

Schedule of Benefits

Employer: Aldine Independent School District
ASA: 620264
Issue Date: November 3, 2014
Effective Date: January 1, 2015
Schedule: 6A
Booklet Base: 6

For: Open Access Aetna Select - Consumer Limited Plus Plan

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

Aetna HealthFund

Plan Features

Annual HealthFund Amount

- \$200 Individual
- \$450 Employee and Spouse
- \$450 Employee and Child(ren)
- \$700 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**.

Note: If you have a Flexible Spending Account (FSA) this will allow eligible out-of-pocket health care expenses to be paid automatically from your Flexible Spending Account first. Eligible expenses include deductible and out-of-pocket payment percentage. The Flexible Spending Account must be exhausted before any benefits become payable under the Aetna HealthFund.

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* | \$2,000 | Not applicable |
| Family Deductible* | \$3,750 | 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**.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$5,000

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$9,500

| | | |
|--|-----------|----------------|
| 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 |
| <i>Covered Persons through age 21: Maximum Age & 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 physician log onto the Aetna website www.aetna.com, 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. |

| | | |
|---|--|--------------|
| Preventive Care Immunizations <i>Performed in a facility or physician's office</i> | 100% per visit. No copay or deductible applies. | Not Covered |
| 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 |
| <i>Obesity and/or Healthy Diet Benefit Maximum</i> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 & 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. |
| *Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit. | | |
| <i>Misuse of Alcohol and/or Drugs Benefit Maximums</i> 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. | | |
| <i>Use of Tobacco Products</i> 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. | | |
| Well Woman Preventive Visits Office Visits | 100% No Calendar Year deductible applies | Not Covered |
| Maximum Visits per Calendar Year | 1 visit | Not Covered |
| Routine Osteoporosis screenings 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 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 physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i> | Not Covered |
| Lung Cancer Screening Maximums | 1 screening every Calendar Year* | Not Covered |
| *Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the <i>Outpatient Diagnostic and Preoperative Testing</i> section of your <i>Schedule of Benefits</i> . | | |
| 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 <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> . | | |
| 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 after Calendar Year deductible | 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*.

| | | |
|---|---|-------------|
| 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 (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided) | 100% per prescription or refill No calendar year deductible applies. | Not Covered. |
| Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided) | 100% per prescription or refill No calendar year deductible applies. | 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 | Not Covered |
| Specialist Office Visits | 80% per visit after Calendar Year deductible | Not Covered |

Walk-In Clinic Visit (Non-Emergency)**Preventive Care Services***

| | | |
|---------------|----------------|-------------|
| Immunizations | 100% per visit | Not Covered |
|---------------|----------------|-------------|

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.

| | | |
|--|----------------|-------------|
| Individual Screening and Counseling Services for Tobacco Use | 100% per visit | Not Covered |
|--|----------------|-------------|

No **copay** or **deductible** applies.

| | | |
|--|---|----------------|
| 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 | Not Covered |
|--|----------------|-------------|

No **copay** or **deductible** applies.

| | | |
|--|---|----------------|
| 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 |
|--|---|----------------|

***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 | \$150 copay per visit then the plan pays 80% after Calendar Year deductible | Paid same as Network benefits <i>*See Important note below</i> |
| <p>*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.</p> | | |

| | | |
|--|---|-------------|
| Non-Emergency Care in a Hospital Emergency Room | 60% per visit after Calendar Year deductible | 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 <i>(at a non-hospital free standing facility)</i> | 80% after Calendar Year deductible | Not Applicable |
| 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. |

| 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 | | |
|--|--|-----------------------|
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Diagnostic X-Rays (except Complex Imaging Services) | 80% per procedure after Calendar Year deductible | Not Covered |
| Outpatient Surgery | | |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Outpatient Surgery | 80% per visit/surgical procedure after Calendar Year deductible | Not Covered |
| Inpatient Facility Expenses | | |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Birth Center | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered |
| Hospital Facility Expenses | 80% per admission after Calendar Year deductible | Not Covered |
| Room and Board (including maternity) | | |
| 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 |
| Specialty Benefits | | |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Home Health Care(Outpatient) | 80% per visit after the Calendar Year deductible | Not Covered |
| Maximum Visits per Calendar Year | 100 visits | 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 |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Inpatient Treatment of Mental Disorders | | |
| Mental Disorder | Calendar Year deductible then the plan pays 80% | Not Covered |
| Maximum Benefit per Calendar Year (Combined Mental Disorder, Alcoholism and Substance Abuse) | 45 days | Not Covered |
| Outpatient Treatment Of Mental Disorders | | |
| Mental Disorder | Calendar Year deductible then the plan pays 80% | Not Covered |
| Maximum Visits per Calendar Year (Combined Mental Disorder, Alcoholism and Substance Abuse) | 60 visits | Not Covered |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Inpatient Treatment of Alcoholism and Substance Abuse | | |
| Inpatient Treatment | Calendar Year deductible then the plan pays 80% | Not Covered |
| Maximum Days per Calendar Year (Combined Alcoholism, Substance Abuse and Mental Disorder) | 45 days | Not Covered |
| Outpatient Treatment of Alcoholism and Substance Abuse | | |
| Outpatient Treatment | Calendar Year deductible then the plan pays 80% | Not Covered |

| | | |
|---|-----------|-------------|
| Maximum Visits per Calendar Year (Combined Alcoholism, Substance Abuse and Mental Disorder) | 60 visits | Not Covered |
|---|-----------|-------------|

| PLAN FEATURES | NETWORK | 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 (Network non-IOQ Facility or Out-of-Network Facility) |
|---|--|--|
| 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) | \$12,000 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 |
|--|--|----------------------------|----------------|
| 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 | | |
| <i>Acupuncture in lieu of anesthesia</i> | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered |
| <i>Ground, Air or Water Ambulance</i> | 80% after Calendar Year deductible | Not Covered |
| <i>Diabetic Equipment - includes glucometers, insulin pumps, and pump supplies</i> | 80% after Calendar Year deductible | Not Covered |
| <i>Durable Medical and Surgical Equipment</i> | 80% per item after the Calendar Year deductible | 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> | 80% after Calendar Year deductible | Not Covered |
| PLAN FEATURES | NETWORK | OUT-OF-NETWORK |
| Outpatient Therapies | | |
| <i>Chemotherapy</i> | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered |
| <i>Infusion Therapy</i> | Payable in accordance with the type of expense incurred and the place where service is provided. | Not Covered |
| <i>Radiation Therapy</i> | 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 | | |
| <i>Outpatient Physical, Occupational, and Speech Therapy combined - performed in a rehabilitation facility</i> | 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 or office settings (Combined with Autism Spectrum Disorder) | 60 visits | Not Covered |
|--|-----------|-------------|

| PLAN FEATURES | | |
|--|--|-------------|
| <i>Autism Spectrum Disorder</i> | | |
| 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 |
|----------------------------|---|----------------|
| <i>Spinal Manipulation</i> | | |
| | Calendar Year deductible then the plan pays 80% | 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

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.

You may still be responsible for any applicable copayments even if you have met your **Maximum Out-of-Pocket**.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

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**;
- Non-covered expenses;
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**; 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.