



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	None	Individual	\$1,000	Individual
	None	Family	\$2,000	Family

All covered expenses 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	Covered 100%	30%
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Applies to all expenses unless otherwise stated.

Payment Limit (per calendar year)	\$1,500	Individual	\$4,000	Individual
	\$3,000	Family	\$8,000	Family

All covered expenses 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, deductibles, and 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.

Lifetime Maximum	Unlimited except where otherwise indicated.
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Payment for Non-Preferred*	Not Applicable	Recognized Charge*
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*You may choose providers in Aetna's network (physicians and facilities) or you 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 hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

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.

Primary Care Physician Selection	Optional	Not applicable
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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 \$400 per occurrence.

Referral Requirement	None	None
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PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
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Routine Adult Physical Exams/	Covered 100%	Covered 100%
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Immunizations

1 exam every 24 months age 22 - 65 and 1 exam every 12 months age 65 and over.

Routine Well Child Exams/Immunizations	Covered 100%	Covered 100%; deductible waived
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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 22.



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Includes coverage for blood lead level screenings.

Routine Gynecological Care Exams	Covered 100%	30% after deductible
Includes routine tests and related lab fees.		

Routine Mammograms	Covered 100%	30% after deductible
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Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%	30% after deductible
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Colorectal Cancer Screening	Covered 100%	30% after deductible
For all members age 50 and over.		

Routine Eye Exams 1 routine exam per 24 months	Covered 100% after \$30 office visit copay	Not Covered
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Routine Hearing Screening 1 routine exam per 24 months	Covered 100% after \$30 office visit copay	Covered 100%
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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Office Visits to PCP	Covered 100% after \$25 office visit copay	30% after deductible
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Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits	Covered 100% after \$30 office visit copay	30% after deductible
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Allergy Testing	Covered as either PCP or specialist office visit	30% after deductible
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Allergy Injections	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
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DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
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Diagnostic Laboratory and X-ray	Covered 100%	30% after deductible
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		

EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Urgent Care Provider (benefit availability may vary by location)	Covered 100% after \$30 copay	30% after deductible
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Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
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Emergency Room	Covered 100% after \$50 copay	Same as preferred care; after deductible
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Non-Emergency care in an Emergency Room	Not Covered	Not Covered
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Ambulance	Covered 100%; \$50 per trip copay	30% after deductible
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Non-Emergency use of Ambulance	Not Covered	Not Covered
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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient Coverage	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		

Inpatient Maternity Coverage	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		

Outpatient Hospital Expenses (including surgery)	Covered 100%	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
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Inpatient Non-Biologically Based	Covered 100%	30% after deductible
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Limited to 35 days per calendar year.

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay



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Outpatient Non-Biologically Based	Covered 100%	30% after deductible
Limited to 52 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Inpatient Biologically Based	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Biologically Based	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Crisis Intervention Services	Covered 100% after \$30 office visit copay	30% after deductible
Up to 3 visits per calendar year Maximums are combined limit for preferred and non-preferred services.		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	Covered 100%	30% after deductible
Limited to 30 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	Covered 100% after \$30 copay	30% after deductible
Limited to 60 visits per calendar year, of which 20 visits may be used for family counseling The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Maximum are combined limit for preferred and non-preferred services.		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	Covered 100%	30% after deductible
For the first 40 visits, each 4 hours of home health aide services equals one visit; after the first 40 visits, each visit of up to 4 hours is equal to one visit. Each visit by a nurse or therapist is one visit. In the event of early discharge for maternity confinement, i.e. prior to 48 hours for normal delivery, 96 hours for cesarean section, one Home Health Care visit will be covered. This visit is not subject to copays, deductibles, or coinsurance and does not reduce the Home Health Care maximum.		
Hospice Care - Inpatient	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	Covered 100%	30% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	Covered 100% after \$30 copay	30% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
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; after deductible
Covered on the same basis and to the same extent as other neurological disorders covered under the plan.		
Outpatient Short-Term Rehabilitation	Covered 100% after \$30 copay	30% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	Covered 100%	30% after deductible
Durable Medical Equipment	Covered 100%	30% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as PCP office visit cost sharing.	30% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100% after \$30 copay (payable as any other covered expense)	30% (payable as any other covered expense) after deductible



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Transplants	Covered 100% Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Bariatric	Covered 100%	30% after deductible
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	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	Covered 100%, ART is not covered.	30% after deductible
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.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26	
Pre-existing Conditions Exclusion	Does not apply	

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.

- 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 injectable drugs including injectable 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.



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- 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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