



PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$3,500 Individual \$7,000 Family	\$4,000 Individual \$8,000 Family
All covered expenses including prescription drugs accumulate toward both the preferred and 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. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance	20%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$4,500 Individual \$9,000 Family	\$5,500 Individual \$11,000 Family
All covered expenses including deductible and prescription drugs accumulate toward both the preferred and non-preferred. 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, deductibles, and prescription drug copays (except any 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. There is no Individual Payment Limit to satisfy within the Family Payment Limit.		
Lifetime Maximum		\$2,000,000
Unlimited except where otherwise indicated		
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 age 18 and over.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.	Covered 100%; deductible waived	Not Covered
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%; deductible waived	Not Covered
Routine Mammograms One baseline mammogram for covered females age 35-39; one mammogram per calendar year age 40 and over.	Covered 100%; deductible waived	40%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	40% after deductible
Routine Eye Exams 1 routine exam per 24 months	Covered 100%; deductible waived	Not Covered
Routine Hearing Exams 1 routine exam per 24 months	Covered 100%; deductible waived	Not Covered
Hearing Aids Covered for children twelve years of age or younger. Limited to \$1,000 within a 24 month period.	20% after deductible	40% after deductible
Office Visits to member's selected PCP	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible



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Includes services of an internist, general physician, family practitioner or pediatrician, if the physician is not the member's selected PCP.

Allergy Testing	Covered as either PCP or specialist office visit after deductible	40% after deductible
Allergy Injections	Member cost sharing is based on the	Member cost sharing is based on the t
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray except for Complex Imaging Services	20% after deductible	40% after deductible
Diagnostic X-ray for Complex Imaging Services	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20% after deductible	40% 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	Covered same as Inpatient Hospital services; after deductible	Covered same as Inpatient Hospital services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	Covered same as Specialist Office visit; after deductible	Covered same as Specialist Office visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Residential Treatment Facility	Covered the same as Inpatient Mental Health after deductible	Covered the same as Inpatient Mental Health after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	Covered same as Inpatient Hospital services; after deductible	Covered same as Inpatient Hospital services; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	Covered same as Specialist Office visit; after deductible	Covered same as Specialist Office 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	20% after deductible	40% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20%; deductible waived	25%; deductible waived
Limited to 120 visits per calendar year. Includes Medical Social Services up to \$200 per calendar year for terminally ill individuals.		



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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	20% after deductible	40% after deductible
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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	20% after deductible	40% after deductible
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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	Not Covered	Not Covered
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Treatment of Autism	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
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Habilitative Services for the treatment of autism.

Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
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Includes Speech, Physical, and Occupational Therapy, limited to 60 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; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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Children from birth to age 3; maximum of \$6,400 per child per calendar year. Lifetime maximum of \$19,200.

Spinal Manipulation Therapy	Covered same as any other medical expense after deductible	Covered same as any other medical expense after deductible
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Durable Medical Equipment	20% after deductible	40% after deductible
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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense; after deductible	Covered same as any other medical expense; after deductible
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Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense) after deductible	40% (payable as any other covered expense) after deductible
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Transplants	20% Preferred coverage is provided at an IOE contracted facility only; after deductible	40% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
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Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	
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FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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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
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Diagnosis and treatment of the underlying medical condition.

Comprehensive Infertility Services	20% after deductible	40% after deductible
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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)	20% after deductible	40% after deductible
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ART coverage includes 2 cycles with not more than 2 embryos per cycle of In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), and gamete intrafallopian transfer (GIFT), combined, per lifetime. For covered females under age 40 only.

Maximum applies to all procedures covered by any Aetna plan except where prohibited by law.

Voluntary Sterilization	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
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PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
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The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.

Retail	Covered 100% after combined medical/Rx plan deductible and \$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	40% combined medical/Rx plan deductible and f submitted cost for all drugs up to a 30 day supply.
Mail Order	Covered 100% after combined medical/Rx plan deductible and \$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

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

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

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.



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***You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.**

Aetna pays a percentage of the recognized charge, as defined in Your plan. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

The recognized charge for out-of-network doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them. For out-of-network hospitals and other out-of-network facilities, Aetna pays a percentage as defined in Your plan of the "reasonable" charge as determined by Aetna. Note that any amount the doctor bills You above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

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. 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.



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- All medical and 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 drugs including 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.
- Non-medically 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 procedures, 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.

If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).

Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

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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