PLAN DESIGN AND BENEFITS
ADMINISTERED BY AETNA HEALTH INC. AND CORPORATE HEALTH INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per calendar year)	$150 Individual $300 Family	$300 Individual $900 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Plan Coinsurance	90% after deductible	70% after deductible
Out-of-Pocket Maximum (per calendar year)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers and non-participating providers out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Not Required	Not applicable
Precertification Requirement Certain non-participating services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirements	None	None
PREVENTIVE CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Routine Adult Physical Exams/ Immunizations	Covered 100%, no copay Age 18 to 65 & over, 1 exam per calendar year.	Not Covered
Includes routine immunizations & flu shots. Includes Colorectal Cancer Screenings per AMA guidelines for all members age 50 and older: Fecal occult blood test every year, Sigmoidoscopy (covered every 5 years), Double contrast barium enema (covered every 5 years), Colonoscopy (covered every 5 years). Age limit does not apply for 1st colorectal screening if proof of family history of colon cancer.		
Well Child Exams / Immunizations	Covered 100%, no copay	Not Covered
Includes routine immunizations, travel immunizations and flu shots. 7 exams in 1st 12 months of life, 2 exams in 13th-24th month; 1 exam per calendar year for 24 months to age 18 years.		
Routine Gynecological Care Exams Includes Pap smear and related lab fees. One routine exam per calendar year. May self-refer to network provider. Note that providers billing under Sloan Kettering TIN will be reimbursed as Participating.	Covered 100%, no copay	70% after deductible
Routine Mammograms One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over. May self-refer to network provider. Age limit does not apply for mammogram if proof of family history of breast cancer.	Covered 100%, no copay	70% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test 1 annual DRE & PSA for males age 40 and over.	Covered 100%, no copay	70% after deductible

Routine Eye Exam 1 exam every 2 calendar years on a self-referral basis to a network provider.	Covered 100% after $15 copay	Not Covered
Routine Hearing Screening 1 exam every 2 calendar years.	Covered 100% after $15 copay	Not Covered
PHYSICIAN SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Office Visits to member's selected Primary Care Physician	Covered 100% after $15 copay	70% after deductible
Specialist Office Visits	Covered 100% after $15 copay	70% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Acupuncture Covered in lieu of anesthesia only.	Covered 90% after deductible.	70% after deductible.
Outpatient Surgery	Covered 100% after $15 copay	70% after deductible
Outpatient Surgery outside office setting	Covered 90% after deductible	70% after deductible
Maternity Coverage	Covered after $15 copay for initial visit, covered 100% for subsequent visits	70% after deductible
Diagnostic Laboratory	Covered 100% after $15 copay	70% after deductible
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.		
Diagnostic X-ray for Complex Imaging	Covered 90% after deductible	70% after deductible
EMERGENCY MEDICAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Urgent Care	Covered 100% after $50 copay Copay waived if admitted.	Refer to participating provider benefit.
Non-Urgent use of Urgent Care Provider	Covered at out of network benefit level: 70 % after deductible	70% after deductible
Emergency Room	Covered 100% after $50 E.R. copay. Copay waived if admitted.	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 90% after deductible	Refer to participating provider benefit.
HOSPITAL CARE	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Coverage	Covered 90% after deductible	70% after deductible
Inpatient Maternity Coverage	Covered 90% after deductible	70% after deductible

Outpatient Hospital Expenses	Covered 90% after deductible	70% after deductible
Including Facility charges for outpatient surgery in Hospital Outpatient Dept or Ambulatory Surgical Center		
MENTAL HEALTH SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Mental Illness	Covered 90% after deductible	70% after deductible
Limited to 60 days per calendar year, combined with inpatient detoxification.		
Outpatient Mental Illness Not integrated in and out of network	Covered 100% after $15 copay for up to 10 visits, $25 copay for visits 11 to 60 60 visits per calendar year	50% after deductible 20 visits per calendar year
Maximum outpatient days per calendar year combined with detoxification.		
ALCOHOL/DRUG ABUSE SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Inpatient Detoxification	Covered 90% after deductible	70% after deductible
In a hospital or treatment facility. Limited to 60 days per calendar year, combined with inpatient mental illness.		
Outpatient Detoxification	Covered 100% after $15 copay for up to 10 visits, $25 copay for visits 11 to 60 60 visits per calendar year	50% after deductible 20 visits per calendar year
Maximum outpatient days per calendar year combined with mental illness.		
OTHER SERVICES	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Skilled Nursing Facility	Covered 90% after deductible	70% after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 90% after deductible	70% after deductible
Limited to 120 visits per calendar year Limited to 3 intermittent visit per day by a Participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 90% after deductible	70% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. 6 month lifetime maximum.		
Hospice Care - Outpatient	Covered 90% after deductible	70% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. 6 month lifetime maximum		
Durable Medical Equipment / Prosthetics: (Includes foot orthotics 1 per lifetime)	Covered 90% after deductible	70% after deductible
Vision - Limited to $100 per calendar year for prescription frames, lens, or contact lens (does not apply to exams)	Covered 100% up to $100 per calendar year	Covered 100% up to $100 per calendar year

Private Duty Nursing 70 shifts per calendar year	Covered 90% after deductible	70% after deductible
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy. Limited to 120 visits per calendar year, PT/ OT / ST combined.	$15 per visit copay	70% after deductible per visit
Chiropractic Care	$15 per visit copay Limited to 60 visits per calendar year, in & out network combined	70% after deductible
FAMILY PLANNING	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS**
Infertility Treatment Covers diagnosis & treatment of the underlying cause, artificial insemination, ovulation induction, Advanced Reproductive Technology (ART), Invitro Fertilization (IVF), GIFT, ZIFT, Cryo-preserved embryo transfers & ICSI or ovum microsurgery.	Covered 100% after $15 office visit copay Covered 90% after deductible for inpatient or Surgical Facility Artificial Insemination & ovulation induction limited to $5000 per calendar year (cross accumulation between in-network & out-of-network).	70% after deductible
Voluntary Sterilization Including tubal ligation and vasectomy. Excludes reversals.	Covered 90% after deductible	70% after deductible
Contraceptive Devices, Implants & Injectibles Medical plan covers associated office visit only for injection of Depo-Provera and Lunell, Diaphragm fitting, and Cervical Cap, IUD & Norplant devices	Not covered.	Not covered.
Voluntary Abortion	Covered 90% after deductible.	70% after deductible.

Participating Providers can be located in our online provider directory at: http://www.aetna.com/docfind/custom/columbia
If you need additional assistance in locating a Participating Provider please call Aetna Member Services at the toll-free number on your ID card.

Exclusions and Limitations

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 the plan design or rider(s) purchased.

• 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.
• Cosmetic surgery.
• 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
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Nonmedically 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.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered in the plan documents.

• 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 material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and therefore, cannot guarantee any results or outcomes. Consult the plan document (i.e. Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or visit maximums. With the exception of Aetna Rx Home Delivery, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

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 obtains covered services from participating providers, the provider will obtain precertification. If the Member obtains covered services from a nonparticipating provider, the Member must obtain the precertification. Precertification requirements may vary. Members may refer to their plan documents for a complete list of medical services that require precertification. Certain benefits like comprehensive infertility and advanced reproductive technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.

Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Certain benefits like comprehensive infertility and advanced reproduction technology (ART) services, if covered under your plan, are subject to a select network of participating providers, from which you will be required to seek care to receive covered benefits.