



**PLAN DESIGN & BENEFITS  
 PROVIDED BY AETNA LIFE INSURANCE COMPANY**

<b>PLAN FEATURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Deductible</b> (per calendar year)	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family
All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Deductible. 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.		
<b>Member Coinsurance</b>	30%	50%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
All covered expenses, excluding prescription drugs, accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
<b>Lifetime Maximum</b>		
\$1,000,000		
<b>Primary Care Physician Selection</b>	Not Applicable	Not Applicable
<b>Certification Requirements -</b>	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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	30%; after deductible	50%; after deductible
1 exam every 12 months for members age 18 and older.		
<b>Routine Gynecological Care Exams</b>	30%; after deductible	50%; after deductible
One exam per calendar year. Includes routine tests and related lab fees.		
<b>Routine Mammograms</b>	30%; after deductible	50%; after deductible
One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.		
<b>Routine Digital Rectal Exam</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Prostate-specific Antigen Test</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Colorectal Cancer Screening</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

For all members age 50 and over.



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<b>Routine Eye Exams</b>	Not Covered	Not Covered
<b>Routine Hearing Exams</b>	Not Covered	Not Covered
<b>PHYSICIAN SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Office Visits to non-Specialist</b> Includes services of an internist, general physician, family practitioner or pediatrician.	30%; after deductible	50%; after deductible
<b>Specialist Office Visits</b>	30%; after deductible	50%; after deductible
<b>E-visit to non-Specialist</b> An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	30%; after deductible	50%; after deductible
<b>E-visit to Specialist</b> An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.	30%; after deductible	50%; after deductible
<b>Walk-in Clinics</b> Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	30%; after deductible	50%; after deductible
<b>Allergy Testing</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>Allergy Injections</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
<b>DIAGNOSTIC PROCEDURES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Diagnostic Laboratory and X-ray</b> (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	30%; after deductible	50%; after deductible
<b>Diagnostic Outpatient Complex Imaging</b>	30%; after deductible	50%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Urgent Care Provider</b>	\$100 copay; after deductible	50%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	\$200 copay; after deductible	Same as preferred care.
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	\$100 copay; after deductible	\$100 copay
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Inpatient Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	30%; after deductible	50%; after deductible
<b>Inpatient Maternity Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	30%; after deductible	50%; after deductible
<b>Outpatient Hospital Expenses</b> (including surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	30%; after deductible	50%; after deductible



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<b>MENTAL HEALTH SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
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Not Covered

<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
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<b>Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	30%; after deductible	50%; after deductible
<b>Residential Treatment Facility</b>	30%; after deductible	50%; after deductible
<b>Treatment Facility</b>	30%; after deductible	50%; after deductible
<b>Outpatient</b> Covered up to \$4,500 per calendar year, includes treatment facility expenses. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	30%; after deductible	50%; after deductible

<b>OTHER SERVICES</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
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<b>Convalescent Facility</b> Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	30%; after deductible	50%; after deductible
<b>Home Health Care</b> Limited to 60 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	30%; after deductible	50%; after deductible
<b>Hospice Care - Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	30%; after deductible	50%; after deductible
<b>Hospice Care - Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	30%; after deductible	50%; after deductible
<b>Private Duty Nursing - Outpatient</b>	Not Covered	Not Covered
<b>Outpatient Short-Term Rehabilitation</b> Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	30%; after deductible	50%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 20 visits per calendar year.	plan pays 30; after deductible	50%; after deductible
<b>Durable Medical Equipment</b> Maximum benefit of \$5,000 per member per calendar year.	30%; after deductible	50%; after deductible
<b>Diabetic Supplies</b> -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Transplants</b>	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Not Covered	Not Covered
<b>"Other" Health Care</b> -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".		

<b>FAMILY PLANNING</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
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<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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Diagnosis and treatment of the underlying medical condition.



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<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Voluntary Sterilization</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered.; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered.

Including tubal ligation and vasectomy.

<b>PHARMACY</b>	<b>PREFERRED CARE</b>	<b>NON-PREFERRED CARE</b>
<b>Retail</b>	30% copay for generic drugs, 30% copay for formulary brand-name drugs, and 50% copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	40% of submitted cost after the applicable preferred copay
<b>Mail Order</b>	Same as Retail	Not Applicable

**Aetna Specialty CareRx**

First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

**Mandatory Generic with DAW override (MG W/DAW Override)** - the member pays the applicable copay. If the physician requires brand, member would pay brand name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.

Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).

Precert for growth hormones included. Expanded Precert included with 90 day Transition of Care.

<b>Prescription Drug Calendar Year Deductible</b> (must be satisfied before any drug benefits are paid)	\$200 Individual  \$600 Family	\$200 Individual  \$600 Family
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All covered pharmacy expenses accumulate toward both the preferred and non-preferred pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable. Once family pharmacy deductible is met, all family members will be considered as having met their pharmacy deductible for the remainder of the calendar year

**GENERAL PROVISIONS**

**Pre-existing Conditions Exclusion** On effective date: Waived  
 After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may 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, care, or treatment was recommended or received or for which the individual took prescribed drugs within 180 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 180 days 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 creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.



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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 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 Aetna Member Services at 1-888-982-3862 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. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 by your employer.



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- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862)**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.



UFCW Local 951  
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Open Choice<sup>®</sup> (PPO) - Michigan

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