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 form the application of deductible and coinsurance percentage (except 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.	
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
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

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

PREVENTIVE CARE, cont.	MEMBER COST SHARE
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
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, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy and infusion therapy	20% after deductible

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

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; 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
Outpatient Short-Term Rehabilitation Includes speech, physical and occupational therapy If provided in the outpatient hospital department, paid under the outpatient hospital benefit Limited to 30 combined visits per member per calendar year	20% after deductible
Spinal Manipulation Therapy (Chiropractic) If provided in the outpatient hospital department, paid under the outpatient hospital benefit	20% after deductible
Durable Medical Equipment Maximum benefit of $1,500 per member per calendar year	50% after deductible

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

OTHER SERVICES, cont.	MEMBER COST SHARE
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 *Note: Some Diabetic Supplies not obtainable at a pharmacy, such as Insulin Pumps, Insulin Pump Supplies, and others, are covered under the Durable Medical Equipment benefit detailed above.*	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
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	

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

** 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.

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

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 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.

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 manufactures 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