



PLAN DESIGN AND BENEFITS

PROVIDED BY AETNA LIFE INSURANCE COMPANY - INSURED

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family
All covered expenses accumulate simultaneously 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.		
Member Coinsurance	20%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$2,000 Individual \$4,000 Family	\$3,000 Individual \$6,000 Family
All covered expenses accumulate simultaneously toward both the preferred and 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, copays, 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	\$2,000,000 per member's lifetime.	
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 \$400 per occurrence. Precertification for certain procedures/treatment - excluded amount is \$200 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	\$35 office visit copay; deductible waived	50%
1 exam every 24 months age 18 - 65 and 1 exam every 12 months age 65 and over.		
Routine Well Child Exams/Immunizations	\$35 office visit copay; deductible waived	50%
7 exams the first 12 months of life, 3 exams the 13th - 36th month of life, 1 exam every 12 months thereafter to age 18.		
Routine Gynecological Care Exams	\$50 office visit copay; deductible waived	50%
Includes routine tests and related lab fees		
Routine Mammograms	Covered 100%; deductible waived	50%
One baseline mammogram for females age 35-39, and one annual mammogram for females age 40 and over.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	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
For covered males age 40 and over.		
Colorectal Cancer Screening	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
For all members age 50 and over.		
Routine Eye Exams	\$50 office visit copay	50%
1 routine exam per 12 months		
Routine Hearing Exams	\$50 office visit copay	50%
1 routine exam per 24 months		
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE



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Office Visits to member's selected PCP	\$35 office visit copay; deductible waived	50%
Specialist Office Visits	\$50 office visit copay; deductible waived	50%
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; deductible waived	50%
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
DIAGNOSTIC PROCEDURES		
Diagnostic Laboratory and X-ray	PREFERRED CARE	NON-PREFERRED CARE
	20%	50%
EMERGENCY MEDICAL CARE		
Urgent Care Provider	PREFERRED CARE	NON-PREFERRED CARE
(benefit availability may vary by location)	\$75 copay; deductible waived	50%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%	50%
HOSPITAL CARE		
Inpatient Coverage	PREFERRED CARE	NON-PREFERRED CARE
	20%	50% after \$250 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	50% after \$250 per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20%	50%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES		
Inpatient	PREFERRED CARE	NON-PREFERRED CARE
	20%	50% after \$250 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$50 copay	50%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES		
Inpatient	PREFERRED CARE	NON-PREFERRED CARE
	20%	50% after \$250 per confinement deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	\$50 copay	50%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES		
Convalescent Facility	PREFERRED CARE	NON-PREFERRED CARE
Limited to 90 days per calendar year.	20%	50%
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	Covered 100%	50%
Limited to 100 visits per calendar year.		
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%	50%
Limited to 30 days per lifetime.		



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

Hospice Care - Outpatient	20%	50%
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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 - Outpatient (Limited to 70 eight hour shifts per calendar year)	20%	50%
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Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.

Outpatient Short-Term Rehabilitation	\$50 copay	50%
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Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.

Spinal Manipulation Therapy	\$50 copay	50%
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Unlimited visits per calendar year

Durable Medical Equipment	20%	50%
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Maximum annual benefit of \$2,500 per member per calendar year

Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
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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)	50% (payable as any other covered expense)
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Vision Eyewear	100% up to \$200 every 12 months.	Same as preferred care.
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Transplants	20%	50%
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If procedure is performed through an Institute of Excellence® facility benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence® facility benefits would be paid at the non-preferred level.

Preferred coverage is provided at an IOE contracted facility only. Non-preferred coverage is provided at a non-IOE facility.

Certain dental procedures for minors 8 years of age and younger or severely disabled are covered. Please see plan documents for details.

Out of Area Dependents	20% member coinsurance, all benefits and limitations apply.	
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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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
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Diagnosis and treatment of the underlying medical condition.

Comprehensive Infertility Services	20%	50%
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Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime). Lifetime 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	Member cost sharing is based on the type of service performed and the place of service where it is rendered
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Including tubal ligation and vasectomy

PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
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Retail	\$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name drugs up to a 30 day supply at participating	50% of submitted cost after \$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name drugs up to a 30 day supply.
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Mail Order	\$30 copay for generic drugs, \$70 copay for formulary brand-name drugs, and \$120 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable
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Pharmacy Managed Self Injectables (PMSI)
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

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 fertility drugs, Diabetic supplies.
Precert for growth hormones included

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 19 or to age 24 if in school.

Pre-existing Conditions Exclusion On effective date: Full Postponement
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 90 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. 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. 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 drug.
- 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.

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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