

PLAN DESIGN AND BENEFITS - NY Indemnity 1-10/10*

PLAN FEATURES		MEMBER COST SHARE	
Deductible (per calendar year)		\$2,500 Individual \$7,500 Family	
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, including member cost sharing for prescription drugs, as indicated in the plan, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.			
Member Coinsurance Applies to all expenses unless otherwise stated		20% after deductible	
Maximum Out-of-Pocket Limit (per calendar year, includes deductible)		\$5,000 Individual \$15,000 Family	
Certain member cost sharing elements may not apply toward the Maximum Out-of-Pocket Limit. Only those expenses resulting from the application of deductible and coinsurance percentage (not including any penalty amounts) may be used to satisfy the Maximum Out-of-Pocket Limit. Once the Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year. Members must continue to pay any prescription drug copays and penalty amounts after meeting their Out-of-Pocket Maximum.			
Lifetime Maximum (per member lifetime)		Unlimited	
Provider Payment		Usual & Customary**	
Primary Care Physician Selection		Not applicable	
Certification Requirements - Certification for certain types of 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, and Hospice Care is required. Benefits will be reduced by \$400 per occurrence if Certification is not obtained.			
Referral Requirement		None	
PHYSICIAN SERVICES		MEMBER COST SHARE	
Office Visits to Primary Care Physician Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury		20% after deductible	
Specialist Office Visits		20% after deductible	
Maternity OB Visits		20% after deductible	
Surgery (in office)		20% after deductible	
Allergy Testing (given by a physician)		20% after deductible	
Allergy Injections (not given by a physician)		20% after deductible	

** Payment for care is determined based upon the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as "reasonable" or "recognized" charges.

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PREVENTIVE CARE	MEMBER COST SHARE
Routine Adult Physical Exams / Immunizations 1 exam every 12 months ages 19 and over	0%; deductible waived
Well Child Exams / Immunizations 7 exams in the first 12 months of life; 3 visits in the second 12 months of life; 3 visits in the third 12 months of life; 1 exam per year thereafter to age 19	0%; deductible waived
Routine Gynecological Care Exams Two routine exams per calendar year	0%; deductible waived
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over	0%; deductible waived
Routine Digital Rectal Exam / Prostate Specific Antigen Test 1 exam per calendar year for men with prior history, 1 exam per calendar year age 50 and over if asymptomatic, 1 exam per calendar year ages 40 and over if family history or other risk factor	0%; deductible waived
Routine Colorectal Cancer Screening Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over Colonoscopy - 1 every 10 years for all members age 50 and over Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over	0%; deductible waived
Routine Eye Exams at Specialist One routine exam every 24 months	0%; deductible waived
Routine Hearing Exams	Not covered
DIAGNOSTIC PROCEDURES	MEMBER COST SHARE
Outpatient Diagnostic Laboratory and X-ray including Complex Imaging Services If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	20% after deductible
EMERGENCY MEDICAL CARE	MEMBER COST SHARE
Urgent Care Provider	20% after deductible
Non-Urgent use of Urgent Care Provider	Not covered
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	Not covered
Emergency Ambulance	20% after deductible

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HOSPITAL CARE	MEMBER COST SHARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants	20% after deductible
Outpatient Surgery	20% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, dialysis, radiation therapy and infusion therapy	20% after deductible
MENTAL HEALTH SERVICES	MEMBER COST SHARE
Inpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited days per member per calendar year	20% after deductible
Outpatient Biologically Based Mental Illness and Children with Serious Emotional Disturbances Unlimited visits per member per calendar year	20% after deductible
Inpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 30 days per member per calendar year	20% after deductible
Outpatient Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances Limited to 20 visits per member per calendar year	20% after deductible
ALCOHOL / DRUG ABUSE SERVICES	MEMBER COST SHARE
Inpatient Detoxification Limited to 7 days per member per calendar year	20% after deductible
Outpatient Detoxification Limited to 60 visits per member per calendar year, including 20 visits per calendar year for family counseling	20% after deductible
Inpatient Rehabilitation Limited to 30 days per member per calendar year	20% after deductible
Outpatient Detoxification Limited to 60 visits per member per calendar year, including 20 visits per calendar year for family counseling	20% after deductible
OTHER SERVICES	MEMBER COST SHARE
Skilled Nursing Facility Limited to 60 days per member per calendar year	20% after deductible
Home Health Care Limited to 40 visits per member per calendar year; Limited to 3 intermittent visits per day by a Home Health Care agency, 1 visit equals a period of 4 hours or less	25% after deductible
Inpatient Hospice Care	20% after deductible
Outpatient Hospice Care	20% after deductible
Private Duty Nursing - Outpatient	Not covered

PLAN DESIGN AND BENEFITS - NY Indemnity 1-10/10*

OTHER SERVICES, cont.		MEMBER COST SHARE
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy Limited to 30 combined visits per member per calendar year		20% after deductible
Spinal Manipulation Therapy (Chiropractic)		20% after deductible
Durable Medical Equipment Maximum benefit of \$1,500 per member per calendar year		50% after deductible
Diabetic Drugs and Supplies obtainable at a pharmacy Including, but not limited to, insulin, test strips, lancets and syringes		20% after deductible
Diabetic Supplies not obtainable at a pharmacy Including, but not limited to, insulin pumps and insulin pump supplies		20% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy Includes coverage for contraceptive visits		20% after deductible
Glasses and Contact Lens Reimbursement		\$100 per member every 24 months
FAMILY PLANNING		MEMBER COST SHARE
Infertility Treatment Coverage only for the diagnosis and treatment of the underlying medical condition		Member cost sharing is based on the type of service performed and the place of service rendered
Comprehensive Infertility Services		Member cost sharing is based on the type of service performed and the place rendered
Voluntary Sterilization Including tubal ligation and vasectomy		Member cost sharing is based on the type of service performed and the place rendered
PHARMACY - PRESCRIPTION DRUG BENEFITS		MEMBER COST SHARE
Retail Up to a 30-day supply		\$15 copay for generic drugs, \$35 copay for brand name formulary drugs, and \$70 copay for brand name non-formulary drugs
Mail Order 31-90 day supply		\$30 copay for generic drugs, \$70 copay for brand name formulary drugs, and \$140 copay for brand name non-formulary drugs
Specialty CareRx - First Prescription for a specialty drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy		
Precert and Step Therapy included and 90 day Transition of Care (TOC) for Precertification and Step Therapy included		

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* This medical plan is available only to employees that reside outside an Aetna network service area.

What's Not Covered

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.**

- 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, other than reconstructive surgery following a mastectomy;
- Custodial care;
- Dental care and x-rays, other than treatment of sound teeth due to an accidental injury within 12 months following the injury or care needed to repair congenital defects or anomalies;
- Donor egg retrieval;
- Experimental and investigational procedures, except in connection with certain types of clinical trials;
- Hearing aids;
- 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, counseling and prescription drugs, unless medically necessary;
- Treatment of those services for or related to treatment of obesity or for diet or weight control, unless medically necessary.

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might 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 or treatment was recommended or received or for which the individual took prescribed drugs within 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months 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 credible coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

PLAN DESIGN AND BENEFITS - NY Indemnity 1-10/10*

If you had no prior creditable coverage within 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 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 your Aetna Member Services representative at 1-800-80-AETNA 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 under the age of 19. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, 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.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. 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. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

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

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to

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