deductible	Not Covered
Other than Room and Board	75% per admission after Calendar Year deductible	Not Covered
Physician Services	75% per admission after Calendar Year deductible	Not Covered

##### *Inpatient Residential Treatment Facility Expenses*

75% per admission after Calendar Year deductible Not Covered

##### *Inpatient Residential Treatment Facility Expenses Physician Services*

75% after Calendar Year deductible Not Covered

#### *Outpatient Treatment of Substance Abuse*

<b>Outpatient Services</b>	75% per visit after the Calendar Year deductible	Not Covered
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### PLAN FEATURES NETWORK (IOQ Facility Only) OUT-OF-NETWORK

#### *Obesity Treatment Non Surgical*

<b>Outpatient Obesity Treatment (non surgical)</b>	50% per visit after the Calendar Year deductible	Not Covered
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### PLAN FEATURES NETWORK (IOQ Facility Only) OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility)

#### *Obesity Treatment Surgical*

<b>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</b>	50% per admission after the Calendar Year deductible	Not Covered
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<b>Outpatient Morbid Obesity Surgery</b>	50% per service after Calendar Year deductible	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	\$10,000 per lifetime	Not Covered
This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna		

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b>Transplant Services Facility and Non-Facility Expenses</b> <12SECTION075>			
<b>Transplant Facility Expenses</b>	75% per admission after Calendar Year deductible	Not Covered	Not Covered
<b>Transplant Physician Services</b> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Other Covered Health Expenses</b>		
<b>Acupuncture in lieu of anesthesia</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Ground, Air or Water Ambulance</b>	75% after Calendar Year deductible	Not Covered
<b>Diabetic Equipment and Education - includes glucometers, insulin pumps, and pump supplies</b>	75% after Calendar Year deductible	Not Covered
<b>Durable Medical and Surgical Equipment</b>	75% per item after the Calendar Year deductible	Not Covered
<b>Clinical Trial Therapies</b> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
<b>Routine Patient Costs</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

<i>Prosthetic Devices</i>	75% after Calendar Year deductible	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		

<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		

<i>Outpatient Physical, Occupational, and Speech Therapy combined - performed in a rehabilitation facility</i>	Calendar Year deductible then the plan pays 75%	Not Covered
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Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year for all hospitals, rehabilitation facilities of office settings (combined with Autism Spectrum Disorder visits)	60 visits	Not Covered
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PLAN FEATURES		
<i>Autism Spectrum Disorder</i>		
<b>Applied Behavioral Analysis</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Behavioral Therapy</b>	75% per visit after Calendar Year deductible	Not Covered
<b>Occupational Therapy, Physical Therapy and Speech Therapy*</b>	75% per visit after Calendar Year deductible	Not Covered
*Autism Spectrum Disorder Occupational Therapy, Physical Therapy and Speech Therapy are combined with the Short Term Rehabilitation visit maximum.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	Calendar Year deductible then the plan pays 75%	Not Covered

Spinal Manipulation Maximum visits per Calendar Year	20 visits	Not Covered
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## 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

All **covered expenses** accumulate toward the **network provider deductible** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

## Network Provider Calendar Year Deductible

### Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

### Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

## 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.

#### Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

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

## Network Provider Maximum Out-of-Pocket Limit

### Individual

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



### **Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

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

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

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room; and
- Expenses incurred for obesity treatment surgery.

## **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.