



PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	\$500 Employee	\$500 Employee
All covered expenses accumulate toward both the preferred and non-preferred deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable, except for PCP office visits.		
Member Coinsurance	10%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	\$2,500 Employee	\$6,500 Employee
All covered expenses accumulate 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, copays, and penalty amounts) may be used to satisfy the payment limit.		
Lifetime Maximum	\$5,000,000 per member's lifetime.	
Primary Care Physician Selection	Optional	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. Precertification for certain procedures/treatments - excluded amount is \$200 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	\$20 office visit copay	ded then 30%
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	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
For covered males age 40 and over.		
Colorectal Cancer Screening	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
For all members age 50 and over.		
Routine Eye Exams	\$20 office visit copay	ded then 30%
1 routine exam per 24 months		
Routine Hearing Exams	\$20 office visit copay	ded then 30%
1 routine exam per 24 months		
PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits (non surgical) to PCP	\$20 office visit copay	ded then 30%
Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.		
Specialist Office Visits (non-surgical)	\$20 office visit copay	ded then 30%
Outpatient Surgery	10%	30%
Allergy Testing	Covered as either PCP or specialist office visit; deductible waived	30%
Allergy Injections (Copay waived when an office visit charge is not made)	Covered as either PCP or specialist office visit	30%
DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	100% deductible waived	30%
MRIs, CAT Scans & PET Scans are covered after the deductible at 80% coinsurance		
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE

PRIEST VERSION



The Diocese of Cheyenne
 Effective Date: 01-01-2010
 (Priest)

Urgent Care Provider (benefit availability may vary by location)	\$50 copay	30%
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Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
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Emergency Room	\$100 copay; deductible waived then 90%	\$100 copay; deductible waived then 90%
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Non-Emergency care in an Emergency Room	Not Covered	Not Covered
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Ambulance	10%	10%
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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient Coverage	ded then 10%	30% after \$500 per confinement deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient Hospital Expenses (including surgery)	10%	30%
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The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit

MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient	10%	30% after \$500 per confinement deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient	\$20copay	30%
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit
 Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services

ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Inpatient	ded then 10%	30%
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Outpatient	\$20copay	30%
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Limited to 30 visits per calendar year.
 The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit
 Combined Mental Health and Alcohol/Drug maximum for preferred and non-preferred services

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
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Convalescent Facility	10%	30%
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Limited to 100 days per calendar year.
 The member cost sharing applies to all covered benefits incurring during a member's inpatient stay

Home Health Care	Covered 100%	30%
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Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts 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.

Hospice Care - Inpatient	10%	30% after \$500 per confinement deductible
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Up to a maximum lifetime benefit of \$10,000 combined inpatient/outpatient
 The member cost sharing applies to all covered benefits incurred during a member's inpatient stay

Hospice Care - Outpatient	10%	30%
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Up to a maximum lifetime benefit of \$10,000 combined inpatient/outpatient
 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit

Outpatient Speech Therapy	\$20copay	30%
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Limited to 20 visits per calendar year

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 limitation 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.

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.