Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	Aspen HR PEO, LLC
Policyholder number:	GP-0175126
Control number:	CN-0175126
	CN-0175127
	CN-0175128
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	Schedule of Benefits: 7A
	Traditional Choice $1,000 80%
Group policy effective date:	September 1, 2021
Plan effective date:	September 1, 2022
Plan issue date:	September 1, 2022

Underwritten by Aetna Life Insurance Company in the state of California.

Schedule of benefits

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

How to read your schedule of benefits

- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles**, and **copayments**, and**/coinsurance**.
- **The coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance.**
- 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**
  - Maximums

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** 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 or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

Plan features	
Deductible	
You have to meet your Calendar Year **deductible** before this plan pays for benefits.	
Individual	$1,000 per Calendar Year
Family	$2,000 per Calendar Year
Deductible waiver	
The Calendar Year **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives	
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$4,500 per Calendar Year
Family	$9,000 per Calendar Year
Precertification penalty	
This only applies to out-of-network coverage. The booklet-certificate contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section. Failure to **precertify** your **eligible health services** when required will result in the following penalty: • A $400 penalty will be applied separately to each type of **eligible health services** (the penalty will never exceed the cost of the benefit) **Precertification** and/or **step therapy** for certain **prescription drugs** may be required. In this case, the **prescription drug** will not be covered until you get prior authorization. The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any.	

*See *How to read your schedule of benefit and important note* at the beginning of this schedule of benefits

Eligible health services	
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's** office	100% per visit No **deductible** applies
Covered persons through age 21: Maximum age and visit limits per 12 months	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 **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com 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
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** 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 **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

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Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** 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
Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:	
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.	
Misuse of alcohol and/or drugs maximums:	
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.	

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Use of tobacco products maximums:	
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.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
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 your Aetna member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only (includes participation in the California Prenatal Screening Program	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	

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Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	
Breast feeding durable medical equipment	
Breast pump supplies and accessories	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.	
Family planning services – female contraceptives	
Education and counseling services	
Female contraceptive education and counseling services office visit	100% per visit No **deductible** applies
Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit and follow up services	100% per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies

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Eligible health services	
2. Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	80% (of the **recognized charge**) per visit
Telemedicine consultation by a **physician**	80% (of the **recognized charge**) per visit
Telemedicine consultation by a **specialist**	80% (of the **recognized charge**) per visit

Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	80% (of the **recognized charge**) per visit
Physician surgical services	
Physicians and **specialists** office visits	
Performed at a **physician's** office	80% (of the **negotiated charge**) per visit

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Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	80% (of the **recognized charge**) per visit
	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 **physician** or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	
3. Hospital and other facility care	
Hospital care	
Inpatient **hospital**	80% (of the **recognized charge**) per admission
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	80% (of the **recognized charge**) per visit
Home health care	
Outpatient	80% (of the **recognized charge**) 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 14 days of discharge
Hospice care	
Inpatient facility	80% (of the **recognized charge**) per admission
Maximum days per lifetime	Unlimited
Hospice care	
Outpatient	80% (of the **recognized charge**) per visit
	Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** 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
Outpatient private duty nursing	
Outpatient private duty nursing	80% (of the **recognized charge**) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.

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

Skilled nursing facility	
Inpatient facility	80% (of the **recognized charge**) per admission
Maximum Days per Calendar Year	60
Eligible health services	
4. Emergency services and urgent care	
Emergency services	
Hospital emergency room	80% (of the **recognized charge**) per visit
Non-emergency care in a **hospital** emergency room	Not covered
Urgent Care	
Urgent medical care (at a non-**hospital** free standing facility)	80% (of the **recognized charge**) per visit

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

Eligible health services*	
5. Specific conditions	
Behavioral health **Mental health treatment - inpatient**	
Inpatient mental health treatment Inpatient **residential treatment facility**	80% (of the **recognized charge**) per admission
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	80% (of the **recognized charge**) per visit
All other outpatient mental health treatment as described in your booklet-certificate (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	80% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits, important note about your cost sharing and important notice* at the beginning of this schedule of benefits

Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient residential treatment facility	80% (of the **recognized charge**) per admission
Substance related disorders treatment - outpatient	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)	80% (of the **recognized charge**) per visit
All other outpatient **substance abuse** services (as described in your booklet-certificate) **Partial hospitalization treatment** **Intensive outpatient program**	80% (of the **recognized charge**) per visit
Birthing center and physician services	
Inpatient	80% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received.
Family planning services - other	
Voluntary sterilization for males	
Outpatient	80% (of the **recognized charge**) per visit

Termination of pregnancy	
Inpatient	Covered according to the type of benefit and the place where the service is received.
Outpatient	Covered according to the type of benefit and the place where the service is received.
Physician's office	Covered according to the type of benefit and the place where the service is received.
Jaw joint disorder treatment	
Jaw joint disorder treatment	Covered according to the type of benefit and the place where the service is received
Maternity and related newborn care	
Inpatient	80% (of the **recognized charge**) per admission
Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	80% (of the **recognized charge**) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.
Pregnancy complications	
Inpatient	80% (of the **recognized charge**) per admission, after the per admission **deductible**
Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received
Reconstructive surgery and supplies	
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received

Eligible health services*	

Transplant services facility and non-facility	
Inpatient **hospital** transplant services	80% (of the **recognized charge**) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.
Eligible health services*	
Treatment of infertility	
Basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received
Eligible health services	
6. Specific therapies and tests	
Diagnostic complex imaging services	
	80% (of the **recognized charge**) per visit
Diagnostic lab work	
	80% (of the **recognized** charge) per visit.
Diagnostic radiological services	
	80% (of the **recognized** charge) per visit.
Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy	
	80% (of the **recognized charge**) per visit
Outpatient radiation therapy	
Radiation therapy	Covered according to the type of benefit and the place where the service is received.

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

Short-term rehabilitation services	
Outpatient Physical, Occupational and Speech Therapies	
	80% (of the **recognized** charge) per visit.

Spinal manipulation	
Spinal manipulation	80% (of the **recognized charge**) per visit

Habilitation therapy services	
Outpatient physical and occupational therapies	
	Covered according to the type of benefit and the place where the service is received
Outpatient speech therapy	
	Covered according to the type of benefit and the place where the service is received

Eligible health services	
7. Other services	
Acupuncture	
Acupuncture	80% (of the **recognized charge**) per visit
Maximum visits per Calendar Year	10

Ambulance service	
Ground, air or water **ambulance**	80% (of the **recognized charge**) per trip

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received

Durable medical equipment (DME)	
DME	50% (of the **recognized charge**) per item
Non-preventive hearing exams	
For adults and children	80% (of the **recognized charge**) per visit

Nutritional supplements	
Nutritional supplements	Covered according to the type of benefit and the place where the service is received
Osteoporosis	
Physician's office visits	Covered according to the type of benefit and the place where the service is received

Prosthetic and orthotic devices	
Prosthetic and orthotic devices	Covered according to the type of benefit and the place where the service is received

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

Vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	100% per visit No **deductible** applies

Maximum visits per 12 consecutive month period	1 visit

All other outpatient services for which cost sharing is not shown above	
All other outpatient services	Covered according to the type of benefit and the place where the service is received

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

Eligible health services	In-network coverage*	Out-of-network coverage*
8. Outpatient prescription drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.		
Deductible and copayment/coinsurance waiver for contraceptives		
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** 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 **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. We will cover brand-name emergency contraceptive "Ella" until such time as a generic equivalent is approved by the FDA. At that time, only a generic equivalent will be covered. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.		
Preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered

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Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$45 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$90 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$140 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$140 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
Specialty drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is 30% (of the **negotiated charge**) but will be no more than $250 per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered

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Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**)	Not Covered
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill	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 secure member website at www.aetna.com or calling the number on your ID card.	

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Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill	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 secure member website at www.aetna.com or calling the number on your ID card.	
Family planning services - female contraceptives		
If your **provider** recommends a particular service or FDA-approved item based on a determination of **medical necessity**, that service or item will be covered without cost sharing, regardless of whether it is generic or brand-name. We will defer to the determination made by your **provider**. **Medical necessity** may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by your **provider**.		
Female contraceptives that are **generic prescription drugs:** • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies	

Female contraceptives that are **brand-name prescription drugs:** • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 per **prescription** or refill No **deductible** 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 tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	

If a **prescriber** prescribes a covered **brand-name prescription drug** where **a generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** is available, you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.

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General coverage provisions

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

Eligible health services that are subject to the **deductible** include **prescription drug eligible health services** provided under the medical plan **prescription drug** plan.

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

Individual
This is the amount you owe for **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 **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**. As it applies to in-network coverage, if **Aetna** compensates **network providers** on the basis of the reasonable amount, your percentage copayment is based on this amount.

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the 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 **coinsurance** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**.

Individual

Once the amount of the **coinsurance** 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 **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 **coinsurance** 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 **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members. In a family plan, an individual is responsible for satisfying only their **maximum out-of-pocket limit** before this plan pays 100% of the **recognized charge** for such covered benefits for the rest of the Calendar Year. Once two family members have individually satisfied their individual **maximum out-of-pocket limit** in a Calendar Year, the individual **maximum out-of-pocket limit** is considered met for the remaining family members for the rest of the Calendar Year.

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

- Charges, expenses or costs in excess of the **recognized charge**
- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- Certain other **eligible health services** in the schedule of benefits that are not essential health benefits

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit

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 certificate.

Outpatient prescription drug maximum out-of-pocket limits provisions

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

See *How to read your schedule of benefit, important note about your cost sharing and important notice* at the beginning of this schedule of benefit