



Retirees Choice POS II Medical Plan

Not eligible for Medicare living in the network area

Schedule of Benefits

Prepared exclusively for:

Employer	State Teachers Retirement System of Ohio (STRS Ohio)
Contract number:	ASA-351630-A
	Schedule of Benefits 3A
Plan effective date:	January 1, 2019
Plan issue date:	November 9, 2018

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

Schedule of benefits

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 a **network provider**.
 - “Out-of-network coverage”, we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and any 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 secure member website at 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*
Deductible		
You have to meet your Calendar Year deductible before this plan pays for benefits.		
Individual	\$2,500 per Calendar Year	\$5,000 per Calendar Year
Deductible waiver		
The Calendar Year in-network deductible is waived for all of the following eligible health services :		
<ul style="list-style-type: none"> • Preventive care and wellness • Family planning services - female contraceptives 		
Maximum out-of-pocket limit		
Maximum out-of-pocket limit per Calendar Year.		
Individual	\$6,500 per Calendar Year	\$13,000 per Calendar Year
Precertification covered benefit reduction		
This only applies to out-of-network coverage. The booklet contains a complete description of the precertification program. You will find details on precertification requirements in the <i>Medical necessity and precertification requirements</i> section.		
Failure to precertify your eligible health services when required will result in the following benefits reduction:		
<ul style="list-style-type: none"> • A \$200 benefit reduction will be applied separately to each type of eligible health services or • The eligible health services will not be covered. 		
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 benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Preventive care and wellness		
Routine physical exams		
Performed at a physician's, PCP office	100% per visit No deductible applies	100% (of the recognized charge) per visit No deductible 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 physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	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 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 Calendar Year	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	1 visit
Preventive care immunizations		
Performed in a facility or at a physician's office	100% per visit No deductible applies	100% (of the recognized charge) per visit No deductible 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 physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	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 secure member website at www.aetna.com or calling the number on your ID card.

*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*
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	100% (of the recognized charge) 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.	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	1 visit

Preventive screening and counseling services

Office visits <ul style="list-style-type: none"> • 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	100% (of the recognized charge) per visit No deductible applies
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Obesity and/or healthy diet counseling maximums:

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)	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)
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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 Calendar Year	5 visits	5 visits
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Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.

*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*
Use of tobacco products maximums:		
Maximum visits per Calendar Year	8 visits	8 visits
Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling maximums:		
Maximum visits per Calendar Year	2 visits	2 visits
Note: In figuring the maximum visits, each session of up to 30 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	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	100% (of the recognized charge) per visit No deductible applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> 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 secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> 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 secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening per Calendar Year	1 screening per Calendar Year
Important note:		
Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.		

*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*
Prenatal care Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% per visit No deductible applies	50% (of the recognized charge) per visit
Important note: 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.		
Comprehensive lactation support and counseling services		
Lactation counseling services – facility or office visits	100% per visit No deductible applies	50% (of the recognized charge) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits	Not applicable
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	50% (of the recognized charge) per item
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Counseling services		
Female contraceptive counseling services office visit	100% per visit No deductible applies	50% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits	Not applicable
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.		

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Eligible health services	In-network coverage*	Out-of-network coverage*
Devices		
Female contraceptive device provided, administered, or removed, by a physician during an office visit	100% per item No deductible applies	50% (of the recognized charge) per item
Female voluntary sterilization		
Inpatient	100% per admission No deductible applies	50% (of the recognized charge) per admission
Outpatient	100% per visit No deductible applies	50% (of the recognized charge) per visit
Physicians and other health professionals		
Physicians and specialists office visits (non-surgical)		
Physician services		
Office hours visits (non-surgical) non preventive care First 2 visits per Calendar Year	\$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	50% (of the recognized charge) per visit
Visits thereafter in the same Calendar Year	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy injections		
Performed at a physician's, PCP or specialist office when you do not see the physician	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy testing, treatment and injections		
Performed at a physician's, PCP or specialist office	80% (of the negotiated charge) per visit	50% (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	In-network coverage*	Out-of-network coverage*
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.	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 negotiated charge) per visit	50% (of the recognized charge) per visit
Physician surgical services		
Physicians and specialists office visits		
Performed at a physician's, PCP office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Performed at a specialist's office	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Alternatives to physician office visits		
Walk-in clinic visits		
Preventive Care Services		
Immunizations	100% per visit No deductible applies	100% (of the recognized charge) per visit No deductible 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 physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	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 secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*	Out-of-network coverage*
All non preventive care services for which cost sharing is not shown above		
All other services First 2 visits per Calendar Year	\$20 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	50% (of the recognized charge) per visit
Visits thereafter in the same Calendar Year	80% (of the negotiated charge) per visit	50% (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	In-network coverage*	Out-of-network coverage*
Hospital and other facility care		
Hospital care		
Inpatient hospital	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Home health care		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Hospice care		
Inpatient facility	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum days per lifetime	Unlimited	Unlimited
Hospice care		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Skilled nursing facility		
Inpatient facility	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum days per confinement	90	90

*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*
Emergency services and urgent care		
Emergency services		
Hospital emergency room	\$150 then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
<p>Important Note:</p> <ul style="list-style-type: none"> ▪ 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-hospital free standing facility)	\$40 then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	\$40 then the plan pays 80% (of the balance of the recognized charge) per visit thereafter
A separate urgent care deductible or copayment/payment percentage will apply for each visit to an urgent care provider .		

*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*
Specific conditions		
Autism spectrum disorder		
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
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
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other illness under this plan.		
Birth center		
Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Diabetic equipment, supplies and education		
Diabetic insulin pump equipment, pump supplies and education For diabetic testing supplies, insulin, and syringes, see separate prescription drug plan.	80% (of the negotiated charge) per item or visit	50% (of the recognized charge) per item or visit
Family planning services - other		
Voluntary sterilization for males		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Abortion		
Outpatient	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maternity and related newborn care		
Inpatient	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission

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Eligible health services	In-network coverage*	Out-of-network coverage*
Mental health treatment - inpatient		
Inpatient mental health treatment Inpatient residential treatment facility Coverage is provided under the same terms, conditions as any other illness .	80% (of the negotiated charge) per admission	50% (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 Coverage is provided under the same terms, conditions as any other illness .	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Outpatient mental health treatment office visits to a physician or behavioral health provider includes telemedicine cognitive behavioral therapy consultation	80% (of the negotiated charge) per visit	50% (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	In-network coverage*	Out-of-network coverage*
<p>Other outpatient mental health treatment (includes skilled behavioral health services in the home)</p> <p>Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)</p> <p>Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)</p>	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Substance related disorders treatment - inpatient		
<p>Inpatient substance abuse detoxification during a hospital confinement</p> <p>Inpatient substance abuse rehabilitation during a hospital confinement</p> <p>Inpatient residential treatment facility during a hospital confinement</p> <p>Coverage is provided under the same terms, conditions as any other illness.</p>	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission

*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*
Substance related disorders treatment - outpatient: detoxification and rehabilitation		
<p>Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation)</p> <p>Coverage is provided under the same terms, conditions as any other illness.</p>	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<p>Outpatient substance abuse office visits to a physician or behavioral health provider includes telemedicine cognitive behavioral therapy consultations</p> <p>Coverage is provided under the same terms, conditions as any other illness.</p>	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
<p>Other outpatient substance abuse services (includes skilled behavioral health services in the home)</p> <p>Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment)</p> <p>Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)</p>	80% (of the negotiated charge) per visit	50% (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	In-network coverage*	Out-of-network coverage*	
Obesity surgery			
Inpatient hospital (includes surgical procedure and acute hospital services)	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission	
Outpatient obesity surgery			
	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit	
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	Covered according to the type of benefit and the place where the service is received	
Reconstructive breast surgery			
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	
Reconstructive surgery and supplies			
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	
Eligible health services			
	Network (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*
Transplant services facility and non-facility			
Inpatient hospital transplant services	80% (of the negotiated charge) per transplant	50% (of the negotiated charge) per transplant	50% (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.	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*
Treatment of infertility		
Basic infertility		
Basic infertility	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
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Diagnostic lab work		
	80% (of the negotiated charge) per visit.	50% (of the recognized charge) per visit.
Diagnostic radiological services		
	80% of the negotiated charge per visit.	50% of the recognized charge per visit.
Chemotherapy		
	80% of the negotiated charge per visit.	50% of the recognized charge per visit.
Outpatient infusion therapy		
	80% of the negotiated charge per visit.	50% of the recognized charge per visit.
Outpatient radiation therapy		
Radiation therapy	80% of the negotiated charge per visit.	50% of the recognized charge per visit.
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	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	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*
Short-term rehabilitation services		
Short-term rehabilitation services (outpatient physical, occupational therapies) combined with Habilitation therapy services (outpatient physical, occupational therapies)		
	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Short-term rehabilitation services (outpatient speech therapies) combined with Habilitation therapy services (outpatient speech therapies)		
	80% (of the negotiated charge) per visit	50% (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	In-network coverage*	Out-of-network coverage*
Other services		
Acupuncture		
Acupuncture	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Ambulance service		
Ground, air or water ambulance		
Emergency	80% (of the negotiated charge) per trip	80% (of the recognized charge) per trip
Non-emergency	80% (of the negotiated charge) per trip	50% (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	Covered according to the type of benefit and the place where the service is received
Experimental or investigational treatment lifetime maximum	\$10,000	\$10,000
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	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
DME	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Prosthetic devices		
Prosthetic devices	80% (of the negotiated charge) per item	50% (of the recognized charge) per item
Maximum benefit for wigs	1 every 3 years	1 every 3 years
Spinal manipulation		
Spinal manipulation	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit

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

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
Eligible health services applied to the out-of-network deductibles will not be applied to satisfy the in-network deductibles . Eligible health services applied to the in-network deductibles will not be applied to satisfy the out-of-network deductibles .
The deductible may not apply to certain eligible health services . You must pay any applicable copayments/payment percentage for eligible health services to which the deductible does not apply.
Individual This is the amount you owe for in-network and 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.
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 not 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 not 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 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.

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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/recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

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
- Any out of pocket costs for use of the emergency room
- Any out of pocket costs incurred for use of an **urgent care provider**
- 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 be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will 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