

Schedule of Benefits

Employer: The Vanguard Group, Inc.

ASA: 697478-A

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Schedule: 3A

Booklet Base: 3

For: Choice POS II - \$1,250 Option - Retirees

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$1,250	\$1,250
Family Deductible*	\$2,500	\$2,500

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

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

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined: \$2,500.

Family Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined: \$5,000.

<i>Lifetime Maximum Benefit per person</i>	Unlimited	Unlimited
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Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Preventive Care</i>		
<i>Routine Physical Exams</i> Adults only. Includes coverage for immunizations	100% per exam No deductible applies	70% per exam after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Screening & Counseling Services</i>	100% per visit No copay or deductible applies.	70% per visit after Calendar Year deductible
<i>Office Visits</i> <i>Obesity and/or Healthy Diet</i> <i>Misuse of Alcohol and/or Drugs & Use of Tobacco Products</i> <i>Sexually Transmitted Infections</i> <i>Genetic Risk for Breast and Ovarian Cancer</i>		

Obesity and/or Healthy Diet

Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(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)*</i>	26 visits <i>(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)*</i>
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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

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.**

Use of Tobacco Products

Maximum Visits per Calendar Year	8 visits*	8 visits*
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***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Sexually Transmitted Infections Benefit Maximums

Maximum Visits per Calendar Year	2 visits*	2 visits*
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***Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

**Well Woman Preventive Visits
Office Visits**

100% per visit	70% per exam after Calendar Year deductible
No Calendar Year deductible applies.	

Well Woman Preventive Visits

Maximum Visits per Calendar Year	1 visit	1 visit
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Routine Hearing Exam

100% per exam	70% per exam after Calendar Year deductible
No deductible applies.	

Maximum exams per 24 month period	1 exam	1 exam
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PLAN FEATURES	NETWORK	OUT OF NETWORK
Hearing Aid Maximum per 36 month period	100% up to \$500 No deductible applies.	100% up to \$500 No deductible applies.
Routine Cancer Screening Outpatient	100% per visit No Calendar Year deductible applies.	70% per visit after Calendar Year deductible
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. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>	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. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>
Skin Cancer Screening Preventive screening for malignant neoplasms of the skin	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year	1 test	1 test
Lung Cancer Screening Maximum	One screening every 12 months*	One screening every 12 months*
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.		
Prenatal Care Office Visits	100% per visit No deductible applies.	70% per visit after Calendar Year deductible.
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prenatal/Child Safety Classes per 24 month period (Available to covered employees and dependents)	100% up to \$200 No deductible applies.	100% up to \$200 No deductible applies.
<i>Comprehensive Lactation Support and Counseling Services</i>		
Lactation Counseling Services <i>Facility or Office Visits</i>	100% per visit No deductible applies.	70% per visit after Calendar Year deductible.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per Calendar Year	Not Applicable
*Important Note: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
Breast Pumps & Supplies		
	100% per item. No deductible applies.	100% per item. No deductible applies.
Important Note: Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.		
<i>Family Planning Services</i>		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No or deductible applies.	70% per visit after Calendar Year deductible.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
<i>Family Planning - Other</i>		
Voluntary Termination of Pregnancy Outpatient	90% per visit after Calendar Year deductible.	70% per visit after Calendar Year deductible.
Voluntary Sterilization for Males Outpatient	90% per visit after Calendar Year deductible.	70% per visit after Calendar Year deductible.

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit	70% per visit after Calendar Year deductible.
Outpatient	No deductible applies. 100% per visit	70% per visit after Calendar Year deductible.
	No deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Family Planning Services - Female Contraceptives		
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill	70% per prescription or refill after calendar year deductible.
	No calendar year deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	90% per visit after Calendar Year deductible.	70% per visit after Calendar Year deductible
Specialist Office Visits <i>All specialists except those specifically listed in this schedule.</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Physician Office Visits-Surgery		
Physician	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Specialist	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT OF NETWORK
Walk-In Clinics Non-Emergency Visit	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Administration of Anesthesia	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

Allergy Testing and Treatment	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Allergy Injections	100% per visit No deductible applies	70% per visit after Calendar Year deductible
Immunizations when not part of the physical exam	100% per visit No deductible applies.	70% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Emergency Medical Services		
Hospital Emergency Facility	90% per visit after Calendar Year Deductible	90% per visit after Calendar Year Deductible
See Important Note Below		
<p>Important Note: Please note that as these providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance), 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. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered
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Urgent Care Services		
Urgent Medical Care (at a non-hospital free standing facility)	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Urgent Medical Care (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Non-Urgent Use of Urgent Care Provider (at a non-hospital free standing facility)	Not Covered	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Diagnostic and Preoperative Testing</i>		
<i>Diagnostic and Preoperative Testing (except complex imaging services)</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

<i>Complex Imaging Services</i>		
<i>Complex Imaging</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Diagnostic Laboratory Testing</i>		
Performed at a Hospital Outpatient Facility	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

<i>Diagnostic X-Rays</i>		
Diagnostic X-Rays (except Complex Imaging Services)	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Performed in a Physician's Office</i>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
<i>Performed at a Hospital Outpatient Facility</i>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
<i>Performed at any other Facility</i>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birthing Center</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Hospital Facility Expenses</i>		
Room and Board (including maternity)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Skilled Nursing Inpatient Facility</i>		
	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Days per Calendar Year	240 days	240 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care(Outpatient)</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Visits per Calendar Year *Visits also include 1 post natal visit and 1 visit following the release of an inpatient admission for mastectomy patients within 48 hours.	200 visits*	200 visits*
<i>Skilled Nursing Care (Outpatient)</i>	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
<i>Private Duty Nursing (Outpatient)</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Visit Limit per Calendar Year	Unlimited	Unlimited

Hospice Benefits

<i>Hospice Care –Facility Expenses</i> (Room & Board)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Hospice Outpatient Visits</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
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Maximum Benefit per lifetime (Respite Care is included however, up to a maximum of 7 days in a 6 month period.)	Unlimited	Unlimited
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Infertility Treatment

Basic Infertility Expenses

Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.

Office Visits	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Other than Office Visits	90% after Calendar Year deductible	70% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT OF NETWORK
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Comprehensive Infertility Expenses and Advanced Reproductive Technology (ART) Expenses

Office Visits	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Other than Office Visits	90% after Calendar Year deductible	70% after Calendar Year deductible

Artificial Insemination Maximum Benefit*	6 courses of treatment per lifetime*	6 courses of treatment per lifetime*
Ovulation Induction Maximum Benefit*	6 courses of treatment per lifetime*	6 courses of treatment per lifetime*
Maximum per lifetime*	\$15,000*	\$15,000*

*Does not apply toward the plan out-of-pocket limit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		
<i>Mental Disorder</i>	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible

<i>Outpatient Treatment of Mental Disorders</i>		
<i>Mental Disorder</i>	90% per visit after Calendar Year deductible	70% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Substance Abuse</i>		
<i>Inpatient Treatment</i>	90% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Outpatient Treatment of Substance Abuse</i>		
<i>Outpatient Treatment</i>	90% per visit after Calendar Year deductible	70% per procedure after Calendar Year deductible

<i>Obesity Treatment Surgical and Non Surgical</i>			
PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Outpatient Obesity Treatment (non surgical)</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Outpatient Morbid Obesity Surgery</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Transgender (Sex Change) Surgery</i>		
<i>Facility Expenses</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Physician Services</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Transplant Services Facility and Non-Facility Expenses</i>			
PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Facility Expenses</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Physician Services</i> (including office visits)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>(See Booklet for more information regarding types of treatments that are covered.)</i>		

<i>Ground, Air or Water Ambulance</i>	90% after Calendar Year deductible	90% after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Autism Spectrum Disorders</i>	90% after Calendar Year deductible	70% after Calendar Year deductible
*Maximum benefit per Calendar Year	\$36,000	\$36,000
*The maximum benefit for Autism Spectrum Disorders does not apply to Applied Behavioral Analysis.		

<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>		
<i>Office Visit (including oral surgery performed in an office)</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>All Other Covered Expenses (See Booklet for more information regarding types of treatments that are covered.)</i>	90% after Calendar Year deductible	70% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	90% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible
<i>Prosthetic Devices</i>	90% per item after the Calendar Year deductible	70% per item after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Infusion Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Radiation Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical Therapy	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Outpatient Occupational and Speech Therapy combined	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits	60 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Network Calendar Year Deductible

This is an amount of **network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Network Family Deductible Limit

When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Coinsurance

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Coinsurance”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The coinsurance may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Maximum Out-of-Pocket Limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

This plan has an Individual **Maximum Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Maximum Out-of-Pocket Limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the Family **Maximum Out-of-Pocket Limit** amount in the *Schedule of Benefits*, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** 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 **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Calendar Year **Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

Lifetime **Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A reduced coinsurance of 50% will apply separately to the eligible expenses incurred for each type or service.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.