Schedule of Benefits

Employer:	**Katy Independent School District**
ASA:	724976
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Schedule:	5A
Booklet Base:	5

For: Open Access Aetna Select - Consumer Plus Limited Plan

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

Aetna HealthFund

Plan Features

Annual HealthFund Amount	$650 Individual $900 Employee and Spouse $900 Employee and Child(ren) $1,150 Family

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
Calendar Year Deductible*		
Individual Deductible*	$1,750	Not applicable
Family Deductible*	$3,500	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: $4,500

Family Maximum Out of Pocket Limit:

- For **network** expenses: $9,000

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 Benefits		
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	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** or Member Services by logging onto the Aetna website www.aetna.com, or calling 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. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your* ***physician*** *or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Screening & Counseling Services ***Office Visits*** ***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.

Well Woman Preventive Visits ***Office Visits*** Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% No Calendar Year **deductible** applies	Not Covered
Maximum Visits per Calendar Year	1 visit	Not Covered
Hearing Exam	100% No **deductible** applies.	Not Covered
Maximum exams Child - per 12 consecutive month period Adult - per 24 consecutive month period	 1 exam 1 exam	 Not Covered Not Covered
Routine Osteoporosis screening for covered females age 65 and over	100% No **deductible** applies.	Not Covered
Routine Cancer Screening ***Outpatient***	100% per visit No Calendar Year **deductible** applies.	Not Covered

Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*
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 **copay** or **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	80% per visit after Calendar Year **deductible.**	Not Covered.
Voluntary Sterilization for Males		
Outpatient	80% per visit after Calendar Year **deductible.**	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)	100% No **deductible** applies.	Not Covered
Maximum Benefit:		
Child (to age 18) - per 12 consecutive month period	1 exam	Not Covered
Adult - per 24 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**	80% per visit after Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	80% per visit after 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	80% per visit after Calendar Year **deductible**	Not Covered

Physician Office Visits-Surgery	80% per visit after Calendar Year **deductible**	Not Covered

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	Not Covered

Administration of Anesthesia	80% after Calendar Year **deductible**	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	$250 **copay** per visit then the plan pays 70% after Calendar Year **deductible**	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	Not Covered	Not Covered

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**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	80% after Calendar Year **deductible** applies	Not Applicable

Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	80% per test after Calendar Year **deductible**	Not Covered
Diagnostic Laboratory Testing		
	80% per procedure after Calendar Year **deductible**	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	80% per procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	80% per admission after Calendar Year **deductible**	Not Covered

Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible**	Not Covered
Maximum Days per Calendar Year	60 days	Not Covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits		
Home Health Care(Outpatient)	80% per visit after the Calendar Year **deductible**	Not Covered
Maximum Visits per Calendar Year	100 visits	Not Covered
Skilled Nursing Care (Outpatient)	80% per visit after the Calendar Year **deductible**	Not Covered
Private Duty Nursing (Outpatient)	80% per visit after the Calendar Year **deductible**	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)	80% per admission after Calendar Year **deductible**	Not Covered
Hospice Care – Other Expenses during a stay	80% per admission after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**	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
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Artificial Insemination Maximum Benefit*	6 courses of treatment per lifetime	Not Covered
Ovulation Induction Maximum Benefit*	6 courses of treatment per lifetime	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	80% per admission after Calendar Year **deductible**	Not Covered
Physician Services	80% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year **deductible**	Not Covered
Outpatient Treatment Of Mental Disorders		
Outpatient Services	80% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	80% per admission after Calendar Year **deductible**	Not Covered
Physician Services	80% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year **deductible**	Not Covered
Outpatient Treatment of Substance Abuse		
Outpatient Services	80% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	80% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	80% per admission after the Calendar Year **deductible**	Not Covered
Outpatient Morbid Obesity Surgery	80% per service after Calendar Year **deductible**	Not Covered

Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	80% per admission after Calendar Year **deductible**	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	80% after Calendar Year **deductible**	Not Covered
Diabetic Equipment and Education - includes glucometers, insulin pumps, and pump supplies	80% after Calendar Year **deductible**	Not Covered
Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	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	80% after Calendar Year **deductible**	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 rehabilitation facility	Calendar Year **deductible** then the plan pays 80%	Not Covered
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year for all hospitals, rehabilitation facilities of office settings (combined with Autism Spectrum Disorder)	60 visits	Not Covered

PLAN FEATURES		
Autism Spectrum Disorder		
Applied Behavioral Analysis	80% per visit after Calendar Year **deductible**	Not Covered
Behavioral Therapy	80% per visit after Calendar Year **deductible**	Not Covered
Occupational Therapy, Physical Therapy and Speech Therapy*	80% 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
Spinal Manipulation		
	80% per visit after the Calendar Year **deductible**	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.

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

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:

- 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.