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PLAN FEATURES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the Network and Non-Network 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 may contribute more than the Individual Deductible amount to the Family Deductible. Deductible credit applies. Deductible Carryover does not apply.		
Plan Coinsurance*	80%	60%
Maximum Out-of-Pocket (per calendar year, includes deductible)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the Network and Non-Network Maximum Out-of-Pocket. Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket amount to the Family Maximum Out-of-Pocket.		
Lifetime Maximum	Unlimited	Plans Effective Prior to 10/1/10: $5,000,000 Plans Effective on or after 10/1/10: Unlimited
Payment for Services from a Non-Network Provider	Not Applicable	Allowed Charges**
Primary Care Physician Selection	Recommended ***	Not Applicable
Pre-Approval Requirements – Certain services require pre-approval or benefits will be reduced. Refer to your plan documents for a complete list of services that require pre-approval.		
Referral Requirement	Not Applicable	Not Applicable
PHYSICIAN SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Primary Care Physician Visits* **	Office Hours: $30 Copay, deductible waived After Office Hours/Home: $35 Copay, deductible waived	60% after deductible
Specialist Office Visits* **	$50 Copay, deductible waived	60% after deductible
Maternity / OB Visits	$50 Copay for initial visit only, deductible waived	60% after deductible
Allergy Treatment	Applicable office visit cost-sharing	60% after deductible
Allergy Testing	$50 Copay, deductible waived	60% after deductible
PREVENTIVE CARE	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Routine Adult Physical Exams / Immunizations (Limited to one exam per calendar year. Network and Non-Network combined.)	$0 Copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care. See Covered Charges with Special Limitations section of the plan documents.

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PREVENTIVE CARE (CONTINUED)	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Well Child Exams / Immunizations (Age and frequency schedules apply. Network and Non-Network combined.)	$0 Copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine Gynecological Exams (Includes Pap smear and related lab fees. Limited to one routine exam and pap smear per 365 days. Network and Non-Network combined.)	$0 Copay, deductible waived	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and Non-Network combined.)	$0 Copay, deductible waived	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
Routine Digital Rectal Exams / Prostate Specific Antigen Test (For covered males age 40 and over. Age and frequency schedules may apply. Network and Non-Network combined.)	$0 Copay, deductible waived	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
Routine Colorectal Cancer Screening (For members age 50 and over as recommended for an average risk individual and to younger members who are considered to be high risk for colorectal cancer as medically necessary. Frequency schedule applies. Network and Non-Network combined.)	$0 Copay, deductible waived	Refer to Adult Physical Exam/Immunizations, Preventive Care Benefit.
Routine Eye Exams at Specialist (Limited to one routine exam per 24 months.)	$0 Copay, deductible waived	Not Covered, except vision screening for covered dependent children through age 17, 60% after deductible.
Vision Corrective Lenses/Contact Lenses Allowance	$100 reimbursement payable once per 24-month period, deductible waived Network and Non-Network combined.	
Routine Hearing Screening at PCP	Covered as part of a routine physical exam.	Not Covered, except screenings as provided by Preventive Care Benefit.

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DIAGNOSTIC PROCEDURES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
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 cost sharing.)	$0 Copay, deductible waived	60% after deductible
Diagnostic X-ray (except for Complex Imaging Services) - Outpatient Hospital or Other Outpatient Facility	$50 Copay, deductible waived	60% after deductible
Diagnostic X-ray for Complex Imaging Services (Includes MRA, MRS, MRI, PET and CAT Scans)	80%, deductible waived	60% after deductible
EMERGENCY MEDICAL CARE	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Urgent Care Provider	80%, deductible waived	Refer to Network provider benefit.
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (waived if admitted)	80%, deductible waived	Refer to Network provider benefit.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	$0 Copay, deductible waived	Refer to Network provider benefit.
HOSPITAL CARE	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Inpatient Coverage	80% after deductible	60% after deductible
Inpatient Maternity Coverage	80% after deductible	60% after deductible
Outpatient Surgery Performed at a Hospital Outpatient Facility	80% after deductible	60% after deductible
Outpatient Surgery Performed at a Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	80% after deductible	60% after deductible. Maximum benefit of $2,000 per member per calendar year.
MENTAL HEALTH SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Inpatient Mental Illness	80% after deductible	60% after deductible
Outpatient Mental Illness	$50 Copay, deductible waived	60% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Inpatient Detoxification	80% after deductible	60% after deductible
Outpatient Detoxification	$50 Copay, deductible waived	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
Outpatient Rehabilitation	$50 Copay, deductible waived	60% after deductible
Residential Treatment Facility	80% after deductible	60% after deductible
OTHER SERVICES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Skilled Nursing Facility (Limited to 60 days per member per calendar year. Network and Non-Network combined.)	80% after deductible	60% after deductible
Home Health Care (Limited to 60 visits per member per calendar year. Network and Non-Network combined.)	$50 Copay, deductible waived	60% after deductible
Inpatient Hospice Care	80% after deductible	60% after deductible
Outpatient Hospice Care	$0 Copay, deductible waived	60% after deductible

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OTHER SERVICES (CONTINUED)	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Private Duty Nursing	Not Covered, except as provided under Home Health Care	Not Covered, except as provided under Home Health Care
Outpatient Speech and Cognitive Therapy (Limited to 30 visits combined per member per calendar year. Network and Non-Network combined.)	Effective Prior to 4/1/11: $50 Copay, deductible waived Effective on or after 4/1/11: $20 Copay, deductible waived	60% after deductible
Outpatient Physical and Occupational Therapy (Limited to 30 visits combined per member per calendar year. Network and Non-Network combined.)	Effective Prior to 4/1/11: $50 Copay, deductible waived Effective on or after 4/1/11: $20 Copay, deductible waived	60% after deductible
Chiropractic (Subluxation) (Limited to 30 visits per member per calendar year. Network and Non-Network combined.)	Effective Prior to 4/1/11: $50 Copay, deductible waived Effective on or after 4/1/11: $25 Copay, deductible waived	60% after deductible
Durable Medical Equipment (Maximum benefit of $2,500 per member per calendar year. Network and Non-Network combined.)	50%, deductible waived	50% after deductible
Prosthetics	$30 Copay, deductible waived	60% after deductible
Orthotics	$30 Copay, deductible waived	60% after deductible
Hearing Aids (Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months. Network and Non-Network combined.)	$30 Copay, deductible waived	60% after deductible
Transplants	80% after deductible	60% after deductible
FAMILY PLANNING	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Infertility Treatment (Coverage for the diagnosis and surgical treatment of the underlying medical cause; artificial insemination and standard dosages, lengths of treatment and cycles of therapy of prescription drugs to enhance fertility. For services and supplies specifically excluded, refer to plan documents and the Exclusions and Limitations below.)	Member cost sharing is based on the type of service performed and the place rendered.	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.	Member cost sharing is based on the type of service performed and the place rendered.

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ADDITIONAL EMPLOYER PLAN OPTIONS: The following optional RX benefits are available only if elected by your employer.		
PHARMACY - PRESCRIPTION DRUG BENEFITS -- RX $15/$35/$60, No Opt	**NETWORK PHARMACIES**	**NON-NETWORK PHARMACIES**
Prescription Drug Deductible	Not Applicable	Not Covered
Prescription Drugs Up to 30 day supply	$15 Copay for generic formulary drugs, $35 Copay for brand-name formulary drugs, $60 Copay for generic and brand-name non-formulary drugs	Not Covered
Retail or Mail Order 31 - 90 day supply	$30 Copay for generic formulary drugs, $70 Copay for brand-name formulary drugs, $120 Copay for generic and brand-name non-formulary drugs	Not Covered
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay only.		
Plan includes: Self-injectables, diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. **Plan excludes:** Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		
Prescription Drug Benefits do not apply to the Maximum Out-of-Pocket Limit.		
PHARMACY - PRESCRIPTION DRUG BENEFITS -- RX $20/$40/$70, No Opt	**NETWORK PHARMACIES**	**NON-NETWORK PHARMACIES**
Prescription Drug Deductible	Not Applicable	Not Covered
Prescription Drugs Up to 30 day supply	$20 Copay for generic formulary drugs, $40 Copay for brand-name formulary drugs, $70 Copay for generic and brand-name non-formulary drugs	Not Covered
Retail or Mail Order 31 - 90 day supply	$40 Copay for generic formulary drugs, $80 Copay for brand-name formulary drugs, $140 Copay for generic and brand-name non-formulary drugs	Not Covered
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay only.		
Plan includes: Self-injectables, diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. **Plan excludes:** Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		
Prescription Drug Benefits do not apply to the Maximum Out-of-Pocket Limit.		

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PHARMACY - PRESCRIPTION DRUG BENEFITS -- RX $15/50%, No Opt	NETWORK PHARMACIES	NON-NETWORK PHARMACIES
Prescription Drug Deductible	Not Applicable	Not Covered
Prescription Drugs Up to 30 day supply	$15 Copay for generic drugs, 50% Coinsurance for brand-name drugs	Not Covered
Retail or Mail Order 31 - 90 day supply	$30 Copay for generic drugs, 50% Coinsurance for brand-name drugs	Not Covered
Open Formulary – Covers drugs on the Formulary Exclusion List.		
No Mandatory Generic (No MG) - Member is responsible to pay the applicable copay or coinsurance only.		
Plan includes: Self-injectables, diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. **Plan excludes:** Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		
Prescription Drug Benefits do not apply to the Maximum Out-of-Pocket Limit.		

PHARMACY - PRESCRIPTION DRUG BENEFITS -- OON RX w/Opt	NETWORK PHARMACIES	NON-NETWORK PHARMACIES
Prescription Drug Deductible (Must be satisfied before any prescription drug benefits are paid.)	Prescription Drug Deductible Integrated with Non-Network Medical Deductible. Non-Network Deductible applies to all covered drugs.	
Prescription Drug Maximum Out-of-Pocket	Prescription Drug Maximum Out-of-Pocket Integrated with Non-Network Medical Maximum Out-of-Pocket	
Prescription Drugs Up to 30 day supply	60% after Non-Network deductible	
Retail or Mail Order 31 - 90 day supply	60% after Non-Network deductible	
Plan includes: Self-injectables; contraceptive drugs and devices obtainable from a pharmacy; diabetic supplies obtainable from a pharmacy; and drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.		
Precertification included.		

* The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

** We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "network" or "non network." We want to help you understand how much Aetna pays -- and what you may have to pay -- for your non network care.

As an example, you may choose a doctor in our network. You may choose to visit a non network doctor. If you choose a doctor who is non network, your Aetna health plan may pay some of that doctor's bill.

When you choose non-network care, Aetna limits the amount it will pay. This limit is called the "allowed" amount. This amount is a standard amount based on data about what providers charge. A third-party-organization compiles that data sent to it by Aetna and other insurers.

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Aetna will pay the higher amount of benefits for prosthetic and orthotic appliances. It does not matter if you get this appliance from a network or non-network provider. We will pay the higher of:
Aetna's contracted rate with the network provider or
the federal Medicare reimbursement schedule

Your non network doctor or hospital sets the rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "allows." Your doctor may bill you for the dollar amount that Aetna doesn't "allow." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "allowed amount" counts toward your deductible or maximum out-of-pocket. To learn more about how we pay non network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying non network doctors and hospitals applies when you *choose* to get non network care. When you have no choice, we will pay the bill as if you got network care. You pay your plan's copayments, coinsurance and deductibles for your network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

*** A member may at anytime seek health care from Network Providers without first contacting his or her Primary Care Physician. When a member chooses not to use his or her Primary Care Physician, the member is entitled to receive benefits for covered services and supplies. A member will be subject to the Primary Care Physician (PCP) cost-share when a member obtains covered benefits from any Network Primary Care Physician. A member will be subject to the Specialist cost-share when a member obtains covered benefits from any Network Specialist.

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*.

(1) All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
(2) Custodial care.
(3) Dental care or treatment, including appliances and dental implants, except as otherwise stated in the contract.
(4) Donor egg retrieval.
(5) Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the contract.
(6) Eye surgery, such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
(7) Immunizations for travel or work.
(8) Non-medically necessary services or supplies.
(9) Reversal of sterilization.
(10) Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling.

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(11) Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:
a) procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), donor sperm, surrogate motherhood; and
b) prescription drugs not eligible under the prescription drugs section of the contract.

(12) Services or supplies related to Cosmetic Surgery except as otherwise stated in the contract; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Pre-Existing Conditions Exclusion Provision

The following provisions only apply to small employers of at least two but not more than five eligible employees. These provisions also apply to “late enrollees” for any small employer. However, this provision does not apply to late enrollees if 10 or more late enrollees request enrollment during any 30 day enrollment period. The “Pre-Existing Conditions” provision does not apply to a dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the employee enrolls the dependent and agrees to make the required payments within 30 days after the dependent’s eligibility date. **For plans effective on or after 10/1/10,** the pre-existing condition exclusion provisions are waived for any individual under the age of 19.

A Pre-Existing Condition is an illness or injury which manifests itself in the six months before a member’s enrollment date, and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the enrollment date. This 180 day period may be reduced by the length of time the member was covered under any creditable coverage if, without application of any waiting period, the creditable coverage was continuous to a date not more than 90 days prior to becoming a member.

This limitation does not affect benefits for other unrelated conditions or pregnancy, or birth defects in a covered dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Aetna waives this limitation for a member’s Pre-Existing Condition if the condition was payable under creditable coverage which covered the member right before the member’s coverage under the Aetna plan started.

If a new member was covered under creditable coverage prior to enrollment under the Aetna plan and the creditable coverage was continuous to a date not more than 90 days prior to the enrollment date under the Aetna plan, we will provide credit as follows. We give credit for the time the member was covered under the creditable coverage without regard to the specific benefits included in the creditable coverage. We count the days the member was covered under creditable coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation. The person must sign and complete his or her enrollment form within 30 days of the date the employee’s active full-time service begins. We do not cover any charges actually incurred before the person’s coverage starts. If the small employer has included an eligibility waiting period, an employee must still meet it, before becoming covered.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, please provide Aetna with a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at 1-888-70-AETNA (1-888-702-3862) if assistance is needed in obtaining a Certificate of Creditable Coverage from prior carriers or with any questions on the information provided.

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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 (i.e., Schedule of Benefits, Evidence of Coverage, Contract, Riders and/or Amendments) 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 you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The pharmacy plan includes 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, 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.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies.

While this material is believed to be accurate as of the print date, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.