PLAN DESIGN AND BENEFITS- MC $1,000 80/60 (10/10)

PLAN FEATURES	NETWORK CARE	OUT-OF-NETWORK CARE
Deductible (per calendar year)	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the preferred and non-preferred 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. No one family member can contribute more than the Individual Deductible amount to the Family Deductible.		
Plan Coinsurance (applies to all expenses unless otherwise stated)	80%	60%
Payment Limit (per calendar year, excludes deductible)	$2,000 Individual $6,000 Family	$4,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit: Deductible, amounts exceeding the recognized charge, copays, payment for failure to pre-certify for certain out-of-network services, durable medical equipment, mental health services and substance abuse services (with the exception of substance abuse related to alcohol). Once the Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. No one family member can contribute more than the Individual Payment Limit amount to the Family Payment Limit.		
Lifetime Maximum	Unlimited	
Payment for Non-Preferred Care	Not applicable	Professional: Aetna Market Fee Schedule Facility: Aetna Facility Fee Schedule*
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, and Hospice Care is required. Benefits will be reduced by $1000 or 50%, whichever is less per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Office Visits to Non-Specialist (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)	$30 copay, deductible waived	60%, after deductible
E-visit (register at www.relayhealth.com)	$10 copay, deductible waived	60%, after deductible
Walk-In-Clinics	$30 copay, deductible waived	60%, after deductible
Specialist Office Visits	$50 copay, deductible waived	60%, after deductible
Maternity OB Visits	80%, after deductible	60%, after deductible
Surgery (in office)	$50 copay, deductible waived	60%, after deductible
Allergy Testing (given by a physician)	$50 copay, deductible waived	60%, after deductible
Allergy Injections (not given by a physician)	$5 copay if no office visit is billed, deductible waived	60%, after deductible
PREVENTIVE CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months (includes immunizations); Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible

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PREVENTIVE CARE (CONTINUED)	NETWORK CARE	OUT-OF-NETWORK CARE
Well Child Exams/Immunizations 7 exams in first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams in 25th to 36th months of life, 1 exam every 12 months of life thereafter up to age 18 (includes immunizations); Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One exam per calendar year; Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Mammograms One baseline mammogram for covered females age 35-39 and one per calendar year for covered females age 40 and above; Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over; Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies. Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Eye Exams at Specialist One routine exam per 24 months; Preferred and Non-Preferred combined	$0 copay, deductible waived	60%, after deductible
Routine Hearing Exams	Not Covered	Not Covered
DIAGNOSTIC PROCEDURES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Outpatient Diagnostic Laboratory 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.	$30 copay, deductible waived	60%, after deductible
Outpatient Diagnostic X-ray (except for 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.	80%, after deductible	60%, after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	80%, after deductible	60%, after deductible

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EMERGENCY MEDICAL CARE	NETWORK CARE	OUT-OF-NETWORK CARE
Urgent Care Provider	$50 copay, deductible waived	60%, after deductible
Non-Urgent Use of Urgent Care Provider	50% after deductible or $1000 whichever less	50% after deductible or $1000 whichever less
Emergency Room Copay waived if admitted	$150 copay, deductible waived	Paid as Preferred Care.
Non-Emergency care in an Emergency Room	50% after deductible or $1000 whichever less	50% after deductible or $1000 whichever less
Emergency Ambulance	80%, after deductible	Paid as Preferred Care.
Non-Emergency Ambulance	80%, after deductible	60%, after deductible
HOSPITAL CARE	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) & transplants. If transplant 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.	80%, after deductible	60%, after deductible
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	80%, after deductible	60%, after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, and radiation therapy.	80%, after deductible	60%, after deductible
MENTAL HEALTH SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Mental Illness Limited to 30 days per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Outpatient Mental Illness Limited to 20 visits per member per calendar year Preferred and Non-Preferred combined	$50 copay, deductible waived	60%, after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Inpatient Detoxification	80%, after deductible	60%, after deductible
Outpatient Detoxification Limited to 2 visits per lifetime Preferred and Non-Preferred combined	$50 copay, deductible waived	60%, after deductible
Inpatient Alcohol Rehabilitation	80%, after deductible	60%, after deductible
Inpatient Drug Rehabilitation Limited to 20 days per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Outpatient Rehabilitation Limited to 30 visits per member per calendar year Preferred and Non-Preferred combined	$50 copay, deductible waived	60%, after deductible

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OTHER SERVICES AND PLAN DETAILS	NETWORK CARE	OUT-OF-NETWORK CARE
Skilled Nursing Facility Limited to 60 days per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Home Health Care Limited to 60 visits per member per calendar year Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less.	80%, after deductible	60%, after deductible
Infusion Therapy Provided in the home or physician's office	$50 copay, deductible waived	60%, after deductible Aetna pays up to $50 per visit after deductible
Infusion Therapy Provided in an outpatient hospital department of freestanding facility	80%, after deductible	60%, after deductible Aetna pays up to $50 per visit after deductible
Inpatient Hospice Care	80%, after deductible	60%, after deductible
Outpatient Hospice Care	$50 copay, deductible waived	60%, after deductible
Outpatient Speech Therapy Limited to 12 visits per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Outpatient Physical/Occupational Therapy and Spinal Manipulation Therapy (Chiropractic) Limited to 40 visits per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Durable Medical Equipment Maximum benefit of $2,000 per member per calendar year Preferred and Non-Preferred combined	80%, after deductible	60%, after deductible
Diabetic Supplies not obtainable at a pharmacy	Covered same as any other medical expense	Covered same as any other medical expense
FAMILY PLANNING	**NETWORK CARE**	**OUT-OF-NETWORK CARE**
Infertility Treatment Covered 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 rendered.	60%, after deductible
Comprehensive Infertility Services Services and supplies are only covered for groups with 26 or more eligible	Member cost sharing is based on the type of service performed and the place rendered.	60%, after deductible
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Services and supplies are only covered for groups with 26 or more eligible	Member cost sharing is based on the type of service performed and the place rendered	60%, after deductible

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FAMILY PLANNING (CONTINUED)	NETWORK CARE	OUT-OF-NETWORK CARE
Voluntary Sterilization Including tubal ligation and vasectomy.	80%, after deductible	60%, after deductible
PHARMACY-PRESCRIPTION DRUG BENEFITS	**PARTICIPATING PHARMACIES**	**NON-PARTICIPATING PHARMACIES**
Retail Up to a 30-day supply	$10 copay for generic drugs, $40 copay for brand name formulary drugs, and $65 copay for brand name non-formulary drugs	70% of submitted cost after $10 copay for generic drugs, $40 copay for brand name formulary drugs, and $65 copay for brand name non-formulary drugs
Mail Order Delivery 31-90 day supply	$20 copay for generic drugs, $80 copay for brand name formulary drugs, and $130 copay for brand name non-formulary drugs	Not Covered
Specialty CareRx - First Prescription for a self-injectable drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.		

Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a 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 and diabetic supplies obtainable from a pharmacy. Plan excludes: lifestyle/performance drugs
Precertification included and 90 day Transition of Care (TOC) for Precertification included

*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.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network doctors contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule. 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.

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.

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• 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*
• Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.

• 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;
• Special duty nursing; and
• 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.

*This exclusion only applies to groups with 25 or fewer eligibles and includes injectable infertility drugs. Services and supplies are covered for groups with 26 or more eligibles.

Pre-existing Conditions Exclusion Provision

For members age 19 or over 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, 6 months 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 less than 12 months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

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 days 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 1-888-802-3862 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.

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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 heath 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.

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. Precertification requirements may vary.

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 www.aetna.com.