



PLAN DESIGN

Customer Name: Lancesoft, Inc.

Proposed Effective Date: 06-01-2009

Policy Period: 12

Option: 90/70 PPO-revised

Plan: PPO Plan

Location(s): Virginia

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Ram Kumar K
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 PROVIDED BY AETNA LIFE INSURANCE COMPANY**

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family
All covered expenses, excluding prescription drugs, accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	10%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$1,500 Individual \$3,000 Family	\$4,500 Individual \$9,000 Family
All covered expenses, excluding prescription drugs, accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	\$2,000,000	
Primary Care Physician Selection	Not Applicable	Not Applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 18 and older.	\$30 office visit copay; deductible waived	30%
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.	Covered 100%; deductible waived	Covered 100%
Routine Gynecological Care Exams Includes routine tests and related lab fees.	10%; deductible waived	30%
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	30%
Routine Digital Rectal Exam For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Prostate-specific Antigen Test For covered males age 40 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered



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Colorectal Cancer Screening	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
For all members age 50 and over.		
Routine Eye Exams	\$40 office visit copay; deductible waived	30%
1 routine exam per 12 months.		
Routine Hearing Exams	\$40 copay; deductible waived	30%
1 routine exam per 24 months		
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to non-Specialist	\$30 office visit copay; deductible waived	30%
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	\$40 office visit copay; deductible waived	30%
E-visit to non-Specialist	\$30 office visit copay; deductible waived	30%
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
E-visit to Specialist	\$40 office visit copay; deductible waived	30%
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
Walk-in Clinics	\$30 office visit copay; deductible waived	30%
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray (other than Complex Imaging Services)	Covered 100%	30%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Outpatient Complex Imaging	\$100 copay	30%
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	\$50 copay; deductible waived	30%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	\$150 copay; deductible waived	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	30%
Non-Emergency Use of Ambulance	Not Covered	Not Covered



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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% after \$500 per admission copay	30% after \$750 per admission copay
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% after \$500 per admission copay	30% after \$750 per admission copay
Outpatient Hospital Expenses (including surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	10%	30%
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% after \$500 per admission copay	30% after \$750 per admission deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. All Mental Health and Alcohol/Drug day and visit limits are combined.	\$40 copay; deductible waived	30%
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	10% after \$500 per admission copay	30% after \$750 per admission copay
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. All Mental Health and Alcohol/Drug day and visit limits are combined.	\$40 copay; deductible waived	30%
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%
Home Health Care Limited to 100 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%	30%
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%
Hospice Care - Outpatient Up to a maximum benefit of \$5,000. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	\$40 copay	30%
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	\$40 copay; deductible waived	30%
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	\$40 copay; deductible waived	30%
Durable Medical Equipment Maximum benefit of \$5,000 per member per calendar year.	20%	20%
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.



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Transplants	10% after \$500 copay Preferred coverage is provided at an IOE contracted facility only.	30% after \$750 copay Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	10% after \$500 per admission copay	30% after \$750 per admission deductible

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

"Other" Health Care -- 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred".

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Retail	\$20 copay for generic drugs, \$40 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20%
Mail Order	\$40 copay for generic drugs, \$80 copay for formulary brand-name drugs, and \$140 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable

Pharmacy Managed Self Injectables (PMSI)
 First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

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

Oral fertility drugs included.

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

Step Therapy included with 90 day Transition of Care.

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 19 or age 25 if in school
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full postponement



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This plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

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 state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
Charges related to 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 such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
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; and special duty nursing. 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 results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.



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Some benefits are subject to limitations or visit maximums. 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's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.