Summary of Coverage

This Summary of Coverage is attached to and forms part of your Policy. The benefits shown in this Summary of Coverage are available for the persons listed in the Policy.

Health Expense Coverage For You and Your Dependents

The Policy spells out the period to which each maximum applies. These benefits apply separately to each covered person. All maximums included in this Policy are combined maximums between Preferred and Non-Preferred Care, unless stated otherwise. Read the coverage section in your Policy for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the Policy:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Comprehensive Medical Expense Coverage
Utilization and Preservice Review Procedures

Certain procedures, services, supplies and treatments and certain other types of care must be certified as necessary if full benefits are to be available under the Policy.

The Policy lists the procedures, services, supplies and treatments which must be certified, describes the other types of care affected and gives you details on how to obtain certification and avoid a reduction in benefits payable.

Certification for Certain Procedures/Treatments Excluded Amount: $400.

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Policy in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be described later in the Policy. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." A copy of a Directory which lists these health care providers is available on-line at www.aetna.com/docfind/custom/advplans, or may be requested by calling 866-565-1236.

Deductible Amounts

	Individual	Family
Preferred Care Calendar Year Deductible	$2,500	$5,000
Non-Preferred Care Calendar Year Deductible	$5,000	$10,000

The Calendar Year Deductible applies separately to Preferred and Non-Preferred Care Expenses. The Calendar Year Deductible is not applicable to Preferred Care expenses for:

- Physician’s services for office visits
- Preventive Health Expenses
- Routine screening for cancer expenses
- Hearing Aids
- Generic Drugs

A separate deductible applies to Prescription drugs and medicines.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any deductible amounts, unless otherwise specified above.

For Hospital Expenses

Inpatient Coverage

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%

Outpatient Coverage

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%

Emergency Room

	Preferred Care	Non-Preferred Care
Payment Percentage	70% after $100 copay *	70% after $100 copay *

*Waived if the Member is admitted to the Hospital

Non-Emergency Care in an Emergency Room

	Preferred Care	Non-Preferred Care
Payment Percentage	50%	50%

Skilled Nursing Facility Expenses (In lieu of hospital)

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%
Maximum Days per Calendar Year	30* days	30* days

*Combined for Preferred Care and Non-Preferred Care Expenses

Home Health Care Expenses

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%
Maximum Visits per Calendar Year	30* visits	30* visits

*Combined for Preferred Care and Non-Preferred Care Expenses

Hospice Expenses*

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%
Lifetime Maximum Benefit	$10,000*	$10,000*

*Combined for Preferred Care and Non-Preferred Care Expenses

Ambulatory Surgical Facility Expenses

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%

Physicians' Services

Office Visits (non-surgical) **to Non-Specialist** (internist, general physician, family practitioner, or pediatrician).

	Preferred Care	Non-Preferred Care
Payment Percentage	$30 copay Deductible waived	50%

Office Visits to Specialists

	Preferred Care	Non-Preferred Care
Payment Percentage	$40 copay Deductible waived	50%

Other Physicians' Services

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%

Preventive Health Expenses

For Members to Age 18: Covers immunizations against: Diphtheria; Hepatitis B; Human Papiloma Virus, Measles; Mumps; Pertussis; Polio; Rubella; Tetanus; Varicella; Haemophilus Influenza B; and Hepatitis A. Calendar Year Deductible does not apply to Preferred Care Expenses.

For Members Age 18 or Over: Covers 1 exam every 365 days.

	Preferred Care	Non-Preferred Care
Payment Percentage	$30 copay Deductible waived	50%
Maximum Benefit per Calendar Year	$200*	$200*

*Combined for Preferred Care and Non-Preferred Care Expenses

Routine Screening for Cancer
Includes one annual screening mammogram; one routine OB/GYN exam per Calendar Year, including a Pap smear, Human Pappiloma Virus(HPV) screening and related services; one colorectal screening per Calendar Year; and one prostate antigen test (PSA) once each Calendar Year for males age 40 or older.

	Preferred Care	Non-Preferred Care
Payment Percentage	100% Deductible waived	50%

Prescription Drug Benefits (Out of Hospital)

	Preferred Care	Non-Preferred Care
Prescription Drug Calendar Year Deductible per Member	$500	$500

	Retail Pharmacy *30 day supply*	*Retail Pharmacy* *30 day supply*
Generic Drugs		
Payment Percentage	100% after $15 copay Deductible waived	50% after $15 copay Deductible waived
Formulary brand name drugs		
Payment Percentage	100% after $35 copay	50% after $35 copay
Non-formulary brand name drugs		
Individual Prescription		
Payment Percentage	100% after $50 copay	50% after $50 copay
Prescription Drug Maximum Benefit per calendar year	Unlimited	Unlimited
	*Mail Order Pharmacy****	*Mail Order Pharmacy*
Payment Percentage	100%	No Benefit
Copay	2x the copay for Retail Pharmacy	

***Limited to not more than a 60 day supply

Durable Medical Equipment

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%
Maximum Benefit per Calendar Year	$2,000*	$2,000*

*Combined for Preferred Care and Non-Preferred Care Expenses

Ambulance Expenses

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	70%
Maximum Benefit Per trip	$1,000	$1,000

Physical Therapy, Chiropractic Therapy and Spinal Manipulation

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%
Maximum Benefit per Visit	$25	$25
Maximum visits per Calendar year	24*	24*

*Combined for Preferred Care and Non-Preferred Care Expenses

Hearing Aid

One hearing aid per ear every 36 months up to $200 per hearing aid (includes repairs). Batteries and auxiliary equipment are excluded. Deductible and coinsurance do not apply. Not covered for first 12 months.

Organ Transplants

	Preferred Care	Non-Preferred Care
Payment Percentage	70%	50%

All Other Covered Medical Expenses
100% as to National Medical Excellence Travel and Lodging Expenses.

The Payment Percentage shown below as to all other covered medical expenses not specified above:

Preferred Care	Non-Preferred Care
70%	50%

Payment Limits
These limits apply to Covered Medical Expenses. These limits apply separately to Preferred and Non-Preferred Care. Expenses which are Excluded Amounts for failure to precertify certain procedures/treatments, and expenses that apply to copay amounts for other expenses will not count toward these limits.

Payment Limit which Applies to Expenses for a Member
When a Member's Covered Medical Expenses for which no benefits are paid reach $7,000 for Preferred Care or $12,500 for Non-Preferred Care in a Calendar Year, benefits will be payable at 100% for all of the Member's Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Medical Expenses for which no benefits are paid reach $14,000 for Preferred Care or $25,000 for Non-Preferred Care in a Calendar Year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

Private Room Limit The institution's semiprivate rate.

Lifetime Maximum Benefit

Preferred Care	Non-Preferred Care
$5,000,000*	$5,000,000*

*Combined for Preferred Care and Non-Preferred Care Expenses

Adjustment Rule

If, for any reason, a Member is entitled to a different amount of coverage, coverage will be adjusted as of its effective date.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Policy provisions. In other words, there are no vested rights to benefits based upon provisions of this Policy in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the Policy. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR POLICY