Schedule of Benefits

Employer: **Houston Independent School District**

ASA: 620266

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For: Open Access Aetna Select

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

Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Maximum Out of Pocket Limit includes plan **copayments**. **Individual Maximum Out of Pocket Limit:** ▪ For **network** expenses: $2,500 **Family Maximum Out of Pocket Limit:** ▪ For **network** expenses: $5,000		
Lifetime Maximum Benefit per person	Unlimited	Not applicable

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
Preventive Care		
Routine Physical Exams		
Office Visits -	100% per visit. No copay or **deductible** applies.	Not Covered

Covered Persons through age 21: Maximum Age & Visit Limits per Calendar Year	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. *For details, contact your* ***physician*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	Not Covered.

Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit. No **copay** or **deductible** applies.	Not Covered

Preventive Care Drugs and Supplements Preventive care drugs and supplements filled at a retail **pharmacy** for each 30 day supply. 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 www.aetna.com or calling the number on the back of your ID card.	100% per item No **copay** or **deductible** applies.	Not Covered.

Important Note:
Refer to the Booklet and the *Preventive Care* 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.

Screening & Counseling Services		
-Obesity and/or Healthy Diet ***- Misuse of Alcohol and/or Drugs*** ***-Use of Tobacco Products*** ***-Sexually Transmitted Infections*** ***-Genetic Risk for Breast and Ovarian Cancer***	100% per visit. No **copay** or **deductible** applies.	Not Covered
Obesity and/or Healthy Diet Benefit Maximums		
Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(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)****	Not Covered.
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.
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.
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
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 **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. 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.	100% per item No **copay** or **deductible** applies.	Not Covered.

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 or calling the number on the back of your ID card.		
Well Woman Preventive Visits Office Visits	100% No Calendar Year **deductible** applies	Not Covered
Maximum Visits per Calendar Year	1 visit	Not Covered
Hearing Exam **(for covered dependent children through age 16)**	100% No Calendar Year **deductible** applies.	Not Covered
Newborn Screening Test for Hearing Loss and Necessary Follow-up Care Related to Test for covered children birth through age 2 years. (See your Booklet for details.)	100% per test No Calendar Year **deductible** applies.	Not Covered
Routine Osteoporosis screening for covered females age 65 and over.	100% No Calendar Year **deductible** applies.	Not Covered
Routine Cancer Screening Outpatient	100% per visit No Calendar Year **deductible** applies.	Not Covered

Routine Cancer Screening 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. *For details, contact your* ***physician,*** *log onto the* ***Aetna*** *website www.aetna.com, or call the number on the back of your ID card.*	Not Covered

Lung Cancer Screening Maximum	One screening every 12 months*	Not Covered
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.		

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

Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	Not Covered.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per **Calendar Year**	Not Covered
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps & Supplies	100% per item. No **copay** or **deductible** applies.	Not Covered

Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	85% per visit No **deductible** applies.	Not Covered.
Voluntary Sterilization for Males		
Outpatient	85% per visit No Calendar Year **deductible** applies.	Not Covered.
Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit No Calendar Year **deductible** 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 *Physician Services* office visit section of the *Schedule of Benefits*.		

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

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

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations (including refraction) for covered dependent children through age 16	100% No Calendar Year **deductible** applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Aexcel Designated Network Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Non-Designated Network Specialist	$50 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, 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 *Preventive Care Benefit* 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 *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
***Important Note**: Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.		
All Other Services	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered

Physician Office Visits-Surgery		
Primary Care	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Aexcel Designated Network Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Non-Designated Network Specialist	$50 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered

Physician Services for Inpatient Facility and Hospital Visits	85% per visit No Calendar Year **deductible** applies.	Not Covered
Aexcel Designated Network Specialist	85% per visit No Calendar Year **deductible** applies.	Not Covered
Non-Designated Network Specialist	75% per visit **No** Calendar Year **deductible** applies.	Not Covered
Administration of Anesthesia	85% after Calendar Year **deductible**	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	85% per visit No Calendar Year **deductible** applies	Paid same as Network benefits **See Important note below*

***Important Note**: Please note that as these providers are not Network Providers and do not have a contract with **Aetna**, 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 **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	85% per visit No Calendar Year **deductible applies**	Not Covered
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	85% No Calendar Year **deductible** applies	Not Covered
Urgent Medical Care *(from other than a non-hospital free standing facility)*	85% No Calendar Year **deductible** applies.	Not Covered

Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	85% per visit No Calendar Year **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging (Precertification for High Tech Radiology applies)	85% per test No Calendar Year **deductible** applies	Not Covered
Diagnostic Laboratory Testing		
Performed in a Physician's Office	100% per procedure after applicable **copay** No Calendar Year **deductible** applies	Not Covered
Performed at a Hospital Outpatient Facility	85% per procedure No Calendar Year **deductible** applies	Not Covered
Performed at any other Facility	85% per procedure No Calendar Year **deductible** applies	Not Covered
Diagnostic X-Rays (except Complex Imaging Services)		
Performed in a Physician's Office	100% per procedure after applicable **copay** No Calendar Year **deductible** applies	Not Covered
Performed at a Hospital Outpatient Facility	85% per procedure No Calendar Year **deductible** applies	Not Covered
Performed at any other Facility	85% per procedure No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	85% per visit/surgical procedure No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	85% per admission No Calendar Year **deductible** applies.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	85% per admission No Calendar Year **deductible** applies	Not Covered
Other than Room and Board	85% per admission No Calendar Year **deductible** applies	Not Covered
Skilled Nursing Inpatient Facility	85% per admission No Calendar Year **deductible** applies	Not Covered
Maximum Days per Calendar Year	60 days	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	85% per visit No Calendar Year **deductible** applies.	Not Covered
Maximum Visits per Calendar Year	100 visits	Not Covered

Skilled Nursing Care (Outpatient)	85% per visit No Calendar Year **deductible** applies.	Not Covered
Private Duty Nursing (Outpatient)	85% per visit No Calendar Year **deductible** applies.	Not Covered
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
Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	85% per admission No Calendar Year **deductible** applies	Not Covered
Hospice Care – Other Expenses during a stay	85% per admission No Calendar Year **deductible** applies	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	85% per visit No Calendar Year **deductible** applies.	Not Covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	85% per admission No Calendar Year **deductible** applies.	Not Covered
Other than Room and Board	85% per admission No Calendar Year **deductible** applies.	Not Covered
Physician Services	85% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	85% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	85% per visit No Calendar Year **deductible** applies.	Not Covered
Outpatient Treatment Of Mental Disorders		
Outpatient Services	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	85% per admission No Calendar Year **deductible** applies	Not Covered
Other than Room and Board	85% per admission No Calendar Year **deductible** applies.	Not Covered
Physician Services	85% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	85% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	85% per visit No Calendar Year **deductible** applies.	Not Covered
Outpatient Treatment of Substance Abuse		
Outpatient Services	$20 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility)
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	50% per visit No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility)
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	50% per admission No Calendar Year **deductible** applies	Not Covered
Outpatient Morbid Obesity Surgery	50% per service No Calendar Year **deductible** applies	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna	$10,000 per lifetime	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered
Transplant Physician Services (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
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Ground, Air or Water Ambulance	85%	Not Covered
Diabetic Equipment and Education - includes glucometers, insulin pumps and pump supplies	85% No Calendar Year **deductible** applies.	Not Covered

Durable Medical and Surgical Equipment	85% per item No Calendar Year **deductible** applies	Not Covered
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	85% No Calendar Year **deductible** applies.	Not Covered

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational, and Speech Therapy combined		
Performed in a Physician's Office	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Performed at any other Facility	85% per visit No Calendar Year **deductible** applies.	Not Covered
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year including all hospital rehabilitation facilities or office settings (combined with Autism Spectrum Disorder visits)	60 visits	Not Covered

PLAN FEATURES		
Autism Spectrum Disorder		
Applied Behavioral Analysis	85% per visit No Calendar Year **deductible** applies.	Not Covered
Behavioral Therapy	85% per visit No Calendar Year **deductible** applies.	Not Covered
Occupational Therapy, Physical Therapy and Speech Therapy*	85% per visit No Calendar Year **deductible** applies.	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
Spinal Manipulation		
	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Spinal Manipulation Maximum visits per Calendar Year	20 visits	Not Covered

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.

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 any 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; and
- Expenses incurred for bariatric 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.