Schedule of Benefits

Employer:	**Houston Independent School District**
ASA:	620266
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Schedule:	4B
Booklet Base:	4

For: Open Access Aetna Select with AHF - Consumer Choice Basic Plan

Aetna HealthFund

Plan Features

Annual HealthFund Amount	$0 Individual $0 Employee and Spouse $0 Employee and Child(ren) $0 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 **hospitals** and **specialists**, the **Choice Network.** You can choose from a range of **hospitals** and **specialists** that are divided into two tiers. In most cases, you will receive the Plan's maximum level of coverage when you receive care from a **Choice Network** Tier I **hospital** or **specialist**. If care is provided by **hospitals and specialists** that are not designated as Tier I, that care is also covered, but your cost sharing will be higher.

If you are not located in an area in which there are **Choice Network** providers, your deductibles, out-of-pocket limits and level of coverage will be the same as described in this Schedule of Benefits. If you receive care from an **Aexcel Designated Network Provider**, your deductibles, out-of-pocket limits and level of coverage will be the same as shown for Tier I **Choice Network** providers. If you receive care from a provider that is not an **Aexcel Designated Provider**, your deductibles, out-of-pocket limits and level of coverage will be the same as shown for Tier II **Choice Network** Providers.

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

Aetna Select Medical Plan

PLAN FEATURES	CHOICE NETWORK Tier I	CHOICE NETWORK Tier II	OUT-OF-NETWORK
Calendar Year Deductible*			
Individual Deductible*	$2,500	$2,750	Not applicable
Family Deductible*	$5,000	$5,250	Not applicable
Per Admission Copayment/Deductible	Not Applicable	$500 per admission	Not applicable

NON-HOSPITAL PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$2,500	Not Applicable
Family Deductible*	$5,000	Not Applicable

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

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

Individual Maximum Out of Pocket Limit:

- Tier I **network** expenses: $6,900
- Tier II **network** expenses: $7,150

Family Maximum Out of Pocket Limit:

- Tier I **network** expenses: $13,800
- Tier II **network** expenses: $14,300

Lifetime Maximum Benefit per person	Unlimited	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	CHOICE NETWORK HOSPITALS Tier I	CHOICE NETWORK HOSPITALS Tier II	OUT OF NETWORK
Hospital Facility Expenses Room and Board (including maternity)	75% after Calendar Year **deductible**	$500 per admission **copay** then the plan pays 55% after the Calendar Year **deductible**	Not Covered
Other than Room and Board	75% per admission after Calendar Year **deductible**	55% per admission after Calendar Year **deductible**	Not Covered
Outpatient Diagnostic and Preoperative Testing (performed in a Hospital)			
Diagnostic and Preoperative Testing (except complex imaging services)	75% per procedure after Calendar Year **deductible**	55% per procedure after Calendar Year **deductible**	Not Covered
Complex Imaging Services (performed in a Hospital)			
Complex Imaging (Pre-certification for High Tech Radiology applies)	75% per test after Calendar Year **deductible**	55% per test after Calendar Year **deductible**	Not Covered
Diagnostic Laboratory Testing (performed in a Hospital)			
Diagnostic Laboratory Testing	75% per procedure after Calendar Year **deductible**	55% per procedure after Calendar Year **deductible**	Not Covered
Diagnostic X-Rays (except Complex Imaging Services) performed in a Hospital			
Diagnostic X-Rays	75% per procedure after Calendar Year **deductible**	55% per procedure after Calendar Year **deductible**	Not Covered
Outpatient Surgery (performed in a Hospital)			
Outpatient Surgery	75% per visit/surgical procedure after Calendar Year **deductible**	55% per visit/surgical procedure after Calendar Year **deductible**	Not Covered

Short Term Outpatient Rehabilitation Therapies (performed in a Hospital)			
Outpatient Physical, Occupational, and Speech Therapy combined	75% per visit after Calendar Year **deductible**	55% per visit after Calendar Year **deductible**	**Not Covered**
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year for all hospital, rehabilitation facility or office setting (combined with Autism Spectrum Disorder visits)	60 visits	60 visits	Not Covered

NON-HOSPITAL 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 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** 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
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. **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.**	100% per item No **copay** or **deductible** applies.	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.

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. 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.	100% per item No **copay** or **deductible** applies.	Not Covered.

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
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
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(at an ambulatory surgical center)	75% per visit after Calendar Year **deductible.**	Not Covered.
Voluntary Sterilization for Males		
Outpatient(at an ambulatory surgical center)	75% per visit after Calendar Year **deductible.**	Not Covered.
NOTE: Any services provided on an inpatient basis are paid at the Choice Hospital Network Tier I and Tier II levels shown above.		

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**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	75% per visit after Calendar Year **deductible** applies.	Not Covered

PLAN FEATURES	CHOICE NETWORK Tier 1	CHOICE NETWORK Tier II	OUT-OF-NETWORK
Choice Network Specialist Office Visits	75% per visit after Calendar Year **deductible**	55% after Calendar Year **deductible**	Not Covered

PLAN FEATURES Members outside the Houston metropolitan area	NETWORK	OUT-OF-NETWORK
Aexcel Designated Network Specialist Office Visits	75% per visit after the Calendar Year **deductible**	Not Covered
Non-Designated Network Specialist Office Visits	55% per visit after the Calendar Year **deductible**	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
All Other Services	75% per visit after Calendar Year **deductible**	Not Covered

***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**.

PLAN FEATURES	CHOICE NETWORK Tier 1	CHOICE NETWORK Tier II	OUT-OF-NETWORK
Choice Network Specialist Office Visits - Surgery	75% per visit after Calendar Year **deductible**	55% per visit after Calendar Year **deductible**	Not Covered

PLAN FEATURES Members located outside the Houston metropolitan area	NETWORK	OUT-OF-NETWORK
Aexcel Designated Network Specialist Office Visits - Surgery	75% per visit after Calendar Year **deductible**	Not Covered
Non-Designated Network Specialist Office Visits - Surgery	55% per visit after Calendar Year **deductible**	Not Covered

Specialist Office Visits - Surgery *(outside the Choice or Aexcel Designated Network)*	75% per visit after Calendar Year **deductible**.	Not Covered

PLAN FEATURES	CHOICE NETWORK Tier 1	CHOICE NETWORK Tier II	OUT-OF-NETWORK
Physician Services for Inpatient Facility and Hospital Visits - Choice Network Specialist	75% per visit after Calendar Year **deductible**	55% after Calendar Year **deductible**	Not Covered

PLAN FEATURES ***Members located outside the Houston metropolitan area***	NETWORK	OUT-OF-NETWORK
Physician Services for Inpatient Facility and Hospital Visits - Aexcel Designated Network Specialist	75% per visit after Calendar Year **deductible**	Not Covered
Physician Services for Inpatient Facility and Hospital Visits - Non-Designated Network Specialist	55% per visit after Calendar Year **deductible**	Not Covered

Physician Services for Inpatient Facility and Hospital Visits - Specialists *(outside the Choice or Aexcel Designated Network)*	75% per visit after Calendar Year **deductible**	Not Covered

Administration of Anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$300 **copay** per visit then the plan pays 75% after 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	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)*	75% per visit after Calendar Year **deductible**	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)*	75% per visit after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services (Not Performed in a Hospital)		
Performed in a Physician's Office	75% per test after Calendar Year **deductible**	Not Covered
Performed at Freestanding Facility	75% per test after Calendar Year **deductible**	Not Covered
Diagnostic Laboratory Testing Not Performed in a Hospital)		
Performed in a Physician's Office	75% per procedure after Calendar Year **deductible**	Not Covered
Performed at Freestanding Facility	75% per procedure after Calendar Year **deductible**	Not Covered
Diagnostic X-Rays(except Complex Imaging Services) Not Performed in a Hospital)		
Performed in a Physician's Office	75% per procedure after Calendar Year **deductible**	Not Covered
Performed at Freestanding Facility	75% per procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Performed in a Physician's Office	75% per visit/surgical procedure after Calendar Year **deductible**	Not Covered
Performed at Freestanding Facility	75% 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
Skilled Nursing Inpatient Facility	75% 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)	75% per visit after the Calendar Year **deductible**	Not Covered
Maximum Visits per Calendar Year	100 visits	Not Covered
Skilled Nursing Care (Outpatient)	75% per visit after the Calendar Year **deductible**	Not Covered
Private Duty Nursing (Outpatient)	75% 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)	75% per admission after Calendar Year **deductible**	Not Covered
Hospice Care – Other Expenses during a stay	75% per admission after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	75% 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 DISORDERS		
Hospital Facility Expenses		
Room and Board	75% per admission after Calendar Year **deductible** applies.	Not Covered
Other than Room and Board	75% per admission after Calendar Year **deductible** applies.	Not Covered
Physician Services	75% per admission after Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	75% per admission after Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	75% per visit after Calendar Year **deductible** applies.	Not Covered
Outpatient Treatment Of Mental Disorders		
Outpatient Services	75% 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	75% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	75% per admission after Calendar Year **deductible**	Not Covered
Physician Services	75% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	75% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	75% per admission after Calendar Year **deductible**	Not Covered

Outpatient Treatment of Substance Abuse		
Outpatient Services	75% 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)	50% per admission 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)	50% per admission after the Calendar Year **deductible**	Not Covered
Outpatient Morbid Obesity Surgery	50% per admission after the Calendar Year **deductible**	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	75% 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	75% after Calendar Year **deductible**	Not Covered
Diabetic Equipment and Education - includes glucometers, insulin pumps and pump supplies	75% after Calendar Year **deductible**	Not Covered
Durable Medical and Surgical Equipment	75% 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	75% after the 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 75%	Not Covered
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year - including all hospital, rehabilitation facility or office (combined with Autism Spectrum Disorder visits)	60 visits	Not Covered

PLAN FEATURES		
Autism Spectrum Disorder		
Applied Behavioral Analysis	75% per visit after Calendar Year **deductible**	Not Covered
Behavioral Therapy	75% per visit after Calendar Year **deductible**	Not Covered
Occupational Therapy, Physical Therapy and Speech Therapy*	75% per visit after Calendar Year **deductible**	Not Covered

*Autism Spectrum Disorder Occupational Therapy, Physical Therapy and Speech Therapy are combined with the Short Term Rehabilitation visit maximum.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	75% 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

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.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in a Choice Network Tier II inpatient facility. A **copayment** 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable

under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

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**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. You are responsible for expenses that do not apply to your **out-of-pocket** limit as listed below; these include:

- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room; 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.