Schedule of Benefits

Employer:	**The Vanguard Group, Inc.**
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Booklet Base:	3

For: Choice POS II - 950 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*	$950	$950
Family Deductible*	$1,900	$1,900

*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**:** $1,900.

Family Maximum Out of Pocket Limit:

- For **network** and **out of network** expenses combined**:** $3,800.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

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
Preventive Care		
Routine Physical Exams Adults only. Includes coverage for immunizations	100% per exam No **deductible** applies	70% per exam after Calendar Year **deductible**
Covered Persons through age 21: Maximum Age & Visit Limits	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.
Covered Persons ages 22 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
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **deductible** applies.	70% per visit after Calendar Year **deductible**
Obesity Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)**	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)**
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*	5 visits*

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*

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

Well Woman Preventive Visits ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	70% per exam after Calendar Year **deductible**

Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	1 visit

Routine Hearing Exam	100% per exam No **deductible** applies.	70% per exam after Calendar Year **deductible**
Maximum exams per 24 month period	1 exam	1 exam

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.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screening		
Routine Mammography	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Baseline mammogram for covered females age 35 but less than age 40.	1 baseline mammogram	1 baseline mammogram
Maximum tests per Calendar Year for females age 40 and over	1 test	1 test

Prostate Specific Antigen Test For covered males age 40 and over	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Routine Pap Smears	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
PLAN FEATURES	**NETWORK**	**OUT OF NETWORK**
Fecal Occult Blood Test	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per Calendar Year	1 test	1 test
Sigmoidoscopy Age 50 and over	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per 5 consecutive year period	1 test	1 test
Double Contrast Barium Enema (DCBE) Age 50 and over	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per 5 consecutive year period	1 test	1 test

Colonoscopy age 50 and over	100% per test No **deductible** applies.	70% per test after Calendar Year **deductible**
Maximum tests per 10 consecutive year period	1 test	1 test
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
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.
Comprehensive Lactation Support and Counseling Services **Lactation Counseling Services** *Facility or Office Visits*	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 *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps & Supplies	100% per item. No **deductible** applies.	100% per item. No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		

Family Planning Services		
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 *Physician Services* office visit section of the *Schedule of Benefits.*		
Family Planning - Other		
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 No **deductible** applies.	70% per visit after Calendar Year **deductible.**
Outpatient	100% per visit No **deductible** applies.	70% per visit after Calendar Year **deductible.**

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 No calendar year deductible applies.	70% per prescription or refill after calendar year deductible.

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 *All specialists except those specifically listed in this schedule.*	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% 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
Emergency Medical Services		
Hospital Emergency Facility	90% per visit after Calendar Year Deductible	90% per visit after Calendar Year Deductible See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (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.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered
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 *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at a non-hospital free standing facility)*	Not Covered	Not Covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing (except complex imaging services)	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
Complex Imaging Services		
Complex Imaging	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT OF NETWORK**
Diagnostic Laboratory Testing		
Performed at a Hospital Outpatient Facility	90% per procedure after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**
Diagnostic X-Rays		
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**
Outpatient Surgery		
Performed in a Physician's Office	90% per visit/surgical procedure after Calendar Year **deductible**	70% per visit/surgical procedure after Calendar Year **deductible**

Performed at a Hospital Outpatient Facility	90% per visit/surgical procedure after Calendar Year **deductible**	70% per visit/surgical procedure after Calendar Year **deductible**
Performed at any other Facility	90% per visit/surgical procedure after Calendar Year **deductible**	70% per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility Expenses		
Birthing Center	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Hospital Facility Expenses 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**
Skilled Nursing Inpatient Facility	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**
Specialty Benefits		
Home Health Care(Outpatient)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Private Duty Nursing (Outpatient)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Maximum Visit Limit per Calendar Year	Unlimited	Unlimited
Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Hospice Care – Other Expenses during a stay	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**

Hospice Outpatient Visits	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime (Respite Care is included however, up to a maximum of 7 days in a 6 month period.)	Unlimited	Unlimited

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.		
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**
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
Inpatient Treatment of Mental Disorders		
Mental Disorder	90% per admission after the Calendar Year **deductible**	70% per admission after the Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Treatment Of Mental Disorders		
Mental Disorder	90% per visit after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**

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

PLAN FEATURES	NETWORK	OUT OF NETWORK
Outpatient Treatment Of Substance Abuse		
Outpatient Treatment	90% per visit after Calendar Year **deductible**	70% per procedure after Calendar Year **deductible**

Obesity Treatment Surgical and Non Surgical			
PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Outpatient Obesity Treatment (non surgical)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery	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
Transgender (Sex Change) Surgery		
Facility Expenses	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**

Transplant Services Facility and Non-Facility Expenses			
PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Facility Expenses	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services (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
Other Covered Health Expenses		
Acupuncture *(See Booklet for more information regarding types of treatments that are covered.)*	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	90% after Calendar Year **deductible**	90% after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorders	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.		

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Infusion Therapy	90% per visit after Calendar Year **deductible**	70% per visit after Calendar Year **deductible**
Radiation Therapy	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.