

Aetna

Affordable

Health ChoicesSM

Overview: Options I and II

Medical

A Limited Major Medical Insurance Plan.

The table on the right gives you a quick overview of the Medical Coverage.

- Use any licensed provider for covered expenses or any certified hospital.
- No precertification or approval is required.
- After you pay a \$100 deductible each coverage year, the plan will pay 80% of the recognized charges incurred for covered medical expenses until your \$1,000 annual out-of-pocket maximum is reached. Once your out-of-pocket maximum has been met, the plan will pay 100% of the recognized charges incurred for covered medical expenses up to a lifetime maximum benefit of \$50,000 per cause.
- Chiropractic services are included under spinal manipulation.
- Maternity is a covered expense.
- Option II includes Dental. See reverse for details.

Exclusions and limitations apply. Refer to the Exclusions and Limitations section for details.

Additional Benefit

- Aetna's Vision One® discount program, a nationwide network of vision care providers, offers you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at a discounted price. Plus, you can receive discounts on eye exams and LASIK eye surgery.

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BENEFIT

Medical Expense Benefit

	Option I	Option II
Annual deductible ¹	\$100	\$100
Percentage of eligible expenses paid by plan ² (until annual out-of-pocket maximum is met)	80%	80%
Annual out-of-pocket maximum (includes deductible) ¹	\$1,000	\$1,000
Percentage paid by plan after out-of-pocket maximum is met ²	100%	100%
Per cause maximum lifetime benefit ³	\$50,000	\$50,000
Pre-existing conditions maximum benefit ⁴	\$1,000	\$5,000
Prescription drugs ⁵	50% ⁶	Covered
Pregnancy ⁵	Covered	Covered
Preventative exam benefit (annual maximum) ^{1,7}	None	\$150
Dental benefits (see reverse for details)	None	See reverse

Other covered expenses⁵ include fees for diagnosis & treatment by a doctor, surgeon, registered nurse, professional anesthetist, or radiologist; hospital charges; laboratory, diagnostic, and x-ray examinations; rental or purchase (whichever is less) of durable medical equipment; emergency professional ambulance service to the nearest hospital; elective termination of pregnancy; and serious mental & nervous disorders (schizophrenia, bipolar disorders, major depressive disorders, schizo-affective disorders, obsessive-compulsive disorders, panic disorders, eating disorders including anorexia nervosa and bulimia nervosa, and delusional disorders).

Benefit Limits

Hospital benefits

▪ Daily room & board maximum ⁸	\$600	\$600
▪ Daily intensive care facility maximum ⁸	\$1,200	\$1,200
▪ Other hospital services (inpatient or outpatient) ¹	\$2,000	\$2,000

Substance abuse treatment ⁹

▪ Maximum number of outpatient visits ¹	60	60
▪ Maximum benefit per outpatient visit	\$35	\$35
▪ Inpatient maximum ¹	\$10,000	\$10,000

Specified therapies

(including acupuncture, physical therapy, and spinal manipulation) ¹⁰

▪ Outpatient maximum ^{1,11}	\$1,000	\$1,000
▪ Inpatient maximum ^{1,11}	\$10,000	\$10,000

Maximum benefit for injury due to motor vehicle accident ^{1,11} \$10,000 \$10,000

Maximum benefit for injury due to organized sports injury ^{1,11} \$5,000 \$5,000

Injury to sound, natural teeth, maximum benefit per tooth ^{1,11} \$250 \$250

Maximum benefit for emergency professional ambulance service ¹ \$250 \$250

Accidental Death Benefit

Maximum benefit paid to beneficiary if insured dies due to, or resulting from, a covered accident (on or off the job) within 365 days after the date of the accident.	None	\$10,000
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Footnotes

- Per coverage year.
- Where benefit is expressed as a percentage, the recognized charge(s) will be the basis of payment.
- You first have to meet your annual out-of-pocket maximum.
- Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage, subject to the limitations of the plan.
- Coinsurance, deductible medical benefit maximums, and benefit limits apply.
- Under Option I, prescription drug benefit pays 50% until out-of-pocket maximum has been satisfied, then pays 100%, subject to the maximum lifetime benefit of the plan.
- Not subject to a deductible.
- Plan will pay the maximum or actual hospital charges, whichever is less (room & board based on a semi-private room).
- Maximum of one occurrence, inpatient or outpatient, per lifetime.
- Covered only if immediately following covered surgery or hospital confinement.
- Per cause or occurrence.

Dental Insurance Plan (Option II only)

- Use any licensed dentist you want.
- \$1,500 coverage year maximum after a \$25 deductible per covered person.
- Covers most common services.

This table gives a quick overview of the Dental Coverage. Exclusions and limitations apply. Refer to the Exclusions and Limitations section for details.

COMMON DENTAL SERVICES

Type of charges covered by the Plan	Plan pays ¹
Diagnostic and preventive	80%
Fillings	\$28 to \$85
Oral surgery	\$25 to \$86
Crowns and bridges repair	\$7 to \$70
Dentures repair	\$37 to \$113
Perio and endodontic ²	\$15 to \$200
Crowns and bridges ²	\$58 to \$398
Dentures ²	\$18 to \$345

¹ Where benefit is expressed as a percentage, the recognized charge(s) will be the basis of payment.

² 12-month waiting period

MONTHLY PREMIUMS

	Option I	Option II
Standard Cost	\$116.00	\$146.00
Continuation of Coverage	\$118.32	\$148.92

Questions?

**Call SRC toll free at
1-800-788-6557**

**Monday through
Friday, 8 a.m. to
8 p.m. Eastern Time**

Exclusions and Limitations

This is a summary list. Coverages, features, limitations and exclusions may vary by state. This is not a contract. Only the insurance policy can provide the actual terms, coverages, amounts, conditions, limitations and exclusions. Except to the extent coverage for such benefit is specifically provided in your Booklet Summary of Coverage and/or Certificate, coverage is not provided for the following charges:

Medical Pre-existing Condition Limitation:

A "pre-existing condition" is an injury or disease for which a person received treatment or services; or took prescribed drugs or medicines during the 180 days right before the person's effective date of coverage (or, if the Plan requires you to serve a probationary period, the 180 days right before the first day of the probationary period).

During the first 365 days of a person's current period of coverage, benefits paid for Eligible Medical Expenses incurred for the treatment of a pre-existing condition will not exceed \$1,000 under Option I or \$5,000 under Option II; unless the person has been covered for 180 continuous days and has received no care, treatment, or advice for the condition or has not taken prescribed drugs or medicines for the condition.

If a person had creditable coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) in this Plan, then any limitation as to a pre-existing condition will be reduced by the number of days of prior creditable coverage. Also, if a person enrolls (or is enrolled) in this Plan immediately after any applicable probationary period has been served, and that person had creditable coverage which terminated within 63 days prior to the first day of such probationary period, then any limitation as to a pre-existing condition will be reduced by the number of days of prior creditable coverage. As used above: "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. The pre-existing condition limitation above does not apply to newborn or adopted children, or to any pregnancy.

Medical Exclusions:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the covered persons household.
- Injury arising out of or in the course of employment; or which is compensable under any Workers' Compensation or Occupational Disease Act or Law;

- Care, treatment, services or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist;
- Experimental or investigational services, drugs or supplies except to the extent required by law;
- Cosmetic or reconstructive surgery: This does not apply to reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or because of congenital disease or anomaly of a covered person; or reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy;
- Dental care and treatment, except that required by injury and rendered within 6 months of the injury;
- Educational testing, or training related to learning disabilities or developmental delays;
- Services of a resident physician or intern rendered in that capacity;
- Charges made only because there is insurance or a person is not legally obligated to pay;
- Custodial care;
- Any expense incurred before the effective date of the policy or after the date the policy terminates;
- Eye surgery mainly to correct refractive errors;
- Education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy;
- Performance, or lifestyle enhancement drugs or supplies;
- Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered;
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet-Certificate;
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- Speech therapy, except to restore speech to a person who has lost existing speech function as the result of a disease or injury;
- Inpatient or outpatient treatment of mental disorders; except serious mental illness;
- Private duty nursing;
- An injury sustained while the covered person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the injury occurred;
- An injury sustained while the covered person was voluntarily using any drug, narcotic or controlled substance unless as prescribed by a physician;
- Charges made by a hospital or treatment facility owned or run by the U.S. government unless a charge is made for such services in the absence of insurance;
- Charges made to treat an illness or injury sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by; for; or under; the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country;
- Charges made by a hospital that does not unconditionally require payment (this does not apply to charges billed by Veterans Administration Hospitals);
- Charges made for outpatient services and supplies that are not deemed to be physician office visits; emergency room visits; diagnostic and surgical services; or prescription drugs and medicines;
- Voluntary sterilization procedure or the reversal of a sterilization procedure;
- Weight control services including: surgical procedures, medical treatments, weight control/loss programs; food supplements; or exercise programs;
- Charges furnished, paid for, or for which benefits are provided or required under any law of a government;
- Charges in excess of the recognized charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

Medical Accidental Death Benefit Exclusions (Option II only):

- A bodily or mental infirmity.
- A disease, ptomaine, or bacterial infection.*
- Medical or surgical treatment.*
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A war or any act of war (declared or not declared).
- Voluntary inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.
- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Air or space travel. This does not apply if a covered person is a passenger aboard a commercial flight.

* These do not apply if the loss is caused by:

- An infection that results directly from the injury.
- Surgery needed because of the injury. The injury must not be one that is excluded by the terms of this section.

Dental Exclusions (Option II only):

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part: under any other part of this Plan; or under any other plan of group benefits provided by your AmeriCorps program.
- Those for services and supplies to diagnose or treat a disease or injury that is not: a non-occupational disease; or a non-occupational injury.
- Those for services not listed in the Dental Care Schedule that applies; except as specifically provided.

- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Those for any of the following services:
 - (a) an appliance, or modification of one, if an impression for it was made before the person became a covered person;
 - (b) a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
 - (c) root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any jaw joint disorder; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for orthodontic treatment; except as specifically provided.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with another necessary covered service.
- Those for treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- Those for a crown; cast; or processed restoration unless:
 - (a) it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
 - (b) the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.

- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed: in the calendar year of the accident which causes the injury; or in the next calendar year. Facings on molar crowns and pontics will always be considered cosmetic.
- Orthognathic surgery;
- Prescribed drugs; pre-medication; or analgesia;
- Any instruction for diet, plaque control and oral hygiene;
- Charges for implants of any type, and all related procedures, removal of implants; precision or semi-precious attachments, denture duplication, over-dentures and any associated surgery or other customized services or attachments;
- Failure to keep a scheduled visit or charges for the completion of any claim forms;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child) marriage (e.g., spouse or in-law) or adoption or is normally a member of the covered persons household;
- Treatment of malignancies, cysts, and neoplasms;
- Charges in excess of the excess of the Recognized Charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Aetna Affordable Health Choices health insurance coverage is underwritten by Aetna Life Insurance Company and plans are administered by Strategic Resource Company (SRC).

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 arranges for the provision of health care services. However, Aetna itself is not a provider of health care services, and therefore, cannot guarantee any results or outcomes. Consult the plan documents (e.g., Booklet, Booklet-certificate, 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 and by plan design. Health insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. 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. While this material is believed to be accurate as of the print date, it is subject to change.

Important Disclosure Information

For Indemnity Plans

Plan of Benefits

Your plan of benefits will be determined by your plan sponsor and underwritten by the Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut, 06156. The benefits and main points of the Group Policy for persons covered under your plan of benefits will be set forth in the Description of Coverage Booklet which will be provided to you at a later date.

Cost Sharing

You are responsible for any copayments, coinsurance and deductibles for covered services. These obligations are paid directly to the provider or facility at the time the service is rendered. Copayment, coinsurance and deductible amounts are listed in your benefits summary and plan documents.

Claims Payment and Use of Claims Software

Aetna determines the usual, customary and reasonable fee for a provider by referring to commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area or by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources. Aetna may also use computer software and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Medically Necessary

"Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- Clinically appropriate in accordance with **generally accepted standards of medical practice** in term of type frequency, extent, site and duration,
- Considered effective in accordance with **generally accepted standards of medical practice** for the illness, injury or disease; and

- Not primarily for your convenience, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

"Generally accepted standards of medical practice"

means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. In the absence of such credible scientific evidence, the Plan's determinations of whether a service or supply meets "generally accepted standards of medical practice" shall be consistent with physician specialty society recommendations and otherwise shall be based on the views of physicians practicing in relevant clinical areas and any other relevant factors.

Clinical Policy Bulletins ("CPBs")

Aetna's CPBs describe Aetna's policy determinations of whether certain services or supplies are medically necessary, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna's CPBs do not constitute medical advice. Treating providers are solely responsible for your medical advice and treatment. You should discuss any CPB related to their coverage or condition with their treating provider.

While Aetna's CPBs are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your provider will need to consult your benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna's CPBs are available online at www.aetna.com.

Complaints, Appeals and External Review

Filing a Complaint or Appeal

Aetna is committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll-free number on your ID card. If Member Services is unable to resolve your issue to your satisfaction, it will be forwarded to the appropriate department for handling.

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. If you are not satisfied after filing a formal appeal, you may request a second level appeal of the decision. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

External Review

Aetna established an external review process to give eligible you the opportunity of requesting an objective and timely independent review of certain coverage denials. Once the applicable appeal process has been exhausted, eligible members may request an external review of the decision if the coverage denial, for which the member would be financially responsible, involves more than \$500*, and is based on lack of medical necessity or on the experimental or investigational nature of the proposed service or treatment. Standards may vary by state, if a state-mandated external review process exists and applies to your plan.

An independent review organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. After all necessary information is submitted, an external review generally will be decided within 30 calendar days of the request.

Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. Once the review is complete, the plan will abide by the decision of the external reviewer. The cost for the review will be borne by Aetna (except where state law requires members to pay a filing fee as part of the state-mandated program).

Certain states mandate external review of additional benefit or service issues; some may require a filing fee. In addition, certain states mandate the use of their own external review process for medical necessity and experimental/ investigational coverage decisions. These state mandates may not apply to self-funded plans. For further details regarding your plan's appeal process and the availability of an external review process, call the Member Services toll-free number on your ID card where you may obtain an external review request form. You also may call your state insurance or health department or consult their website for additional information regarding state-mandated external review procedures.

Confidentiality and Privacy Notices

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

* Does not apply in some states, including North Carolina.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and antifraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that many individuals do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at www.aetna.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Other Disclosures

Louisiana

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

Michigan

Intractable Pain Coverage

Aetna provides benefits for the evaluation and treatment of intractable pain when it is determined to be medically necessary and otherwise eligible by Aetna. Intractable pain means “a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain is possible or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.”

To obtain this and further information on the health plan, you may call Member Services at 1-888-772-9682.

Health Insurance Portability and Accountability Act Member Notice*

The following information is provided to inform the member of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by the member in accordance with Federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

Members of insured plan sponsors and members of self insured plan sponsors who have contracted with us to provide Certificates of Prior Health Coverage have the option to request a certificate. This applies to terminated members, and it applies to members who are currently active but who would like a certificate to verify their status. Terminated members can request a certificate for up to 24 months following the date of their termination. Active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on the back of your ID card.

* While this Member Notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services department if you have any questions.

Notice to Members

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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The company that underwrites benefits coverage is Aetna Life Insurance Company. Aetna offers part-time and hourly workers access to affordable health and preventive care services through Strategic Resource Company (SRC), an Aetna company.

**If you need this material translated into another language, please call Member Services at 1-888-772-9682.
Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-772-9682.**