

## **Open Access Aetna Select Medical Plan**

### **Schedule of Benefits**

**Prepared exclusively for:**

<b>Employer:</b>	City of La Porte
<b>Contract number:</b>	ASA-870576 Schedule of Benefits 4A
Plan effective date:	January 1, 2020
Plan issue date:	December 30, 2019

**These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.**

## Schedule of benefits

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This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

### How to read your schedule of benefits

- When we say:
  - “In-network coverage”, we mean you get care from **network providers**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

#### Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

<b>Plan features</b>	<b>Deductible/Maximums</b>
	<b>In-network coverage*</b>
<b>Deductible</b>	
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.	
Individual	\$1,000 per Calendar Year
Family	\$3,000 per Calendar Year
<b>Deductible waiver</b>	
The Calendar Year in-network <b>deductible</b> is waived for all of the following <b>eligible health services</b> :	
<ul style="list-style-type: none"> <li>• Preventive care and wellness</li> <li>• Family planning services - female contraceptives</li> </ul>	
<b>Maximum out-of-pocket limit</b>	
<b>Maximum out-of-pocket limit</b> per Calendar Year.	
Individual	\$3,000 per Calendar Year
Family	\$9,000 per Calendar Year
<b>Annual HealthFund amount</b>	
Individual	\$500 per Calendar Year
Family	\$1,000 per Calendar Year

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
<b>Preventive care and wellness</b>	
<b>Routine physical exams</b>	
Performed at a <b>physician's, PCP</b> office	100% per visit  No <b>deductible</b> applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 12 months	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit
<b>Preventive care immunizations</b>	
Performed in a facility or at a <b>physician's</b> office	100% per visit  No <b>deductible</b> applies
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna's secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>	
Performed at a <b>physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN</b> office	100% per visit  No <b>deductible</b> applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Preventive screening and counseling services</b>	
Office visits <ul style="list-style-type: none"> <li>• Obesity and/or healthy diet counseling</li> <li>• Misuse of alcohol and/or drugs</li> <li>• Use of tobacco products</li> <li>• Sexually transmitted infection counseling</li> <li>• Genetic risk counseling for breast and ovarian cancer</li> </ul>	100% per visit  No deductible applies
<b>Obesity and/or healthy diet counseling maximums:</b>	
Maximum visits per 12 months  (This maximum applies only to covered persons age 22 and 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)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
<b>Misuse of alcohol and/or drugs maximums:</b>	
Maximum visits per 12 months	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
<b>Use of tobacco products maximums:</b>	
Maximum visits per 12 months	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
<b>Sexually transmitted infection counseling maximums:</b>	
Maximum visits per 12 months	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.	
<b>Genetic risk counseling for breast and ovarian cancer maximums:</b>	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

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<b>Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)</b>	
Routine cancer screenings	100% per visit  No <b>deductible</b> applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• 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</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
<b>Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.	
<b>Prenatal care Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>	
Preventive care services only	100% per visit  No <b>deductible</b> applies
<b>Important note:</b> You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.	
<b>Comprehensive lactation support and counseling services</b>	
Lactation counseling services – facility or office visits	100% per visit  No <b>deductible</b> applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>Physician</b> services office visits.	

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Breast feeding durable medical equipment</b>	
Breast pump supplies and accessories	100% per item  No <b>deductible</b> applies
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.	
<b>Family planning services – female contraceptives</b>	
<b>Counseling services</b>	
Female contraceptive counseling services office visit	100% per visit  No <b>deductible</b> applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*
<b>*Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under <b>Physician</b> services office visits.	
<b>Devices</b>	
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit	100% per item  No <b>deductible</b> applies
<b>Female voluntary sterilization</b>	
Inpatient	100% per admission  No <b>deductible</b> applies
Outpatient	100% per visit  No <b>deductible</b> applies

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<b>Eligible health services</b>	<b>In-network coverage*</b>
<b>Physicians and other health professionals</b>	
<b>Physicians and specialists</b> office visits (non-surgical)	
<b>Physician services</b>	
Office hours visits (non-surgical) non preventive care	80% (of the <b>negotiated charge</b> ) per visit
<b>*Telemedicine Consultations</b>	
<i>*The plan may utilize one or more telemedicine vendors. To obtain information regarding potential cost share when utilizing a telemedicine vendor, contact member services at the number on your ID card.</i>	
<b>Allergy testing, treatment and injections</b>	
Performed at a <b>physician's, PCP or specialist</b> office	100% (of the <b>negotiated charge</b> ) per visit No <b>deductible</b> applies
<b>Immunizations that are not considered preventive care</b>	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.
<b>Specialist</b>	
<b>Specialist office visits</b>	
Office hours visits (non-surgical)	80% (of the <b>negotiated charge</b> ) per visit
<b>Physician surgical services</b>	
<b>Physicians and specialists</b> office visits	
Performed at a <b>physician's, PCP</b> office	80% (of the <b>negotiated charge</b> ) per visit
Performed at a <b>specialist's</b> office	80% (of the <b>negotiated charge</b> ) per visit

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<b>Alternatives to physician office visits</b>	
<b>Walk-in clinic visits</b>	
<b>Walk-in clinic</b> non-emergency visit <i>(includes coverage for immunizations)</i>	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

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<b>Eligible health services</b>	<b>In-network coverage*</b>
<b>Hospital and other facility care</b>	
<b>Hospital care</b>	
Inpatient hospital	80% (of the <b>negotiated charge</b> ) per admission
<b>Alternatives to hospital stays</b>	
<b>Outpatient surgery and physician surgical services</b>	
	80% (of the <b>negotiated charge</b> ) per visit
<b>Home health care</b>	
Outpatient	80% (of the <b>negotiated charge</b> ) per visit
Maximum visits per Calendar Year	120  Limited to: 3 intermittent visits per day provided by a participating home health care agency; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care  The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge
<b>Hospice care</b>	
Inpatient facility	80% (of the <b>negotiated charge</b> ) per admission
Maximum days per lifetime	Unlimited
<b>Hospice care</b>	
Outpatient	80% (of the <b>negotiated charge</b> ) per visit
	Part-time or intermittent nursing care by an <b>R.N.</b> or <b>L.P.N.</b> for up to 8 hours a day  Part-time or intermittent home health aide services to care for you up to 8 hours a day

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<b>Outpatient private duty nursing</b>	
Outpatient private duty nursing	80% (of the <b>negotiated charge</b> ) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.
<b>Skilled nursing facility</b>	
Inpatient facility	80% (of the <b>negotiated charge</b> ) per admission
Maximum days per Calendar Year	100

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Emergency services and urgent care</b>		
<b>Emergency services</b>		
Hospital emergency room	80% (of the <b>negotiated charge</b> ) per visit	Paid the same as in-network coverage
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered
<p><b>Important Note:</b>  As <b>out-of-network providers</b> do not have a contract with us the <b>provider</b> may not accept payment of your cost share, (<b>deductible, copayment, and payment percentage</b>, as payment in full. You may receive a bill for the difference between the amount billed by the <b>provider</b> and the amount paid by this plan. If the <b>provider</b> bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the <b>provider</b> over that amount. Make sure the member's ID number is on the bill.</p>		
<b>Urgent care</b>		
Urgent medical care (at a non- <b>hospital</b> free standing facility)	80% (of the <b>negotiated charge</b> ) per visit	Not covered
Non-urgent use of <b>urgent care provider</b> (at a non- <b>hospital</b> free standing facility)	Not covered	Not covered

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>
<b>Specific conditions</b>	
<b>Autism spectrum disorder</b>	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other <b>illness</b> under this plan	
<b>Birthing center</b>	
Inpatient	80% (of the <b>negotiated charge</b> ) per admission
<b>Family planning services - other</b>	
<b>Voluntary sterilization for males</b>	
Outpatient	80% (of the <b>negotiated charge</b> ) per visit
<b>Maternity and related newborn care</b>	
Inpatient	80% (of the <b>negotiated charge</b> ) per admission
<b>Delivery services and postpartum care services</b>	
Performed in a facility or at a <b>physician's</b> office	80% (of the <b>negotiated charge</b> ) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.
<b>Mental health treatment - inpatient</b>	
Inpatient mental health treatment	80% (of the <b>negotiated charge</b> ) per admission
Inpatient <b>residential treatment facility</b>	
Coverage is provided under the same terms, conditions as any other <b>illness</b> .	

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Mental health treatment - outpatient</b>	
<p>Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> consultation</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per visit
<p>Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavior therapy consultation</p>	80% (of the <b>negotiated charge</b> ) per visit
<p>Other outpatient mental health treatment (includes skilled behavioral health services in the home)</p> <p><b>Partial hospitalization treatment</b></p> <p><b>Intensive outpatient program</b></p> <p>The cost share doesn't apply to in-network peer counseling support services</p>	80% (of the <b>negotiated charge</b> ) per visit

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<b>Substance related disorders treatment - inpatient</b>	
<p>Inpatient <b>substance abuse detoxification</b> during a <b>hospital</b> confinement</p> <p>Inpatient <b>substance abuse</b> rehabilitation during a <b>hospital</b> confinement</p> <p>Inpatient <b>residential treatment facility</b> during a <b>hospital</b> confinement</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per admission
<b>Substance related disorders treatment - outpatient: detoxification and rehabilitation</b>	
<p>Outpatient <b>substance abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> consultation</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per visit
<p>Outpatient <b>substance abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavioral therapy consultations</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Other outpatient <b>substance abuse</b> services (includes skilled behavioral health services in the home)	80% (of the <b>negotiated charge</b> ) per visit
<b>Partial hospitalization treatment</b>	
<b>Intensive outpatient program</b>	
The cost share doesn't apply to in-network peer counseling support services	

<b>Oral and maxillofacial treatment (mouth, jaws and teeth)</b>	
Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the <b>negotiated charge</b> ) per visit
<b>Reconstructive breast surgery</b>	
Reconstructive breast <b>surgery</b>	Covered according to the type of benefit and the place where the service is received
<b>Reconstructive surgery and supplies</b>	
Reconstructive <b>surgery</b>	Covered according to the type of benefit and the place where the service is received

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits



Eligible health services	Network (IOE facility)	Network (Non-IOE facility)
<b>Transplant services facility and non-facility</b>		
Inpatient <b>hospital</b> transplant services	80% (of the <b>negotiated charge</b> ) per transplant	Not covered
<b>Physician</b> services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered

Eligible health services	In-network coverage*
<b>Treatment of infertility</b>	
<b>Basic infertility</b>	
Basic <b>infertility</b>	Covered according to the type of benefit and the place where the service is received

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>
<b>Specific therapies and tests</b>	
<b>Outpatient diagnostic testing</b>	

<b>Diagnostic complex imaging services</b>	
	80% (of the <b>negotiated charge</b> ) per visit
<b>Diagnostic lab work</b>	
	80% (of the <b>negotiated charge</b> ) per visit.

<b>Diagnostic radiological services</b>	
	80% (of the <b>negotiated charge</b> ) per visit.

<b>Chemotherapy</b>	
Chemotherapy	Covered according to the type of benefit and the place where the service is received

<b>Outpatient infusion therapy</b>	
	80% (of the <b>negotiated charge</b> ) per visit

<b>Outpatient radiation therapy</b>	
	Covered according to the type of benefit and the place where the service is received.

<b>Short-term cardiac and pulmonary rehabilitation services</b>	
<b>Cardiac rehabilitation</b>	
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received
<b>Pulmonary rehabilitation</b>	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

<b>Short-term rehabilitation services</b>	
<b>Outpatient Physical, Occupational and Speech Therapies</b>	
	80% (of the <b>negotiated charge</b> ) per visit
Maximum visits per Calendar Year	60

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>
<b>Other services</b>	

<b>Acupuncture</b>	
Acupuncture	Covered according to the type of benefit and the place where the service is received

<b>Ambulance service</b>	
Ground, air or water ambulance	80% (of the <b>negotiated charge</b> ) per visit

<b>Clinical trial therapies (experimental or investigational)</b>	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received

<b>Clinical trials (routine patient costs)</b>	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received

<b>Durable medical equipment (DME)</b>	
DME	80% (of the <b>negotiated charge</b> ) per item

<b>Non-preventive hearing exams</b>	
For adults and children	100% (of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies.
Maximum	One exam in any 24 consecutive month period.

<b>Prosthetic devices</b>	
Prosthetic devices	Covered according to the type of benefit and the place where the service is received

<b>Spinal manipulation</b>	
Spinal manipulation	80% (of the <b>negotiated charge</b> ) per visit
Maximum visits per Calendar Year	20

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## General coverage provisions

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This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**

that are listed in the first part of this schedule of benefits.

### Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

#### Individual

This is the amount you owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

#### Family

This is the amount you and your covered dependents owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

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

- The combined **eligible health services** 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

#### Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

### Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

## Maximum out-of-pocket limits provisions

**Eligible health services** that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **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.

### Individual

Once the amount of the **payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

### Family

Once the amount of the **payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **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 **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 **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Calculations; determination of benefits provisions</b>
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Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.
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<b>Outpatient prescription drug maximum out-of-pocket limits provisions</b>
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<b>Eligible health services</b> that are subject to the <b>maximum out-of-pocket limit</b> include <b>eligible health services</b> provided under the medical plan and the outpatient <b>prescription drug</b> plan.
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\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits