The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $1,250,000.

Your health insurance coverage, offered by Aetna Life Insurance Company, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it has the following annual limits:

Medical Coverage Limits

Class 1 Medical	Annual Benefit Maximum	$15,000
Class 1 Medical	Annual Outpatient Limit	$1,500
Class 1 Medical	Annual Inpatient Limit	$1,500
Class 1 Medical	Annual Preventive Services Limit	$125
Class 1 Medical	Annual Prescriptions Drug Limit	$400

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for 8 days.

Class 2 Medical	Annual Benefit Maximum	$30,000
Class 2 Medical	Annual Outpatient Limit	$3,000
Class 2 Medical	Annual Inpatient Limit	$3,000
Class 2 Medical	Annual Preventive Services Limit	$175
Class 2 Medical	Annual Prescriptions Drug Limit	$750

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for 16 days.

Class 3 Medical	Annual Benefit Maximum	$100,000
Class 3 Medical	Annual Outpatient Limit	$10,000
Class 3 Medical	Annual Inpatient Limit	$10,000
Class 3 Medical	Annual Preventive Services Limit	$200
Class 3 Medical	Annual Prescriptions Drug Limit	$2,000

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for 53 days.

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $1,250,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $1,250,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: *www.HealthCare.gov.*

If you have any questions or concerns about this notice, please contact SRC, an Aetna company, at 1-866-292-3374.

Some states offer a Consumer Assistance Program to help you better understand your health coverage options. For more information, please go to:
www.HealthCare.gov/news/factsheets/capgrants_states.html

Dear Plan Participant:

We are providing you with the notice from Aetna required under the Affordable Care Act (sometimes also referred to as the Health Care Reform laws). The purpose of the notice is to advise you that your group health plan contains annual maximums that are lower than those required by the Affordable Care Act, and that Health and Human Services granted your plan a waiver from the requirement to provide higher annual maximums because including higher maximums would render the coverage unaffordable. The annual limits contained in your plan are not a new feature. These limits have always been included in the plan to keep premiums affordable for your coverage, but Aetna is now required to advise you that the limits are lower than what is required under Health Care Reform and advise you that the plan was granted an annual waiver from raising those limits to comply with the Health Care Reform requirements.

Please note that the group health plan that provides your current coverage is provided by your employer in compliance with government statutes and regulations that apply to private employers performing work on certain government contracts. The coverage provided to you is compliant with those applicable laws pertaining to government contracts.

The enclosed notice is only to advise you that the coverage contains annual limits on certain categories of benefits, in the event that you would like to obtain additional coverage at your own expense. If you determine that you would like to obtain additional coverage at your own expense for you or your family members, the information provided in the enclosed notice will direct you how to understand your health care coverage options. However, this information does not in any manner obligate your employer to provide a different level of coverage, nor will obtaining additional health care coverage cause any change in the current coverage provided to you under your employer's plan.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

Unless otherwise indicated, all benefits and limitations are per covered person. Where a benefit is expressed as a percentage, the lower of the negotiated charge(s) or 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 copayments and 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.

Group limited benefit medical coverage is not available if you live and work in New Hampshire. This limited health plan does not meet Massachusetts Minimum Creditable Coverage standards.

How the Plan Works

The plan will pay a benefit amount up to the daily and annual maximums. This plan is not a major medical plan and does not have a coordination of benefits provision. Benefits under this plan are in addition to the benefits available to you under any other plan you may have.

There are three different Classes of Benefits. Under each Class of Benefits, you and your eligible dependents will receive all of the types of benefits shown below. However, the Class of Benefits for which you are eligible determines the amount that will be paid for each type of benefit. The Class of Benefits for which you are eligible is determined based on the number of hours worked or paid during each qualifying month :

Hours of Work Credit	Class of Benefits
1 - 90	I
91 - 130	II
131 & Over	III

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

The Class of Benefits for which you are eligible may change from month to month depending upon the hours worked or paid for by your employer each month. If your hours fluctuate from month to month, so will your level of benefits.

Net Premier

Plan Features	Class I Benefits 1 to 90 Hours	Class II Benefits 91 to 130 Hours	Class III Benefits 131+ Hours
Annual Medical Maximum (Not all charges are paid up to the annual maximum. Carefully review the limits below.)	$15,000	$30,000	$100,000
Limit on other hospital services per coverage year	$1,500	$3,000	$10,000
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 until the maximum benefit per coverage year is reached.			
Limit on outpatient charges per coverage year	$1,500	$3,000	$10,000
Once this limit is reached, this benefit will no longer pay for outpatient charges.			
Inpatient & Outpatient Benefits			
Deductible	In network: $100 Out of network: $200	In network: $300 Out of network: $400	In network: $500 Out of network: $600
Coinsurance	In network: you pay 20% after the deductible Out of network: you pay 40% after the deductible	In network: you pay 20% after the deductible Out of network: you pay 40% after the deductible	In network: you pay 20% after the deductible Out of network: you pay 40% after the deductible
Doctor's Office Visit			
Copay in network / deductible out of network	$15 per visit	$15 per visit	$15 per visit
Coinsurance	In network: 100% coverage after copay Out of network: 50% after the deductible	In network: 100% coverage after copay Out of network: 50% after the deductible	In network: 100% coverage after copay Out of network: 50% after the deductible

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

Net Premier

Plan Features	Class I Benefits 1 to 90 Hours	Class II Benefits 91 to 130 Hours	Class III Benefits 131+ Hours
Preventive visits			
Annual Maximum	$125 per coverage year	$175 per coverage year	$200 per coverage year
Copay	$15 per visit	$15 per visit	$15 per visit
Coinsurance	In network: 100% coverage after copay Out of network: you pay 50% after the deductible	In network: 100% coverage after copay Out of network: you pay 50% after the deductible	In network: 100% coverage after copay Out of network: you pay 50% after the deductible
Prescription Drug Benefit			
Annual Maximum	$ 400 per coverage year	$ 750 per coverage year	$ 2,000 per coverage year
Copay	Generic: $10 Brand-name: $20	Generic: $10 Brand-name: $20	Generic: $10 Brand-name: $20
Coinsurance	In network: 100% coverage after copay Out of network: you pay 50% after the deductible	In network: 100% coverage after copay Out of network: you pay 50% after the deductible	In network: 100% coverage after copay Out of network: you pay 50% after the deductible

Covers only medical prescriptions, except for dental prescriptions issued in connection with treatment resulting from a covered accident.

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.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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Sometimes the plan will treat a service from a non-preferred provider as if that provider were a preferred provider for purposes of determining your copay, coinsurance and deductible. The plan will do this when you have a medical emergency or there is not a preferred provider in your area. You remain responsible, however, for any amount that a non-preferred provider may bill you above the recognized charge. Please note that if you travel to an area that has a preferred provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits.

If you get emergency care from a non-preferred provider, call us within two business days after you start receiving treatment. Member services is available Monday through Friday between 6 a.m. and 7 p.m. and weekends 9 a.m. to 12 p.m. Central Time, at **1-866-292-3374**.

To find out whether a provider is in Aetna's network (a **preferred provider**), use DocFind at **www.aetna.com/docfind/custom/aahc/bn**.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

Net Premier

Other Included coverage

Plan Features	Class I Benefits 1 to 90 Hours	Class II Benefits 91 to 130 Hours	Class III Benefits 131+ Hours
Short Term Disability *Coverage for employee only; coverage is not available if you work in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.*	Weekly benefit for up to 6 months while employee is disabled. 50% of base pay received from the employer that sponsors this program (*plus tips, but no overtime*) up to $80 maximum weekly benefit. Benefits begin after 14-day waiting period (*unless hospitalized, in which case Plan begins paying immediately*)	Weekly benefit for up to 6 months while employee is disabled. 50% of base pay received from the employer that sponsors this program (*plus tips, but no overtime*) up to $110 maximum weekly benefit. Benefits begin after 14-day waiting period (*unless hospitalized, in which case Plan begins paying immediately*)	Weekly benefit for up to 6 months while employee is disabled. 50% of base pay received from the employer that sponsors this program (*plus tips, but no overtime*) up to $135 maximum weekly benefit. Benefits begin after 14-day waiting period (*unless hospitalized, in which case Plan begins paying immediately*)
Term Life with Accidental Death Benefit	$15,000 of term life insurance with a matching accidental death benefit for employees Covered employees receive $2,500 in term life coverage for their eligible dependents over 6 months and $500 for children 6 months of age or younger. The accidental death benefit is not available for dependents. Benefits will be paid to the beneficiary of employee's choice Employee's benefits are reduced by 50% at age 70	$25,000 of term life insurance with a matching accidental death benefit for employees Covered employees receive $2,500 in term life coverage for their eligible dependents over 6 months and $500 for children 6 months of age or younger. The accidental death benefit is not available for dependents. Benefits will be paid to the beneficiary of employee's choice Employee's benefits are reduced by 50% at age 70	$50,000 of term life insurance with a matching accidental death benefit for employees Covered employees receive $2,500 in term life coverage for their eligible dependents over 6 months and $500 for children 6 months of age or younger. The accidental death benefit is not available for dependents. Benefits will be paid to the beneficiary of employee's choice Employee's benefits are reduced by 50% at age 70

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

Net Premier Other included coverage			
Plan Features	**Class I Benefits 1 to 90 Hours**	**Class II Benefits 91 to 130 Hours**	**Class III Benefits 131+ Hours**
Dental Benefits			
Annual Maximum	$650	$950	$1,250
Annual Deductible	$50	$50	$50
Preventive, Diagnostic and Routine Restorative Care	You are responsible for paying up to 20%† of the recognized charges. These services have no waiting period.	You are responsible for paying up to 20%† of the recognized charges. These services have no waiting period.	You are responsible for paying up to 20%† of the recognized charges. These services have no waiting period.
Major Restorative Care	You are responsible for paying up to 50%† of the recognized charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.	You are responsible for paying up to 50%† of the recognized charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.	You are responsible for paying up to 50%† of the recognized charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.

† The percentage of the cost that you are responsible for paying could be lower if you use a participating PPO network dentist (based on provider and location). A non-preferred provider may require that you pay more than the recognized charge, and this additional amount would be your responsibility. The dental PPO network is not available in Alabama, Arkansas, Idaho, Hawaii, Louisiana, Mississippi, New Mexico, or Puerto Rico. To locate a preferred provider, call toll-free 1-866-292-3374 or visit www.aetna.com/docfind/custom/aahc/bn.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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When you enroll in medical coverage, you also receive:

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/bn**. This discount arrangement may not be available to Illinois residents.

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

Informed Health® Line

Aetna's Informed Health® Line gives you and your family access to registered nurses 24 hours a day, 7 days a week. This toll-free line connects you to a team of nurses experienced in providing information on a variety of health topics. Informed Health Line nurses use the Healthwise® Knowledgebase to provide information about health issues, medical procedures and treatment options, and help you and your family communicate more effectively with your doctors. You can also choose to listen to certain health topics of interest through Aetna's new audio health library, which is available in English and Spanish. Contact Aetna's Informed Health Line at **1-800-556-1555**.

Employee Assistance Program

Aetna's Employee Assistance Program helps you and your family manage stress and balance work and life. Resources related to emotional support, childcare, and legal and financial guidance are available by telephone and online. Services also include consultation, information, education and referral services in connection with:

- parenting
- adoption
- grandparent as parent
- childcare and summer care
- temporary back-up care
- special needs
- high-risk adolescents
- adult care and elder care
- mental health
- academic services
- home improvement
- pet care
- consumer information
- legal services
- financial counseling
- child safety information
- pre-natal information

These services are convenient and confidential, available 24 hours a day, 7 days a week by calling **1-888-AETNA-EAP** (1-888-238-6232) or visiting **www.AetnaEAP.com.**

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

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.

A ***copayment*** (or ***copay***) is a fixed amount that you must pay for a medical service. In some cases, you may be responsible for paying a copay as well as a percentage of the remaining charges.

In many instances, the plan requires that a deductible is met before a benefit is paid. A ***deductible*** is the amount 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. Preferred and non-preferred (in-network and out-of-network) deductibles must be met separately. Covered expenses in-network do not count towards the out-of-network deductible, and covered expenses out-of-network do not count towards the in-network deductible.

Once the ***family deductible*** per coverage year is met, all family members will be considered to have met their deductible. You will have met your **family deductible** when two covered family members have each fully paid their own deductibles in a 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 ***negotiated charge*** is the maximum amount that a preferred provider has agreed to charge for the visit, service, or supply. You should not have to pay more than your portion of the negotiated charge, subject to your plan limits. After your plan limits have been reached, the provider may require that you pay the full charge rather than the negotiated charge.

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

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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

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.

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.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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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.

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. Call member services Monday through Friday between 6 a.m. and 7 p.m. CT and weekends 9 a.m. to 12 p.m. CT, by calling toll free **1-866-292-3374**. We're here to answer questions before and after you enroll.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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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 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, unless medically necessary to repair an injury to the mouth, jaw or teeth resulting from an accident.
- 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.

Dental Exclusions:

The following charges are not covered under the dental plan, 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.

BENEFITS SUMMARY

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Short Term Disability Exclusions:

- Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
- Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
- Substance abuse.
- Occupational injury or sickness.

Term Life Exclusions:

- Suicide or attempted suicide (while sane or insane).

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.

BENEFITS SUMMARY

Plan design and benefits provided by Aetna Life Insurance Company (Aetna)

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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.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL (1-877-623-6765) or visit the Connector website (www.mahealthconnector.org). THIS HEALTH PLAN, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.

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. Material is subject to change.

Insurance plans are underwritten by Aetna Life Insurance Company.

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