~ Job Posting ~

Clinical Therapist

Illinois Department of Human Services Treatment & Detention Facility

The Illinois Department of Human Services Treatment & Detention Facility is a secure residential treatment facility which serves approximately 500 detained and civilly committed adult sexual offenders.

The clinical program operates within a state-of-the-art treatment facility located in Rushville, Illinois. Rushville is situated in west central Illinois, and is commutable from the Macomb (home of Western Illinois University), Springfield (the State Capital), and Quincy. Rushville is within a few hours of St. Louis, Chicago and Indianapolis.

Clinical services at the facility are provided by Liberty Healthcare's experienced and dedicated team of over thirty psychologists, social workers, counselors, psychiatrists, and recreation therapists. We offer a full range of diagnostic and treatment services related to sexually deviant behavior, paraphilias and mental illness.

Due to continued growth and expansion of our clinical program, Liberty is accepting applications for full-time Clinical Therapist positions. Job responsibilities include providing a wide range of assessment, counseling, therapy and psycho-educational services; serving as an active member of multidisciplinary treatment teams; and serving as primary therapist for an assigned caseload.

A minimum of a Masters Degree in Psychology, Clinical Social Work or Counseling and professional licensure in Illinois is required, however candidates who are eligible for professional licensure or fulfilling supervision requirements will also be considered. Candidates who have prior experience providing treatment services to sexual offenders, forensic patients or a comparable client population will be given priority consideration.

As a member of our team and employee of Liberty you can expect to receive a competitive salary which is commensurate with your qualifications. Our employees receive a well rounded benefits package which includes health, dental, vision, disability, life and professional liability insurance. Our employees receive six weeks of cumulative paid time off annually. Flexible and compressed (4-day) work weeks may be accommodated. Selected out-of-town applicants receive assistance with interview travel expenses. Financial assistance with relocation expenses is also provided. Our clinicians receive financial assistance with expenses related to relevant professional association membership; professional licensure, and seminars, conferences and training. If you are not licensed professionally in Illinois, we can assist in the process and allow a reasonable amount of time for acquiring professional licensure. Non-licensed clinicians may receive supervision towards licensure requirements from our licensed staff.

Details regarding Liberty's benefits may be found at the end of this information packet.

Illinois Department of Human Services
Treatment & Detention Facility
Rushville, Illinois

In 1998, the State of Illinois passed the Sexually Violent Persons Commitment Act. Four standards must be met, for an individual to be committed under this Act:

1) The person must be within 90 days of release from an adult criminal sentence for a qualifying sexual offense.
2) The person must have a justifiable DSM-IV diagnosis of mental disorder.
3) The person must have a substantial probability of committing future acts of sexual violence because of his mental disorder.
4) It must be proved, beyond a reasonable doubt, that the person's risk of future sexual violence is the result of his mental disorder.

People who are committed under the Act are remanded to the custody of the Illinois Department of Human Services, and admitted to the *Treatment and Detention Facility* located in Rushville, Illinois.

Once admitted to this secure residential treatment facility, residents are provided with a full range of diagnostic, treatment and rehabilitative services to address sexually violent and deviant behaviors. Treatment modalities include individual and group counseling; behavior modification; psychopharmacology, substance abuse counseling; psychosocial and psycho-educational programming; and therapeutic and recreational activities. The facility presently serves 500 residents. Over 60% of the resident actively participate in the treatment program.

Clinical services at the facility are provided through a long-term service contract with Liberty Healthcare Corporation. Liberty employs over thirty experienced Psychologists, Social Workers, Mental Health Counselors, Psychiatrists, Substance Abuse Counselors, Recreation Therapists, and Activity Leaders. The State of Illinois employs a full complement of security and paraprofessional staff to secure the facility and ensure the safety of the facility's staff and residents.

Residents who are discharged from the facility into the community are served by Liberty's *Community Conditional Release Program*. This community-based program employs aggressive case management, GPS monitoring, regular polygraph examinations and drug & alcohol screening, and ongoing outpatient assessment and treatment services.

CLINICAL THERAPIST

POSITION DESCRIPTION

Reports To and Evaluated By: Team Leader

Overview

Provides sex offender specific and related treatment services to civilly committed and detained residents of the Treatment and Detention Facility, utilizing cognitive-behavioral methods. Primary modality for service delivery is group therapy, however individual therapy or individual contact with residents is also utilized. Responsible for directing and facilitating assessment-based individualized treatment for assigned residents as a member of the multi-disciplinary treatment team.

Duties and Responsibilities

1) Comply with all laws, policies and procedures, rules and regulations formulated by the State of Illinois Department of Human Services (DHS) and Liberty Health Care (Liberty), and any applicable professional governing bodies.

2) Deliver cognitive-behavioral treatment, psycho-education and other treatment to individuals and groups as assigned, in accordance with established performance standards. Document service delivery and resident progress on a weekly basis, completed in accordance with established standards and time frames.

3) Serve as primary therapist to assigned residents, with frequency and amount of direct contact with residents consistent with established performance standards. Primary therapy duties include: (a) reviewing and integrating assessment information to write and monitor individualized treatment plans; (b) coordinating referral of residents to appropriate treatment groups and activities; (c) referring clients to psychiatric services and encourage residents to seek medical services or other specialized care as needed; (d) meeting weekly with assigned residents to monitor and review ongoing treatment or other needs; (e) reviewing and revising, as needed, resident individualized treatment plans using established format on a quarterly basis; (f) evaluating clinical appropriateness of property and visitation requests; (g) documenting all individual resident contacts using established formats within established time frames; and (h) other duties related to primary care of assigned residents as directed.

4) Provide training and consultation to treatment and security staff on clinical methods and procedures related to the Sexually Violent Persons population as directed.

5) Administer tests and assessments within scope of licensure, certification and training, as assigned.

6) Attend and actively participate in staff meetings, case conferences, case presentations, staff development meetings and training activities.

7) Provide clinical support and back up to other clinical staff as needed.

8) Works cooperatively in weekly individual supervision with Team Leader for clinical and administrative supervision.

Clinical Therapist job description - continued

9) Perform administrative duties including documentation of work hours, correspondence and coordination with other clinical and facility staff, etc.

10) Other duties as assigned.

Knowledge and Skills

1) Prior clinical experience working with sexual offenders and an understanding of the dynamics of sexual deviance strongly preferred.

2) Familiarity with relevant research literature, clinical assessments, procedures and methods, particularly those designed for sexual offenders.

3) Ability to assess treatment goals and write goal-directed, individualized treatment plans, as well as the ability to monitor and document individual behavior patterns and modify treatment plans to meet changing treatment goals.

4) Ability to instruct others in the implementation of therapeutic and behavioral interventions and procedures.

5) Excellent listening and verbal communication skills.

6) Familiarity with the diagnostic nomenclature outlined in the Diagnostic and Statistical Manual, 4th Edition (or most recent updated edition).

7) Demonstrated interpersonal skills and the ability to establish rapport and maintain objectivity with a criminal or forensic population.

8) Appreciation of the need for and ability to maintain appropriate personal boundaries in working with sexual offender populations.

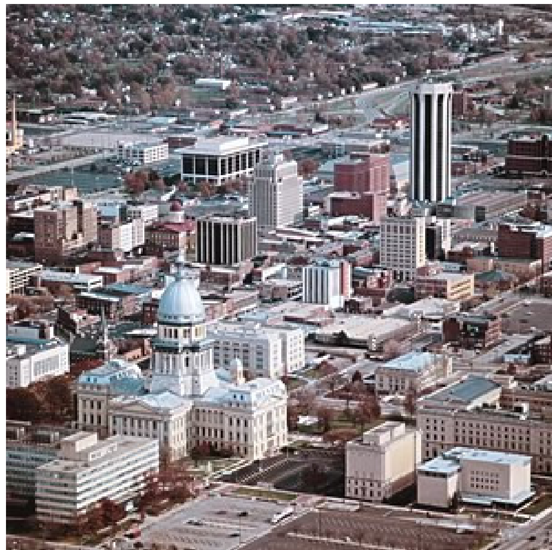
9) Investment in expanding current skills/knowledge and to the transfer of this knowledge to other staff.

10) Ability to form and maintain good working relationships with a diverse staff and a commitment to enhancing cultural competency.

Education/Licensure

1) Masters or Doctoral degree in psychology, social work, counseling.

2) Licensed or license-eligible in Illinois as a Clinical Psychologist (LCP), Clinical Professional Counselor (LCPC), or Clinical Social Worker (LCSW). Individuals who are licensed or licensed-eligible as a Licensed Social Worker (LSW), or Licensed Professional Counselor (LPC) may also be considered for hire but must obtain licensure as an LCSW or LCPC, respectively, within a reasonable amount of time from either date of hire or date of licensure (whichever is earlier)**.**



Downtown Springfield, Illinois
(Illinois State Capital)

A view of Quincy, Illinois and the Mississippi river

Western Illinois University – Macomb, Illinois

Illinois Department of Human Services Treatment & Detention Center

Rushville, IL

Larger towns within commuting distance of Rushville, Illinois

- Macomb – 30 minute drive
- Springfield – 60 minute drive
- Quincy – 60 minute drive

Major cities in the region, with driving distances from Springfield, IL:

• St. Louis, MO – 2.5 hours	regular non-stop flights & train service
• Chicago, IL – 3 hours	regular non-stop flights & train service
• Quad Cities, IL & IA – 3 hours	
• Indianapolis, IN – 3.5 hours	
• Louisville, KY – 5 hours	
• Des Moines, IA – 5 hours	

Useful websites

Liberty Healthcare http://www.libertyhealthcare.com/

Illinois Department of Human Services **http://www.dhs.state.il.us/**

Illinois Department of Professional Regulation

Psychology licensure http://www.idfpr.com/profs/info/psych.asp

Social Work licensure http://www.idfpr.com/profs/info/SocialWorker.asp

Counseling licensure http://www.idfpr.com/PROFS/Info/ProfCounselor.asp

Housing information - national listings

Rental properties / listings by city http://www.rent.com

http://www.apartments.com

Homes for sale / listings by city http://www.realtor.com

Relocation information
& cost of living calculator http://www.homefair.com

Springfield, Illinois

General information http://www.uis.edu/about/springfield.html

http://www.visit-springfieldillinois.com/

Area guide w/link to rentals (link to rental properties)

Chatham Hills Apartments http://www.chathamhillsapts.com

Huntington Ridge Apartments http://www.huntington-ridge.com/

Madison Park Townhomes http://www.youtube.com/watch?v=wRYa2JzSn70

Olde Town Apartments http://www.youtube.com/watch?v=APgaDEOfGv4

Craigslist – Springfield http://springfieldil.craigslist.org/

Springfield airport http://www.flyspi.com/

Amtrak train service http://www.amtrak.com

Journal Register newspaper
(link to rental properties) http://www.sj-r.com/

Springfield public schools http://www.springfield.k12.il.us/

White Oaks Mall / shopping http://www.simon.com/mall/default.aspx?ID=180

Quincy, Illinois

General information http://www.quincy-cvb.org/

Local TV station / news http://www.wgem.com/

Herald Whig newspaper http://www.qps.org/index.html

Quincy public schools http://www.qps.org/index.html

Quincy mall / shopping http://www.atquincymall.com/

Craigslist – Quincy http://quincy.craigslist.org/

Macomb, Illinois

General information (news, relocation info, etc.) http://www.macomb.com/

http://www.makeitmacomb.com/

Western Illinois University http://www.wiu.edu/

Macomb Daily newspaper http://www.macombdaily.com/

Apartments & rentals in Macomb:

Southern Hill Apartments
1007 W. Grant Street
(309) 837-2143

Stratford West Townhouses
10 Rye Court
(309) 837-1689

Triad Square
104 N. Ward Street
(309) 833-2320

Turnberry Village Apartments
101 Wigwam Hollow Circle
(309) 836-6342

Liberty Healthcare Corporation was founded in 1976 by Herbert T. Caskey, M.D.

Since the company's inception, Liberty has been providing clinical consulting, staffing and management services to health care facilities nationwide.

Our mission is to be a progressive developer and manager of quality, consumer-oriented treatment delivery systems. We strive to achieve this goal through:

- Forming collaborative partnerships with our clients
- Customizing programs to meet the unique needs of our client's health care consumers
- Managing programs with a consumer focus
- Recruiting and retaining skilled, dedicated, and compassionate personnel
- Supporting our personnel
- Committing to continuous quality improvement

Our clients range from state governmental departments and agencies to *Fortune 500* companies. We are recognized for our specialized:

- Behavioral health services for people with forensic issues
- Psychiatric care for people with acute and chronic mental illness
- Medical and habilitative services for the geriatric population and people with developmental disabilities
- Primary care and occupational health care services for employees of large industrial companies

Liberty Healthcare is a privately-held organization, which is lead by Dr. Caskey and a management team which is largely comprised of clinicians. Based in suburban Philadelphia – our corporate office supports one thousand employees, among forty clinical programs, throughout twenty states.

We're an organization comprised of dedicated psychologists, counselors, social workers, therapists, nurses, physicians, direct care workers, and administrative support staff. Many of our employees are recognized nationally as leaders in their respective fields. Many serve as surveyors for accrediting agencies such as HCFA and JCAHO, and are published in widely circulated clinical journals and periodicals.

- Liberty Healthcare is an equal opportunity employer -

401 East City Avenue, Suite 820
Bala Cynwyd, Pennsylvania 19004
(800) 331-7122

www.libertyhealthcare.com

Liberty Healthcare Corporation and its Affiliates

Our Vision

is to be the premier developer and manager of customized, highest-quality treatment delivery systems for the public and private sectors in facility and community settings.

Our Mission

is to provide healthcare management solutions of the highest quality in both the public and private sectors that are consumer-focused, cost-effective, gainful and outcomes-oriented. Liberty is dedicated to on-going enhancement of our existing methodologies for delivering quality treatment services, while retaining our entrepreneurial capacity to rapidly create new services to meet emerging opportunities in the market place.

Our Core Values: "S-E-R-V-I-C-E"

Staff: Liberty values its staff. We recognize that the greatest resource of any program is highly skilled staff who are dedicated to the persons and programs they serve. We recruit and retain the best possible people and support them with the best technology and resources to do their jobs.

Entrepreneurial: Liberty is a creative "can do" company that specializes in developing health care solutions for the most complex and challenging situations and populations.

Responsiveness: Although Liberty manages many programs in many regions, we believe that health care delivery must be local and personalized. We empower our local program directors, while ensuring easy access to corporate managers with the clinical and administrative authority to make vital decisions promptly.

Value-Added: Liberty offers depth and diversity of resources in support of our contracts, such as clinical programming, specialist consultations, training, personnel management, information and reporting systems, program accreditation, recruiting and credentialing, and quality management.

Independence: Liberty is not a part of any network, managed care organization, hospital chain or insurance plan. Our sole obligation is to serve the goals of our customers by devising and delivering high quality care to each individual. Our healthcare professionals are compensated to eliminate any incentives to deny needed services or add unnecessary ones.

Collaboration: Liberty forms a close, collaborative partnership with each customer. Instead of trying to make the client fit our goals, we customize our resources to achieve the goals of the client.

Effectiveness: Liberty is accountable for getting results. The quality and cost-effectiveness of every aspect of our contracted program services is critical. We are committed to the principle of measurable excellence and supporting all our programs with state-of-the-art Quality Improvement programming.

BENEFITS INFORMATION

401 E. City Avenue, Suite 820
Bala Cynwyd, PA 19004
800-331-7122

Paid Time Off

Liberty offers 240 hours (equivalent to thirty 8-hour days) of cumulative paid time annually. This includes vacation, holiday, sick and personal time. Employees begin accruing paid time off immediately upon the commencement of employment, and may use their time as soon as it is accrued.

Payday

Employees are paid bi-weekly by direct deposit, every other Friday, a total of 26 times per year.

Section 125

Liberty offers a Section 125 premium conversion plan to its employees. Any employee contributions towards benefits are taken from pre-tax income.

Health Insurance

Liberty employees receive health insurance through Aetna

Aetna's plan is one of the top-rated Preferred Provider Organization (PPO) in the country. Unlike an HMO, this plan gives you freedom of choice of doctors and hospitals, enrollment with a primary care physician is not required, and referrals for specialty care are not necessary.

A prescription plan is also included. Upon commencement of employment, employees receive an information packet detailing participating physicians, co-payments, etc.

Liberty employees who elect to receive health insurance through the company are required to contribute $113.63 per pay period for high option or $68.92 per pay period for low option insurance plans (details on both plans enclosed). Employees may also elect to purchase health insurance for their dependents through Liberty Healthcare. Please consult with a human resources representative regarding the rates for dependent health insurance.

Employees are eligible to receive health, dental and vision insurance benefits approximately 30-60 days from the commencement of employment.

Disability Insurance

Disability insurance enables you to receive income if you become disabled in a non-work-related accident or injury. A human resources representative can provide you with details regarding disability coverage.

Life Insurance

A life insurance policy is purchased for each full time employee. In the event of the employee's death, their beneficiary would receive a one time payment of the employee's annual salary to a maximum of $50,000.00. Employees also have the option of purchasing supplemental life insurance through *Unum Provident.*

Dental Insurance

A voluntary dental plan is offered through *Aetna*
To find a participating dentist visit www.aetna.com

Biweekly payroll deductions:

Employee only	$14.51
Employee & one dependent	$27.50
Employee & full family	$44.43

Vision Plan

Liberty's vision plan is *VSP.* Most exams, frames & contact lenses are covered in-full. Details may be found online at www.vsp.com.

Biweekly payroll deductions:

Employee only	$6.89
Employee & one dependent	$11.03
Employee & full family	$18.15

401 (k)

Liberty employees may participate in the 401(k) plan ninety days from the commencement of employment.

The 401(k) plan is administered by Fidelity Investments. To learn more about the wide variety of investment options offered, please visit www.401k.com.
A representative is available to assist you with your financial planning. Liberty does not offer a match.

AETNA MEDICAL & PRESCRIPTION PLAN

Core High Option – PPO
Bi-Weekly Deductions

Employee	$113.63
EE + Child(ren)	$264.79
EE + Spouse	$367.17
Family	$467.50

Liberty Healthcare Corporation
Proposed Effective Date: 06-01-2011
Open Choice® (PPO) - Pennsylvania

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	None Individual None Family	$1,500 Individual $4,500 Family
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	Covered 100%	80%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	None Individual None Family	$10,000 Individual $30,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Payment for Non-Preferred	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
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	Covered 100%	80%; after deductible
1 exam every 12 months for members age 18 and older.		
Routine Well Child Exams/Immunizations	Covered 100%	80%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.		
Routine Gynecological Care Exams	Covered 100%	80%; after deductible
Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%	80%; after deductible
Routine Digital Rectal Exam	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Prostate-specific Antigen Test	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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; after deductible
For all members age 50 and over.		
Routine Eye Exams	$40 office visit copay	80%; after deductible
1 routine exam per 24 months.		
Routine Hearing Exams	Not Covered	Not Covered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to non-Specialist	$20 office visit copay	80%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		

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Specialist Office Visits	$40 office visit copay	80%; after deductible
E-visit to non-Specialist	$20 office visit copay	80%; after deductible
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	$30 office visit copay	80%; after deductible
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	$20 office visit copay	80%; after deductible
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.	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%	80%; after deductible
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	$50 copay	80%; after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Emergency Room	$100 copay	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%	Covered 100%
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	$250 per admission copay	80%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	$250 per admission copay	80%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses (including surgery)	Covered 100%	80%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	$250 per admission copay	80% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$40 copay per visit	80% per visit; after deductible
Additional outpatient visits may be provided. Each day of inpatient benefits may be converted into two additional outpatient visits. 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.		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	$250 per admission copay	80% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	$250 copay per admission	80% per admission; after deductible

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Outpatient	$40 copay per visit	80% per visit; after deductible
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.		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	$100 per admission copay	80% per admission; after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100% per visit	80% per visit; after deductible
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	Covered 100% per admission	80% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100% per visit	80% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Treatment of Autism	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.
Covered the same as any other expense. Limited to $36,000 annually for eligible individuals under 21 years of age. Includes coverage for habilitative care and Applied Behavioral Analysis. Once the limit has been met, Applied Behavioral Analysis will be covered under Mental Health services.		
Outpatient Speech Therapy	$40 copay per visit	80% per visit; after deductible
Limited to 20 visits per calendar year.		
Outpatient Physical and Occupational Therapy	$40 copay per visit	80% per visit; after deductible
Limited to 30 visits per calendar year combined.		
Spinal Manipulation Therapy	$40 copay per visit	80% per visit; after deductible
Limited to 20 visits per calendar year.		
Durable Medical Equipment	80%	80%; after deductible
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.
Vision Eyewear	Covered 100% up to $100 every24 months	Same as preferred care
Transplants	$250 copay Preferred coverage is provided at an IOE contracted facility only.	80%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
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; after deductible

Diagnosis and treatment of the underlying medical condition.

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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.; after deductible	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.	Not Covered
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
Aetna Specialty CareRx First prescription fill at any retail 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 and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).		
Precert for growth hormones included. Expanded Precert included.		
Step Therapy included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26.	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Full postponement	

For members age 19 or over 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.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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.

***Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.**

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule, which are the standard rates for paying providers within the network. For out-of-network hospitals and other out-of-network facilities, Aetna pays a percentage as defined in the member's plan of the reasonable and customary charge as determined by Aetna. The member may have to pay the difference between the out-of-network facility's bill and the amount that Aetna pays, plus any coinsurance and deductibles due under the plan.

This benefit applies when members choose to get care out of network. When members have no choice in the doctors they see (for example, an emergency room visit after a car accident), they are generally not responsible for the extra out-of-network costs.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. 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 and are subject to change. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Durable medical Equipment
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including 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.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Orthotics except diabetic orthotics.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- 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.

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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).

Translation of the material into another language may be available. Please call Member Services at **1-888-98-AETNA (1-888-982-3862).**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (1-888-982-3862).**

Plan features and availability may vary by location and group size.

AETNA MEDICAL & PRESCRIPTION PLAN

Basic Low Option – PPO
Bi-Weekly Deductions

Employee	$ 68.92
EE + Child(ren)	$229.10
EE + Spouse	$316.92
Family	$404.48

IL-TDF 5/1/12

Liberty Healthcare Corporation
Proposed Effective Date: 05-01-2012
Aetna Health Network Option℠ - New Jersey

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$2,000 Individual $4,000 Family	$5,000 Individual $15,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate separately toward the in-network and out-of-network Deductible. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.		
Out-of-Pocket Maximum (per calendar year)	$3,000 Individual $6,000 Family	$10,000 Individual $30,000 Family
Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All applicable covered expenses accumulate separately toward the in-network and out-of-network Out-of-Pocket-Maximum. In-network expenses include coinsurance, deductible and copays. Out-of-network expenses include coinsurance and copays. Penalty amounts do not apply. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.		
Lifetime Maximum	Unlimited except where otherwise indicated.	Unlimited except where otherwise indicated.
Payment for Non-Preferred Care**	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Optional	Not Applicable
Precertification Requirement Certain non-participating providers/participating provider self referred services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 18 and older.	Covered 100%; deductible waived	Not Covered
Routine Well Child Exams/Immunizations (Age and frequency schedules apply)	Covered 100%; deductible waived	50%; after deductible
Routine Gynecological Care Exams 1 exam per 12 months Includes routine tests and related lab fees.	Covered 100%; deductible waived	50%; deductible waived
Routine Mammograms Recommended: one annual mammogram for covered females age 40 and over.	Covered 100%; deductible waived	50%; deductible waived
Routine Digital Rectal Exams / Prostate Specific Antigen Test Recommended for males age 40 and over.	Covered 100%; deductible waived	Subject to Routine Physical Exam benefit.
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	Subject to Routine Physical Exam benefit.

Frequency schedule applies.

Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months. Includes glaucoma test every 5 years for all covered members age 35 and over.	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam benefit.	Subject to Routine Physical Exam benefit.
Newborn Hearing Testing and Monitoring	Subject to Routine Physical Exam cost sharing.	
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician Visits	Office Hours: $20 copay; After Office Hours/Home: $25 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$40 copay; deductible waived	50%; after deductible
Prenatal OB Care	Covered 100%; deductible waived	50%; after deductible
E-visit to PCP	$20 copay; deductible waived	50%; after deductible
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 copay; deductible waived	50%; after deductible
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	$20 copay; deductible waived	50%; after deductible
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 Treatment	Same as applicable participating provider office visit member cost sharing	50%; after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	50%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic Laboratory	Covered 100%; deductible waived	50%; after deductible
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 X-ray	$50 copay; deductible waived	50%; after deductible
Outpatient hospital or other Outpatient facility (other than Complex Imaging Services)		

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

Diagnostic X-ray for Complex Imaging Services	$50 copay; deductible waived	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	30%; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	30%; deductible waived	Refer to participating provider benefit.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; deductible waived	Refer to participating provider benefit.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage	Covered 100%; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital	Covered 100%; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Biologically Based Mental Illness	Covered 100%; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Non-Biologically Based Mental Illness	Covered 100%; after deductible	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Biologically Based Mental Illness	$40 per visit; deductible waived	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Non-Biologically Based Mental Illness	$40 per visit; deductible waived	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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ALCOHOL/DRUG ABUSE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient Detoxification - Alcohol Abuse	Covered 100%; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Detoxification - Drug Abuse	Covered 100%; after deductible	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Detoxification - Alcohol Abuse	$40 per visit; deductible waived	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Detoxification - Drug Abuse	$40 per visit; deductible waived	
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Inpatient Rehabilitation - Alcohol Abuse	Covered 100%; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Rehabilitation - Drug Abuse	Covered 100%; after deductible	
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	Covered 100%; after deductible	50% per admission; after deductible
Outpatient Rehabilitation - Alcohol Abuse	$40 per visit; deductible waived	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Rehabilitation - Drug Abuse	$40 per visit; deductible waived	
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility	30% per admission; after deductible Limited to 120 days; per calendar year	50% per admission; after deductible Limited to 120 days; per calendar year
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	$50 copay; deductible waived	50%; after deductible
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	30% per admission; after deductible	50% per admission; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	$50 per visit; deductible waived	50% per visit; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Speech Therapy	$20 per visit; deductible waived Limited to 20 visits; per calendar year	50% per visit; after deductible Limited to 20 visits; per calendar year
Outpatient Physical and Occupational Therapy	$20 copay; deductible waived Limited to 30 visits; per calendar year	50%; after deductible Limited to 30 visits; per calendar year
Spinal Manipulation Therapy	$20 copay; deductible waived Limited to 20 visits; per calendar year	50%; after deductible Limited to 20 visits; per calendar year

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Autism	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.
ABA is covered the same as any other expense for eligible individuals who are 21 years of age or younger. Also, unlimited coverage for Habilitative care is provided to children under age 21 who are diagnosed with autism or another developmental disability.		
Durable Medical Equipment	50%; deductible waived	50%; after deductible (must precertify if over $1,500) Limited to $2,500; per calendar year
Hearing Aids	Covered 100%; deductible waived	Covered according to standard claim practice.
Coverage for all persons age 15 or younger. One hearing aid for each impaired ear limited to $1,000 per hearing aid every 24 months.		
Diabetic Supplies	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.	50%; after deductible
Vision Eyewear	Covered 100% up to $100 every24 months; not subject to any plan deductible, if applicable	Covered same as participating provider benefit.
Transplants	Covered 100% per admission; deductible waived Preferred coverage is provided at an IOE contracted facility only.	50% per admission; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Covered 100% per admission; deductible waived	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	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; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Applicable cost sharing based on the type of service performed and place of service where rendered.	Not Covered
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	Applicable cost sharing based on the type of service performed and place of service where rendered.	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 4 complete egg retrievals per lifetime.		
Vasectomy	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; after deductible.
Including tubal ligation and vasectomy.		

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PRESCRIPTION DRUG BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Retail	$20 copay for formulary generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be multiplied.		
Mail Order	$40 copay for formulary generic drugs, $80 copay for formulary brand-name drugs, and $140 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered
No Mandatory Generic (NO MG) - The member pays the applicable copay only.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Precert included		
Prescription Drug Deductible; per calendar year	None Individual None Family	Not Applicable
All covered pharmacy expenses accumulate toward the pharmacy deductible. Unless otherwise indicated, the pharmacy deductible must be met prior to pharmacy benefits being payable.		

GENERAL PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.
• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much Aetna "recognizes" depends on the plan you or your employer picks.
Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits and health insurance plans contain exclusions and limitations.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).

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 and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

The following is a 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectible drugs including injectible infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Orthotics except diabetic orthotics.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

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. Aetna Rx Home Delivery and Aetna Specialty Pharmacy refer to Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, respectively. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are licensed pharmacy subsidiaries of Aetna Inc. that operate through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacies' cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

If you require language assistance from an Aetna representative, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante de Aetna que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

401 City Avenue
Suite 820
Bala Cynwyd, PA 19004
Phone (610) 668-8800
Phone (800) 331-7122
Fax (610) 667-5559

2012
AETNA DENTAL

	DEDUCTIONS PER PAY PERIOD
EMPLOYEE	$14.51
EMPLOYEE +1	$27.50
EMPLOYEE + 2 or more	$44.43

Liberty Healthcare Corporation
Effective Date: 05-01-2012

Dental Benefits Summary

	Active PPO With PPOII Network	
	Participating	Non-participating
Annual Deductible*		
Individual	$50	$50
Family	$150	$150
Preventive Services	100%	100%
Basic Services	100%	80%
Major Services	60%	50%
Annual Benefit Maximum	$1,500	$1,000
Office Visit Copay	N/A	N/A
Orthodontic Services	Not Covered	Not Covered
Orthodontic Deductible	Not Covered	Not Covered
Orthodontic Lifetime Maximum	Not Covered	Not Covered

*The deductible applies to: Basic & Major services only

Partial List of Services	Active PPO With PPOII Network	
Preventive	Participating	Non-participating
Oral examinations (a)	100%	100%
Cleanings (a) Adult/Child	100%	100%
Fluoride (a)	100%	100%
Sealants (permanent molars only) (a)	100%	100%
Bitewing X-rays (a)	100%	100%
Full mouth series X-rays (a)	100%	100%
Space Maintainers	100%	100%
Basic		
Root canal therapy		
Anterior teeth / Bicuspid teeth	100%	80%
Scaling and root planing (a)	100%	80%
Gingivectomy*	100%	80%
Amalgam (silver) fillings	100%	80%
Composite fillings (anterior teeth only)	100%	80%
Stainless steel crowns	100%	80%
Incision and drainage of abscess*	100%	80%
Uncomplicated extractions	100%	80%
Surgical removal of erupted tooth*	100%	80%
Surgical removal of impacted tooth (soft tissue)*	100%	80%
Major		
Inlays	60%	50%
Onlays	60%	50%
Crowns	60%	50%
Crown lengthening	60%	50%
Full & partial dentures	60%	50%
Pontics	60%	50%
Root canal therapy, molar teeth	60%	50%
Osseous surgery (a)*	60%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	60%	50%
General anesthesia/intravenous sedation*	60%	50%
Denture repairs	60%	50%
Crown Build-Ups	60%	50%

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Prepared: 03/07/2012 09:57 PM

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to usual and prevailing charge limits, as determined by Aetna.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. 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.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (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; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. 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.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. 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.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dentals online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.
In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.
All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

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Phone (800) 331-7122
Fax (610) 667-5559

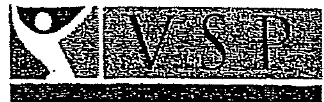
VISION SERVICE PLAN 2011

DEDUCTIONS PER PAY PERIOD

SINGLE -	$ 6.89
SPOUSE -	$11.03
CHILD -	$11.03
CHILDREN -	$11.26
FAMILY -	$18.15

VSP Vision Plan

Benefit Description	In-Network Coverage	Out-of-Network Reimbursement
Eye exam	**Covered in Full after $10 Copay** Max of once every 12 months	$45
Frames	**Covered in full up to $120 Value** Eyeglass frames are covered once every 12months for all members	$47
Single Lenses	**Covered in Full** Max of once every 12 months	$45
Bifocal lenses	**Covered in Full** Max of once every 12 months	$65
Trifocal lenses	**Covered in Full** Max of once every 12 months	$85
Aphakic/Lenticular	**Covered in Full** Max of once every 12 months	$125
Contact Lenses Disposable	**Covered in Full (up to $120 if Elective)** Max of once every 12 months	$210
Contact lenses-Conventional (Hard/Soft/Daily Wear Spherical)	**Covered in Full (up to $120 if Elective)** Max of once every 12 months	$210



VSP Benefits Enhanced

Effective May 1, 2007 VSP Improves Value-Added Discount Program

You deserve the best eyecare benefits, and VSP delivers. In addition to the discounts you currently receive on prescription glasses, you will now enjoy a 20% discount on additional **non-prescription** sunglasses. Plus, value-added discounts will be available from any VSP doctor (not only the doctor who performed the exam) within 12 months of the last covered eye exam.

If you would like to know more about your enhanced Value-Added discounts, visit vsp.com or call VSP Member Services at 800-877-7195.

Passion for people.
Vision for life.

Your vision.
Our passion.

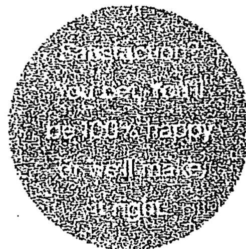
Where will your eyes take you today?

Whether it's a day in the life or a day to remember, you'll get the personalized eyecare you deserve with VSP. We help millions of people see well, stay healthy and fulfill their potential.

Value, choice, doctors.

Enrolling in VSP is an easy way to make your life a little better. Here's a snapshot of what you'll enjoy:

- affordable benefits with great savings
- a WellVision Exam℠ focused on your health
- plenty of eyewear choices you'll love
- VSP doctors nearby with flexible schedules that work for you



Still not decided?

Find doctors in your neighborhood at vsp.com or call us at 800-877-7195. We'd love to talk with you. Once you're signed up, your great benefits are a snap to use.

Enroll today. You'll be glad you did.

VSP. Vision care for life

LIBERTY HEALTHCARE CORPORATION and VSP provide you an affordable eyecare plan. Sign up today.

Your Coverage from a VSP Doctor

$10.00 copay every plan year[1]

WellVision Exam® focuses on your eye health and overall wellness .... ***every 12 months***

Prescription Glasses

Lenses .... ***every 12 months***
- *Single vision, lined bifocal and lined trifocal lenses.*
- *Polycarbonate lenses for dependent children.*

Frame .... ***every 12 months***
- *$130 allowance for frame of your choice.*
- *20% off amount over your allowance*

~OR~

Contact Lens Care .... ***every 12 months***

$130.00 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts.
Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.

Extra Discounts and Savings

Glasses and Sunglasses
•Average 30% savings on lens options like progressives and scratch-resistant and anti-reflective coatings
•20% off additional glasses and sunglasses, including lens options

Contacts*
•15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction
•Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
•After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

**Available from any VSP doctor within 12 months of your last eye exam*

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out of pocket. You'll pay the provider in full and must submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam	*$45.00*
Single Vision Lenses	*$45.00*
Lined Bifocal Lenses	*$65.00*
Lined Trifocal Lenses	*$85.00*
Frame	*$47.00*
Contacts	*$105.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

[1] every 12 months