



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

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$750 Individual \$2,250 Family	\$750 Individual \$2,250 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%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$2,500 Individual \$7,500 Family	\$5,000 Individual \$15,000 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		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Not applicable	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.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	\$20 office visit copay; deductible waived	40%
1 exam every 24 months age 18 - 65 and 1 exam every 12 months age 65 and over.		
Routine Well Child Exams/ Immunizations	\$20 office visit copay; deductible waived	40%
7 exams in the first 12 months of life, 2 exams in the 13th - 24th month of life, 1 exam per calendar year thereafter to age 18.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40%
One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	40%
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	\$20 office visit copay	40%
1 routine exam per 24 months		
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist (non-surgical)	\$20 office visit copay; deductible waived	40%
Includes services of an internist, general physician, family practitioner or pediatrician.		



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Specialist Office Visits (non-surgical) includes	\$20 office visit copay; deductible	40%
Acupuncture	waived	
Office Visits for Surgery	20%	40%
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	40%
Allergy Injections	20%	40%
DIAGNOSTIC PROCEDURES		
	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	20%	40%
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
Urgent Care Provider (benefit availability may vary by location)	20% after \$50 copay; deductible waived	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after \$100 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	50%	50%
Ambulance	20%	40%
HOSPITAL CARE		
	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20%	40%
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	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20%	40%
Includes licensed Community Health Centers		
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES		
	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	20%	40%
Includes hospitals, psychiatric hospitals, and psychiatric treatment facilities		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20%	40%
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%	40%
Limited to 60 days per calendar year.		
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20%	40%
Limited to 120 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%	40%
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%	40%
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%	40%
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Outpatient Short-Term Rehabilitation	20%	40%
Includes speech, physical, and occupational therapy, limited to 60 visits per calendar year.		

Chiropractic and Naturopaths	20%, ded waived	20%, ded waived
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Durable Medical Equipment	20%	40%
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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)	40% (payable as any other covered expense)
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Vision Eyewear	100% up to \$100 every 24 months.	Same as preferred care.
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Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
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"Other" Health Care – 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred"

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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Infertility Treatment Diagnosis and treatment of the underlying medical condition.	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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Voluntary Sterilization Including tubal ligation and vasectomy	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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PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
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Retail	\$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply at participating	40% of submitted cost after \$15 copay for generic drugs, \$35 copay for formulary brand-name drugs, and \$50 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 \$100 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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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 26.
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Pre-existing Conditions Exclusion	On effective date: Waived (on 10/1/08) After effective date: Full Postponement (after 10/1/08)
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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.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and



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Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

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