



**Open Choice (PPO Medical) - 2019 City Preventive Plan**

**Local 77 Employees**

**Schedule of Benefits**

**Prepared exclusively for:**

<b>Employer:</b>	The City of Seattle
<b>Contract number:</b>	100290
	Schedule of Benefits 6A
Plan effective date:	January 1, 2019
Plan issue date:	March 21, 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**.
  - “Out-of-network coverage”, we mean you can get care from **out-of-network providers**.
  - “Other health care coverage”, we mean you can get care from an **out-of-network provider** when you could not reasonably get the services and supplies needed from a **network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- 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. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

#### 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 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.

Plan features	Deductible/Maximums		
	In-network coverage*	Out-of-network coverage*	Other health care*
<b>Deductible</b>			
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.			
Individual	\$0 per Calendar Year	\$250 per Calendar Year	\$0 per Calendar Year
Family	\$0 per Calendar Year	\$750 per Calendar Year	\$0 per Calendar Year
<b>Common Accident Deductible</b>			
Common Accident Deductible	\$0	\$250	\$0

<b>Maximum out-of-pocket limit</b>			
<b>Maximum out-of-pocket limit</b> per Calendar Year.			
Individual	\$500 per Calendar Year	\$3,250 per Calendar Year	\$500 per Calendar Year
Family	\$1,000 per Calendar Year	\$6,750 per Calendar Year	\$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*	Out-of-network coverage*	Other health care
<b>Preventive care and wellness</b>			

<b>Routine physical exams</b>			
Performed at a <b>physician's</b> office	100% per visit No <b>deductible</b> applies.	Not Covered	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.	Not Applicable	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 Calendar Year	1 visit	Not Applicable	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	Not Applicable	1 visit

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<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	Not Covered	100% 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.	Not Applicable	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.
<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>			
Performed at a <b>physician's</b> , obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% per visit  No <b>deductible</b> applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

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<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	Not Covered	100% per visit  No deductible applies
<b>Obesity and/or healthy diet counseling maximums:</b>			
Maximum visits per Calendar Year  (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)*	Not Applicable	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 Calendar Year	5 visits*	Not Applicable	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 Calendar Year	8 visits*	Not Applicable	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 Calendar Year	2 visits*	Not Applicable	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			

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<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	Not applicable	Not subject to any age or frequency limitations
<b>Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)</b>			
Routine cancer screenings	100% per visit No <b>deductible</b> applies.	Not Covered	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.	Not Applicable	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*	Not Applicable	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.			

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<b>Prenatal care</b>			
<b>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	70% (of the <b>recognized charge</b> ) per visit	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	70% (of the <b>recognized charge</b> ) per visit	100% per visit  No <b>deductible</b> applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>Physician</b> services office visits.			
<b>Breast feeding durable medical equipment</b>			
Breast pump supplies and accessories	100% per item  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per item	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	70% (of the <b>recognized charge</b> ) per 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*	2 visits*	2 visits*
<b>*Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under <b>Physician</b> services office visits.			

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<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	70% (of the <b>recognized charge</b> ) per item	100% per item  No <b>deductible</b> applies
<b>Female voluntary sterilization</b>			
Inpatient	100% per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% per admission  No <b>deductible</b> applies
Outpatient	100% per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% per visit  No <b>deductible</b> applies
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</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	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Allergy injections</b>			
Performed at a <b>physician's</b> or <b>specialist</b> office when you do not see the <b>physician</b>	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized 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.	Covered according to the type of benefit and the place where the service is received.	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)	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies

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<b>Physician surgical services</b>			
<b>Physicians and specialists office visits</b>			
Performed at a <b>physician's</b> office	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Performed at a <b>specialist's</b> office	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Alternatives to physician office visits</b>			
<b>Walk-in clinic visits</b>			
<b>Preventive Care Services</b>			
Immunizations	100% per visit  No <b>deductible</b> applies	Not Covered	100% 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.	Not Applicable	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.
<b>All non preventive care services for which cost sharing is not shown above</b>			
All other services	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<b>Hospital and other facility care</b>			
<b>Hospital care</b>			
Inpatient <b>hospital</b>	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<b>Alternatives to hospital stays</b>			
<b>Outpatient surgery and physician surgical services</b>			
	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Home health care</b>			
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Maximum visits per Calendar Year	130  Limited to: 1 intermittent visit per day provided by a participating <b>home health care agency</b> ; 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	130  Limited to: 1 intermittent visit per day provided by a participating <b>home health care agency</b> ; 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	130  Limited to: 1 intermittent visit per day provided by a participating <b>home health care agency</b> ; 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

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<b>Hospice care</b>			
Inpatient facility	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	Not Covered	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<b>Hospice care</b>			
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	Not Covered	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Outpatient private duty nursing</b>			
Outpatient private duty nursing	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Skilled nursing facility</b>			
Inpatient facility	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
Maximum days per Calendar Year	120 days	120 days	120 days
Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	120 days	120 days	120 days
<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>
<b>Emergency services and urgent care</b>			
<b>Emergency services</b>			
Hospital emergency room	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	Paid the same as in-network coverage.	Paid the same as in-network coverage.

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Non-emergency care in a <b>hospital</b> emergency room	\$50 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	\$50 then the plan pays 70% (of the balance of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies	\$50 then the plan pays 100% (of the balance of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
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**Important Note:**

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment and payment percentage**), 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 **provider** 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 **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.

**Urgent care**

Urgent medical care (at a non- <b>hospital</b> free standing facility)	\$35 then the plan pays 100% ( of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	\$35 then the plan pays 100% (of the balance of the <b>recognized charge</b> ) per visit thereafter  No <b>deductible</b> applies
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A separate urgent care **deductible** or **copayment/payment percentage** will apply for each visit to an **urgent care provider**.

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
<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	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	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			

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<b>Birthing center</b>			
Inpatient	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<b>Family planning services - other</b>			
<b>Voluntary sterilization for males</b>			
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Abortion</b>			
Outpatient	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Maternity and related newborn care</b>			
Inpatient	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
<b>Delivery services and postpartum care services</b>			
Performed in a facility or at a <b>physician's</b> office	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	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	100% (of the <b>negotiated charge</b> ) per admission  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per admission	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
Inpatient <b>residential treatment facility</b>  Coverage is provided under the same terms, conditions as any other <b>illness</b> .			

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<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>	<p>\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>70% (of the <b>recognized charge</b>) per visit</p>	<p>100% (of the <b>recognized charge</b>) per visit</p> <p>No <b>deductible</b> applies</p>

<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>	<p>100% (of the <b>negotiated charge</b>) per admission</p> <p>No <b>deductible</b> applies</p>	<p>70% (of the <b>recognized charge</b>) per admission</p>	<p>100% (of the <b>recognized charge</b>) per admission</p> <p>No <b>deductible</b> applies</p>

<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>	<p>\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b>) per visit thereafter</p> <p>No <b>deductible</b> applies</p>	<p>70% (of the <b>recognized charge</b>) per visit</p>	<p>100% (of the <b>recognized charge</b>) per visit</p> <p>No <b>deductible</b> applies</p>

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

<b>Oral and maxillofacial treatment (mouth, jaws and teeth)</b>				
Oral and maxillofacial treatment (mouth, jaws and teeth)	100% (of the <b>negotiated charge</b> ) per visit No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit No <b>deductible</b> applies	
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000	
All other Oral and maxillofacial treatment (mouth, jaws and teeth)	100% (of the <b>negotiated charge</b> ) per visit No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit No <b>deductible</b> applies	
<b>Reconstructive breast surgery</b>				
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
<b>Reconstructive surgery and supplies</b>				
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
<b>Eligible health services</b>	<b>Network Institute of Excellence (IOE facility)</b>	<b>Network (Non-IOE facility)</b>	<b>Out-of-network coverage*</b>	<b>Other health care</b>
<b>Transplant services facility and non-facility</b>				
Inpatient <b>hospital</b> transplant services	100% (of the <b>negotiated charge</b> ) per transplant No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per transplant	70% (of the <b>recognized charge</b> ) per transplant	70% (of the <b>recognized charge</b> ) per transplant
<b>Physician</b> services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	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	In-network coverage*	Out-of-network coverage*	Other health care
<b>Specific therapies and tests</b>			
<b>Outpatient diagnostic testing</b>			
<b>Diagnostic complex imaging services</b>			
	100% (of the <b>negotiated</b> charge) per visit  No <b>deductible</b> applies	70% (of the <b>recognized</b> charge) per visit	100% (of the <b>recognized</b> charge) per visit  No <b>deductible</b> applies
<b>Diagnostic lab work</b>			
	100% (of the <b>negotiated</b> charge) per visit  No <b>deductible</b> applies	70% (of the <b>recognized</b> charge) per visit	100% (of the <b>recognized</b> charge) per visit  No <b>deductible</b> applies.
<b>Diagnostic radiological services</b>			
	100% of the <b>negotiated charge</b> per visit.  No <b>deductible</b> applies.	70% of the <b>recognized charge</b> per visit.	100% of the <b>recognized charge</b> per visit.  No <b>deductible</b> applies.
<b>Chemotherapy</b>			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Outpatient infusion therapy</b>			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Outpatient radiation therapy</b>			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	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>Short-term rehabilitation services</b>			
<b>Outpatient Physical, Massage ,Cardiac, Pulmonary, Speech and Occupational Therapies</b>			
	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter.  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit.	100% (of the <b>recognized charge</b> ) per visit.  No <b>deductible</b> applies

<b>Outpatient Physical, Massage ,Cardiac, Pulmonary, Speech and Occupational Therapies Maximum</b>			
Maximum visits per Calendar Year	20 visits	20 visits	20 visits

<b>Habilitation therapy services - for the treatment of Autism Spectrum Disorder</b>			
<b>Outpatient physical and occupational therapies</b>			
	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Outpatient speech therapy</b>			
	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies

\*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*	Other health care
<b>Other services</b>			

<b>Acupuncture</b>			
Acupuncture	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies.	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies.
<b>All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity</b>			

<b>Ambulance service</b>			
Ground, air or water ambulance	100% (of the <b>negotiated charge</b> ) per trip  No <b>deductible</b> applies.	100% (of the <b>recognized charge</b> ) per trip  No <b>deductible</b> applies.	100% (of the <b>recognized charge</b> ) per trip  No <b>deductible</b> applies.

<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	Covered according to the type of benefit and the place where the service is received	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	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Durable medical equipment (DME)</b>			
DME	100% (of the <b>negotiated charge</b> ) per item  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per item	100% (of the <b>recognized charge</b> ) per item  No <b>deductible</b> applies

<b>Hearing aids and exams</b>			
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	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

Hearing aids	100% (of the <b>negotiated charge</b> ) per item  No <b>deductible</b> applies.	100% (of the <b>recognized charge</b> ) per item	100% (of the <b>recognized charge</b> ) per item  No <b>deductible</b> applies
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Maximum per 36 month period	\$1,000	\$1000	\$1,000
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<b>Non-preventive hearing exams</b>			
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For adults and children	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies.	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies.
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Maximum	One exam in any 12 consecutive month period.		
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<b>Nutritional supplements</b>			
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Nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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<b>Prosthetic devices</b>			
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Prosthetic devices	100% (of the <b>negotiated charge</b> ) per item  No <b>deductible</b> applies.	70% (of the <b>recognized charge</b> ) per item	100% (of the <b>recognized charge</b> ) per item  No <b>deductible</b> applies.
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Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500
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<b>Spinal manipulation</b>			
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Spinal manipulation	\$10 then the plan pays 100% (of the balance of the <b>negotiated charge</b> ) per visit thereafter  No <b>deductible</b> applies	70% (of the <b>recognized charge</b> ) per visit	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
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Maximum visits per Calendar Year	20	20	20
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\*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>Outpatient prescription drugs</b>		
<b>Plan features</b>	<b>Deductible/Copayment/Payment Percentage/Maximums</b>	
<b>Deductible waiver</b>		
The calendar year <b>deductible</b> is waived for all <b>prescription drugs</b> .		
<b>Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to risk reducing breast cancer <b>prescription drugs</b> when obtained at a <b>network pharmacy</b> . This means that such risk reducing breast cancer <b>prescription drugs</b> will be paid at 100%.		
<b>Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to the first two 90-day treatment regimens for tobacco cessation <b>prescription drugs</b> and OTC drugs when obtained at a <b>network pharmacy</b> . This means that such <b>prescription drugs</b> and OTC drugs will be paid at 100%. Your Calendar Year <b>deductible</b> and any <b>prescription copayment/payment percentage</b> will apply after those two regimens have been exhausted.		
<b>Deductible and copayment/payment percentage waiver for contraceptives</b>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> will not apply to female contraceptive methods when obtained at a <b>network pharmacy</b> . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> <li>Certain over-the-counter (OTC) and generic contraceptive <b>prescription drugs</b> and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a <b>generic prescription drug</b> or device is not available for a certain method, you may obtain certain <b>brand-name prescription drugs</b> for that method paid at 100%.</li> </ul>		
The Calendar Year <b>deductible</b> and the per <b>prescription copayment/payment percentage</b> continue to apply to <b>prescription drugs</b> that have a generic equivalent or generic alternative available within the same <b>therapeutic drug class</b> obtained at a <b>network pharmacy</b> unless you are granted a medical exception.		
<b>Outpatient prescription drug maximum out-of-pocket limit</b>		
Outpatient <b>prescription drug maximum out-of-pocket limit</b> per calendar year		
Individual	\$1,200 per calendar year	
Family	\$3,600 per calendar year	

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

<b>Generic prescription drugs (including specialty drugs)</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 34 day supply filled at a <b>retail pharmacy</b>	<p>\$10 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 30 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$20 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
<b>Preferred brand-name prescription drugs (including specialty drugs)</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 34 day supply filled at a <b>retail pharmacy</b>	<p>\$20 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 30 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$40 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
<b>Non-preferred brand-name prescription drugs (including specialty drugs)</b>		
<b>Per prescription copayment/payment percentage</b>		
For each fill up to a 34 day supply filled at a <b>retail pharmacy</b>	<p>\$40 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered
More than a 30 day supply but less than a 91 day supply filled at a <b>mail order pharmacy</b>	<p>\$80 <b>copayment</b> per supply</p> <p><b>Payment percentage</b> is 100% (of the <b>negotiated charge</b>)</p> <p>No Calendar Year <b>deductible</b> applies</p>	Not covered

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

<b>Preventive care drugs and supplements</b>		
Preventive care drugs and supplements filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered
Maximums:	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 member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	
<b>Risk reducing breast cancer prescription drugs</b>		
Risk reducing breast cancer <b>prescription drugs</b> filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered
Maximums:	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 member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	

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

<b>Tobacco cessation prescription and over-the-counter drugs</b>		
Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b>	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only.  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 <b>prescription drugs</b> and OTC drugs, contact 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.	

## General coverage provisions

This section provides detailed explanations about the:

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

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 out-of-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.

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

### **Family**

This is the amount you and your covered dependents owe for out-of-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.

### **Common Accident Deductible**

This limit applies when two or more family members are injured in the same accident. The common accident deductible limit places a limit on your **deductible** expenses when covered expenses are applied toward the separate Calendar Year **deductibles**. When this occurs, and all covered expenses related to the accident in that Calendar Year exceed the common accident deductible limit, your plan will then pay the excess amount based on the plan **payment percentage**. The added benefit will be reduced by any family deductible limit benefit amount paid for the same covered expenses.

### **Deductible carryover**

Any amounts that you paid for **eligible health services** in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year **deductibles**.

### **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.

### **Maximum out-of-pocket limits provisions**

**Eligible health services** applied to the **out-of-network maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/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.

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

**Individual**

Once the amount of the **copayments/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** or **recognized 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 **copayments/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** or **recognized 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
- Amounts you pay toward a **deductible**
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

**Maximum provisions**

**Eligible health services** applied to the **out-of-network** maximum will not be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will not be applied to satisfy the **out-of-network** maximum.

**Calculations; determination of recognized charge; determination of benefits provisions**

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.

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

## General coverage provisions

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This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

### Outpatient prescription drug maximum out-of-pocket limits provisions

The outpatient **prescription drug maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **payment percentage** for **eligible health services** during the Calendar Year. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**. As to the individual outpatient **prescription drug maximum out-of-pocket limit** each of you must meet your outpatient **prescription drug maximum out-of-pocket limit** separately.

#### Individual

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

To satisfy this family outpatient **prescription drug maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug 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 outpatient **prescription drug maximum out-of-pocket limit** amount.

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

- All costs for non-covered services

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