BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna) and administered by Strategic Resource Company (SRC).

Unless otherwise indicated, all benefits and limitations are per covered person.
Where a benefit is expressed as a percentage, the recognized charge(s) will be the basis of payment.

IMPORTANT DISCLOSURE: This plan has a number of specific limits and other restrictions on visits, services and/or the dollar amounts covered under the plan in addition to the overall dollar limit of the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the service in question and you will be responsible for the remaining unpaid charges or expenses. This Benefits Summary explains these visit and service limits, the overall annual benefit maximum, and other cost sharing features of your plan, such as deductibles. Please read it carefully so that you understand the limits to what the plan will pay before you enroll.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the medically necessary treatment of injury or disease. The coverage displayed in this Benefits Summary reflects certain mandate(s) of the state in which this policy was written. However, certain federal laws or other mandate(s) in the state you live and/or work could also effect how this coverage pays.

AmeriCorps Option 2

Medical Expense Benefit: Inpatient and Outpatient (subject to Benefit Limits below)	
Deductible per coverage year	$100
Percentage of eligible expenses you pay (until coinsurance maximum is met)	20%
Percentage of prescription drug charges you pay	20%
Coinsurance maximum per coverage year (After $100 deductible is met. Not all charges are paid up to the maximum. Carefully review the benefit limits listed below.)	$900

After you pay a $100 deductible each coverage year, you will pay 20% of the recognized charges incurred for covered medical expenses and 20% for covered prescription drug expenses until your $900 coinsurance maximum is reached. Once your coinsurance maximum has been met, the plan will begin to pay 100% of the recognized charges incurred for covered medical expenses ***up to the benefit limits listed on the following page*** *.*

Maximum lifetime benefit per cause (You first have to meet your coinsurance maximum. Not all charges are paid up to the lifetime maximum. Carefully review the benefit limits listed on the following page.)	$50,000

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Benefit Limits *Once each limit is reached, the plan will no longer pay for that type of charge.*	
Pre-existing conditions maximum benefit *Benefits for pre-existing conditions are limited to the amount shown when incurred during the first 12 months of coverage. (Waiting period can be reduced or waived by prior creditable coverage. See Exclusions and Limitations section for details.) Full coverage for pre-existing conditions will be provided after 12 consecutive months of coverage. Coverage is subject to the limitations of the plan.*	$5,000
Preventive visits	
Maximum benefit per coverage year	$150
Limits on hospital benefits (Plan will pay the maximum or actual hospital charges, whichever is less. Room and board based on a semi-private room.)	
Limit on hospital room and board per day	$600
Limit on intensive care per day	$1,200
Limit on other hospital services per coverage year (inpatient & outpatient) *Once this limit has been reached, this benefit will no longer pay for many hospital-billed charges. The plan will continue to pay for room and board and inpatient professional services up to the limits for those charges.*	$2,000
Limits on substance abuse treatment (These limits do not apply to policies delivered in some states, including Connecticut.)	
Limit on number of occurences, per lifetime	1
Limit on number of outpatient visits per coverage year	60
Maximum benefit per outpatient visit	$35
Inpatient maximum per coverage year	$10,000
Limits on specified therapies (Including acupuncture and physical therapy. Covered only if immediately following covered surgery or hospital confinement.)	
Outpatient maximum per coverage year (Per cause or occurrence)	$1,000
Inpatient maximum per coverage year (Per cause or occurrence)	$10,000

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Maximum benefit for injury due to motor vehicle accident per coverage year (Per cause or occurrence)	$10,000
Maximum benefit for injury due to organized sports injury per coverage year (Per cause or occurrence)	$5,000
Maximum benefit per tooth due to injury to sound, natural teeth per coverage year (Per cause or occurrence)	$250
Maximum benefit for emergency professional ambulance service per coverage year (This limit does not apply to policies delivered in some states, including Connecticut.)	$250

Other covered expenses (Coinsurance, deductible, medical benefit maximums, and benefit limits on page 2 apply.)

Pregnancy; fees for diagnosis and 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 and 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). For policies delivered in some states, including Connecticut, mental illness is covered and is not limited to serious mental and nervous disorders.

Additional Death Benefit	
Maximum benefit (Paid to the 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.)	$10,000

Medicare Part D Notice: This prescription drug benefit does not meet the criteria for Medicare Part D coverage; it does not match up to the plan offered under Medicare Part D.

To use your prescription benefit:
A) Present your Aetna Affordable Health Choices® identification (ID) card to the pharmacist.
B) You pay the amount charged by the pharmacy.*
C) Submit a medical claim form to SRC for reimbursement.*
* If the pharmacy submits your claim(s) for you, then these steps do not apply.

If you have a pre-existing condition, this plan limits the coverage of this condition to a maximum of $5,000 for the first 12 months of coverage, subject to the other benefit limits of this plan. (Waiting period can be reduced or waived by prior creditable coverage.) For more information on pre-existing condition limitations, please see "Exclusions and Limitations" in this summary or refer to the plan documents.

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Terms defined

A service or supply is ***medically necessary*** if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved.

In many instances, the plan requires that a deductible is met before a benefit is paid. A ***deductible*** is the amount of money you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year.

Other hospital services are charges for certain services and supplies billed by a hospital in addition to those charges for room occupancy. These charges may be significant and may include, but are not limited to: pharmacy; medical and surgical supplies and devices; lab and x-rays; and operating and recovery room expenses. They do not include charges for services such as surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient professional services are charges for surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient charges are charges billed by a hospital or provider when you are admitted as an inpatient and charged for room and board. Inpatient charges are comprised of: room and board charges (daily room rate), professional charges billed by a provider (such as charges by a physician who does not work directly for the hospital), and hospital charges other than room and board.

Outpatient charges are charges billed at doctors' offices, free-standing clinics and facilities, and pharmacies. They also include charges at a hospital when you are not admitted as an inpatient, and you are not billed for room and board charges.

A ***recognized charge*** is the amount that Aetna recognizes that a visit, service, or supply should cost. A provider may require that you pay more than the recognized charge, and this additional amount would be your responsibility.

Percentage of remaining charges you pay refers to the percentage of negotiated or recognized charges you pay after you have fulfilled the deductible and/or copay and before the benefit maximum is reached. This is also known as member coinsurance. A non-preferred provider may require that you pay more than the recognized charge, and this additional amount would also be your responsibility. Once the applicable benefit maximum has been reached, you will be responsible for 100% of the remaining balance.

Preventive visits are charges for routine doctor exams for reasons other than to diagnose or treat an injury or disease. Examples include, but are not limited to: physical exams, gynecological exams, mammograms, certain cancer screenings, and bone mass density measurements. Included as a part of the exam are x-rays, lab and other tests given in connection with the exam; and materials for the administration of immunizations for infectious disease and testing for tuberculosis.
Your plan may or may not offer a preventive visit(s) benefit. Please refer to the benefits chart in this Benefits Summary. Some federal and state laws mandate certain preventive exams that are to be covered by, or in addition to, this benefit if offered under your plan. If a preventive visit(s) benefit is not offered under your plan (see the benefits chart), these federal and/or state mandates will be covered by other benefits under your plan. Please refer to the plan documents for more information.

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Questions and answers:

How do benefit limits work?
This plan has limits on the amount of money it will pay per coverage year. These limits differ for each type of charge and, depending on your plan design as explained in the benefits chart in the previous pages above, may be a maximum number of visits or services, a maximum dollar amount, or both. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. **Before you enroll in the plan, please read the benefits chart in the previous pages carefully to understand these limits and consider what effects they may have.**

Will the plan always pay up to the maximum benefits per coverage year?
No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for certain types of charges you continue to have, even though the overall maximum benefit has not been reached. Please read the benefits chart in the previous pages carefully to understand what types of charges may be limited before the overall maximums in question are reached.

How does this limited benefits insurance plan differ from a traditional major medical health plan?
This limited benefits insurance plan, like a traditional major medical health plan, covers a range of health care services both in and out of the hospital. However, this limited benefits insurance plan places limits on how much it will pay or how many services or visits it will cover. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have considerable out-of-pocket costs if you have a serious or chronic medical condition that requires hospitalization or continuing outpatient care.

Is there an out of pocket limit on my expenses?
No. Because of limits on specific benefits, you may pay more than the $100 deductible and $900 coinsurance maximum. However, the plan will begin to pay 100% of the recognized charges up to the limits on specific benefits and up to the lifetime per cause maximum when your portion of recognized charges reaches $1,000 ($100 deductible, plus $900 coinsurance maximum).

What are my rights for childbirth?
The Newborns' and Mothers' Health Protection Act (NMHPA) states that group health plans and health insurers generally may not limit the benefits for a hospital stay connected to childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, for either the mother or newborn child. However, it generally does not prohibit the mother's or newborn's doctor from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) after consulting with the mother. In any case, plans and insurers may not require that a doctor get authorization from the plan or issuer for prescribing a length of stay up to 48 hours (or 96 hours). This act does not change the benefit maximum, limits or deductibles of your plan. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding childbirth. Please refer to the plan documents.

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What are my rights for reconstructive surgery after a mastectomy?

The Women's Health and Cancer Rights Act (effective 1998) states that any health plan that provides medical benefits for a medically necessary mastectomy must also provide coverage for reconstruction of the same breast, reconstruction of the other breast to achieve symmetry, prostheses, and treatment of physical complications of all stages of mastectomy including lymphedema. This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy. This act does not change the benefit maximum, limits or deductibles of your plan. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding a mastectomy. Please refer to the plan documents.

What if I don't understand something I've read here, or have more questions?

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, by calling toll free **1-888-772-9682**. We're here to answer questions before and after you enroll.

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With your medical coverage enrollment, you also receive:

Dental

Maximum benefit per coverage year	$1,500
Deductible per coverage year	$25
Diagnostic and preventive services (includes checkups and cleanings)	You are responsible for up to 20% of the recognized charges. These services have no waiting period.
Fillings	The plan pays $28 to $85. You are responsible for the remaining charges. These services have no waiting period.
Oral Surgery	The plan pays $25 to $86. You are responsible for the remaining charges. These services have no waiting period.
Crowns and bridges repair	The plan pays $7 to $70. You are responsible for the remaining charges. These services have no waiting period.
Dentures repair	The plan pays $37 to $113. You are responsible for the remaining charges. These services have no waiting period.
Perio and endodontic	The plan pays $15 to $200. You are responsible for the remaining charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.
Crowns and bridges	The plan pays $58 to $398. You are responsible for the remaining charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.
Dentures	The plan pays $18 to $345. You are responsible for the remaining charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.

Aetna Vision℠ Discounts*

Aetna Vision℠ Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call **1-800-793-8616**. For contacts call **1-800-391-5367**. For LASIK customer service call **1-800-422-6600**. You can also locate a local provider by visiting **www.aetna.com/docfind/custom/aahc**. This discount arrangement may not be available to Illinois residents.

*Discount programs provide access to discounted prices and are not insured benefits.

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Exclusions and Limitations

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate 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 may contain exceptions to this list based on state mandates or the plan design purchased.**

Medical Pre-existing Condition Limitation:

During the first 365 days of a person's current period of coverage, benefits paid for Eligible Medical Expenses incurred for the treatment of pre-existing conditions will not exceed $1,000; unless the person has been covered for 180 continuous days prior to your enrollment in this plan and has received no care, treatment, or advice for the condition or has not taken prescribed drugs or medicines for the condition.

The plan will reduce the pre-existing condition period by the number of days of "prior creditable coverage" as of the enrollment date. "Creditable coverage" means prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996. Please provide us with a copy of any certificates of creditable coverage or, if you need help in obtaining one or have questions about creditable coverage, please contact member services at **1-888-772-9682.**

Medical Exclusions:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.
- Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions.

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Dental Exclusions:

In addition to the medical exclusions and limitations listed above, the following charges are not covered under the dental plan coverage, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the Recognized Charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

Accidental Death Benefit Exclusions:

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A disease, ptomaine or bacterial infection except for that which results directly from an injury.
- Medical or surgical treatment except for that which results directly from an injury.
- Voluntarily inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.

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THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE DESCRIBED IN THIS BENEFITS SUMMARY.

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. 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. 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. 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. Discount programs provide access to discounted prices and are not insured benefits. Material is subject to change.

Insurance plans are underwritten by Aetna Life Insurance Company.
Plans are administered by Strategic Resource Company (SRC).

For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.