



PLAN DESIGN

Customer Name: THE CHURCHILL BENEFIT CORP.

Proposed Effective Date: 06-01-2010

Policy Period: 12

Option: HIGH SOLD WITH PLAN CHANGES

Plan: Managed Choice Open Access Plan

Location(s): Connecticut



**PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY**

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$750 Individual \$1,500 Family	\$1,000 Individual \$2,000 Family
All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	10%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$1,500 Individual \$3,000 Family	\$2,000 Individual \$4,000 Family
All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	\$5,000,000	
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$500 or 50% of the scheduled benefit amount per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 18 and older.	\$30 office visit copay; deductible waived	30%
Routine Well Child Exams/Immunizations 9 exams 1 st 24 months of life, 1 exam per year thereafter	\$30 office visit copay; deductible waived	30%
Routine Gynecological Care Exams Includes routine tests and related lab fees.	\$40 office visit copay; deductible waived	30%
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	\$40 copay; deductible waived	30%
Routine Digital Rectal Exam For covered males age 40 and over.	Covered same as PCP office visit cost sharing; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Prostate-specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered



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Colorectal Cancer Screening	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
For all members age 50 and over.		
Routine Eye Exams 1 routine exam per 24 months.	\$40 copay; deductible waived	30%; after deductible
Routine Hearing Exams 1 routine exam per 24 months.	\$40 office visit copay; deductible waived	30%; after deductible
Hearing Aids Covered for children twelve years of age or younger. Limited to \$1,000 within a 24 month period.	10%	30%; after deductible
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	\$30 copay; deductible waived	30%; after deductible
Specialist Office Visits	\$40 copay; deductible waived	30%; after deductible
E-visit to PCP	\$30 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
E-visit to Specialist	\$40 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
Walk-in Clinics	\$30 office visit copay; deductible waived	30%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Outpatient Complex Imaging	Covered 100%; after deductible	30%; after deductible
	Member copays will not exceed \$375 in a calendar year for all complex imaging services.	



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EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	\$50 copay; deductible waived	30%; after deductible
Emergency Room	\$75 copay; deductible waived	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	30%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	10%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10% per admission; after deductible	30% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	\$40 copay; deductible waived	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. All Mental Health and Alcohol/Drug day and visit limits are combined.		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10% per admission; after deductible	30% per admission; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Outpatient	\$40 per visit copay; deductible waived	30% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	10%; after deductible	30%; after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10%; deductible waived	20%; after deductible
Limited to 120 visits per calendar year. Includes medical social services up to \$200 per calendar year for terminally ill individuals. visits per calendar year. Includes medical social services up to \$200 per calendar year for terminally ill individuals. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
Up to a maximum benefit of \$5,000. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Treatment of Autism	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Habilitative Services for the treatment of autism.		



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Outpatient Short-Term Rehabilitation	\$40 copay; deductible waived	30%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 30 visits per calendar year.		
Early Intervention Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Children from birth to age 3; maximum of \$5,000 per child per calendar year.		
Spinal Manipulation Therapy	\$40 copay; deductible waived	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING		
	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	10%; after deductible	30%; after deductible
Coverage includes Artificial Insemination, limited to 3 courses per lifetime, and Ovulation Induction, limited to 4 courses per lifetime. For covered females under age 40 only.		
Advanced Reproductive Technology (ART)	10%; after deductible	30%; after deductible
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Voluntary Sterilization	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Including tubal ligation and vasectomy.		



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PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Retail	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost after the applicable preferred copay
Mail Order	\$30 copay for generic drugs, \$50 copay for formulary brand-name drugs, and \$80 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery [®] .	Not Applicable
Self-Injectables	20% for formulary and non-formulary drugs	Not Covered

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

Precert for growth hormones included. Expanded Precert included.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Pre-existing Conditions Exclusion On effective date: Waived
After effective date: Full postponement

This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 150 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.



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See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical or hospital services not specifically covered in, or which are limited or excluded by your plan documents;
- Cosmetic surgery, including breast reduction;
- Custodial care;
- Dental care and dental X-rays;
- Donor egg retrieval;
- Durable medical equipment;
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial;
- Hearing aids;
- Home births;
- Immunizations for travel or work except where medically necessary or indicated;
- Implantable drugs and certain injectible infertility drugs;
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
- Long-term rehabilitation therapy;
- Nonmedically necessary services or supplies;
- Orthotics except diabetic orthotics;
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies;
- Radial keratotomy or related procedures;
- Reversal of sterilization;
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling or prescription drugs;
- Special duty nursing;
- Therapy or rehabilitation other than those listed as covered;
- Treatment of behavioral disorders;
- Weight control services including surgical procedure, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.



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Open Access[®] Managed Choice[®] POS - Connecticut

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Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862)**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.

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