Liberty Healthcare Corporation

Benefits overview for full-time Liberty Healthcare employees in North Carolina

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

Paid Time Off

Liberty offers two hundred and forty (240) hours of cumulative paid time off annually. Paid time off is used for holidays, vacation, sick and personal leave. Employees begin accruing paid time off immediately upon the commencement of employment, and may use their time as soon as it is accrued. Employees may rollover up to 40 hours (five days) of unused paid time off each year.

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.** Details and a provider directory may be found online at **www.aetna.com**

Two plan options are offered—one without a deductible and one with a deductible. Both plans give 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 with a mail order option.

Liberty employees who elect to receive health insurance through the company are required to contribute a percentage towards the cost of the premium through payroll deductions.

Employees may also elect to purchase health insurance for their dependents through Liberty Healthcare.

Specific plan information including covered services, copays, and payroll deductions may be found below.

Health insurance is effective ninety days after the first day of employee's first full month of employment.

Dental, vision, long-term disability and life insurance benefits are all effective sixty days following the first day of an employee's first full month of employment.

Long Term Disability

Long term disability insurance is an employer-paid benefit, through *The Hartford Group*. This insurance enables a disabled employee to receive 60% of their weekly salary to age 65 if they should be out of work due to a non-work-related accident or illness. Individualized Short-term disability insurance may be purchased as well.

A complimentary travel advisory service as well as Liberty Healthcare's Employee Assistance Program (EAP) are also administered by The Hartford Group.

Life Insurance

A life insurance policy is provided through *The Hartford Group* and purchased by Liberty on behalf of every full-time employee. In the event of an 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.

Dental Insurance

A voluntary dental plan is offered through Aetna. Preventive and Basic restorative services administered by in-network providers are covered at 100%. Major restorative care at 60%. Additional details may be found below.

Vision Plan

Liberty's vision plan is though VSP. Annual examinations and allowances for various types contacts and glasses are included. Details may be found below.

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.
To learn more visit Fidelity online at www.401k.com.
A representative is available to assist you with your financial planning. Liberty does not offer a match.

Bi-weekly payroll deductions
every other week / 26 times per year

	Health insurance (plan w/deductible)	Health insurance (plan w/o deductible)	Dental insurance	Vision insurance	Long-term disability insurance	Basic life insurance
Employee only	68.94	128.80	$14.51	$6.89	no cost	no cost
Employee + one child	202.86	295.22	$27.50	$11.03	n/a	n/a
Employee + two or more children	202.86	295.22	$43.43	$11.26	n/a	n/a
Employee + spouse	403.70	521.29	$27.50	$11.03	n/a	n/a
Family (employee + spouse + one or more children)	577.30	722.35	$43.43	$18.15	n/a	n/a

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 $6,000 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 $9,000 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.
Benefit Limitations -- For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan.		
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.

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Colorectal Cancer Screening For all members age 50 and over. Frequency schedule applies.	Covered 100%; deductible waived	Subject to Routine Physical Exam benefit.
Routine Eye Exams	Covered 100%; deductible waived 1 routine exam per 24 months.	Not Covered
Routine Hearing Screening	Subject to Routine Physical Exam benefit.	Subject to Routine Physical Exam benefit.
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	30%; deductible waived	50%; after deductible
Outpatient hospital or other Outpatient facility (other than Complex Imaging Services)		

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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 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 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.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Detoxification	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 Detoxification	$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.		
Inpatient Rehabilitation	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.		
Residential Treatment Facility	Covered 100%; after deductible	50% per admission; after deductible
Outpatient Rehabilitation	$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.		
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	30%; 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	30% 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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Outpatient Speech Therapy	$40 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	$40 copay; deductible waived Limited to 30 visits; per calendar year	50%; after deductible Limited to 30 visits; per calendar year
Spinal Manipulation Therapy	$40 copay; deductible waived Limited to 20 visits; per calendar year	50%; after deductible
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.		
Durable Medical Equipment	50%; deductible waived	50%; after deductible (must precertify if over $1,500) Limited to $2,500; per calendar year
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; after deductible 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	Not Covered	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	Not Covered	Not Covered
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.		
Advanced Reproductive Technology (ART)	Not Covered	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.		
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
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
Aetna Specialty CareRx℠ First prescription fill at any retail drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.		
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 fertility drugs included. Precert included Step Therapy 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.

• 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.

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PROVIDED BY AETNA HEALTH INC. AND AETNA HEALTH INSURANCE COMPANY - FULL RISK

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

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.

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 Benefits Summary

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.

Keep your eyes healthy with LIBERTY HEALTHCARE CORPORATION and VSP® Vision Care.

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

- **Personalized Care.** You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, we'll make it right.
- **Great Eyewear.** Choose the eyewear that's right for you and your budget.
- **Choice of Providers.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Save with VSP coverage:	Without VSP Coverage	With VSP Coverage
Eye Exam	$144	$10 Copay
Frame	$130	
Single Vision Lenses	$86	
Transitions® Lenses	$99	$0
Anti-reflective Coating	$107	$61
Member-only Annual Contribution	N/A	$179.28
Total	**$566**	**$250.28**

*Comparison based on national averages for comprehensive eye exams and most commonly purchased brands

Average Annual Savings $315.72 with a VSP Doctor

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. Choose from great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Enroll in VSP today.
You'll be glad you did.
Contact us. **vsp.com**
800.877.7195

Your VSP Vision Benefits Summary

LIBERTY HEALTHCARE CORPORATION and VSP provide you with an affordable eyecare plan.

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

VSP Doctor Network: VSP Signature

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance	Combined with exam	Every 12 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Options	• Tints/Photochromic lenses-Transitions • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35-40% off other lens options	$0 $50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation)	$0	Every 12 months
Extra Savings and Discounts	**Glasses and Sunglasses** • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **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		

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $45	Single Vision Lenses.....up to $45	Lined Trifocal Lenses....up to $85	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $65	Progressive Lenses.....up to $65	Tints.....up to $5

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Enroll in VSP today.
You'll be glad you did.
Contact us. **vsp.com**
800.877.7195

TRAVEL ASSISTANCE SERVICES

THE HARTFORD

Even the best planned trips can be full of surprises.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you have access to Travel Assistance Services provided by Europ Assistance USA.[1]

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

Good to go: Multilingual assistance 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.[2,3]

As long as you contact Europe Assistance USA at the time of need, you could be approved for up to $1 million in covered services.[4]

Services from here to there.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

(continued on next page)

Case illustration: Help a world away.[7]

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

Prepare today.
Help protect tomorrow.

TRAVEL ASSISTANCE

THE HARTFORD

Snap the Tag with your phone to save this contact info.

Need the app?
http://gettag.mobi

Travel Assistance Services

THE HARTFORD

TRAVEL ASSISTANCE SERVICES

Emergency Medical Assistance[5]

- Medical referrals
- Medical monitoring
- Medical evacuation
- Repatriation
- Traveling companion assistance
- Dependent children assistance
- Visit by a family member or friend
- Emergency medical payments
- Return of mortal remains

Pre-trip Information

- Visa and passport requirements
- Inoculation and immunization requirements
- Foreign exchange rates
- Embassy and consular referrals

Emergency Personal Services[6]

- Medication and eyeglass assistance
- Emergency travel arrangements
- Emergency cash
- Locating lost items
- Bail advancement

Need more facts?

For a more detailed description of the services please visit our Web site at **thehartford.com/employeebenefits.**

www.thehartford.com

DISCLAIMER: Service Exclusions and Limitations: Europ Assistance USA (EA) services are eligible for payment or reimbursement by EA only if EA was contacted at the time of the services and arranged and/or preapproved the services. Certain terms, conditions and exclusions apply; for further information refer to the Web site listed or call EA at the number provided.

(Please cut here and keep in your wallet.)

TRAVEL ASSISTANCE

What to have ready: Your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and your company policy number, which can be obtained through your Human Resources department.

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.

Call: **1-800-243-6108** Collect from other locations: **202-828-5885** Fax: **202-331-1528**

Travel Assistance Identification Number: **GLD-09012**

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.

[1] Travel Assistance is provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. The Hartford's Privacy Policy policy is available at: thehartford.com/legalinfo/privacy-policy/online-privacy-policy/.

[2] Dependent children are under the age of 19 or under the age of 25 if a full-time student in actual attendance at an accredited school or college and primarily dependent on you for support and maintenance.

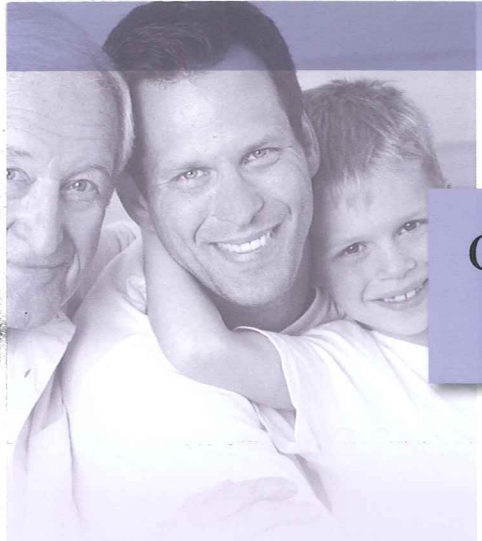
[3] Services are available in every country of the world. Depending on the current political situation in the country to which you are traveling, EA may experience difficulties providing assistance, which may result in delays or even the inability to render certain services. It is your responsibility to inquire, prior to departure, whether assistance service is available in the countries where you are traveling.

[4] The Combined Single Limit (CSL), or amount of money available to the insured under the Travel Assistance Program, is $1 million. One service or a combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL. Note: Certain Accidental Death and Dismemberment programs may offer different CSLs. Please consult with your Human Resources Manager for more details.

[5] In a medical emergency, Europ Assistance USA pays for assistance as described herein, but you are personally responsible for paying your medical/hospital expenses.

[6] Europ Assistance USA provides the described personal services to you in an emergency, but you are personally responsible for the cost of air fare not approved as medically necessary by the attending physician; food, hotel and car expenses; and attorney fees. Emergency cash advances and bail advancement require your personal satisfactory guarantee of reimbursement.

[7] This case illustration is fictitious and for illustrative purposes only.



Getting Support *To Help You Manage Life* Is Simple.

Ability Assist helps you cope with life.

- ***Easy access to professionals – toll-free, 24/7.***
- ***Up to five face-to-face sessions per year.***
- ***Trusted online resources and tools.***

Life presents opportunities and challenges. The Hartford's[1] Ability Assist, offered by ComPsych®[2], helps you and your family cope with life, from the everyday to the unexpected. Whether managing everyday issues such as job pressures, relationships, retirement planning, or finding child care, or faced with grief, loss, or the impact of a disability, Ability Assist is your resource for professional support. You and your family, including spouse and dependents, have access to Ability Assist at no additional cost to you as long as your employer offers a covered product from The Hartford.

COMPREHENSIVE, NOT COMPLICATED – SUPPORT YOU CAN TRUST.

On the Phone – Just One Simple Call.

- Counselors available 24/7, 365 days a year through a toll-free number for assessment and consultations.
- Initial telephone assessment of concerns and reference to resources and in-person providers as needed.
- Simply call 1-800-96-HELPS (1-800-964-3577).

Face-to-Face – Straightforward answers to help you face life.

Ability Assist includes up to five face-to-face confidential sessions (or equivalent professional time) per year with a counselor, financial planner and/or legal advisor, or split among the three types of services. The five sessions per year are a combined total for you and your family.

- You can access **emotional and work-life** counseling for a wide range of topics, such as stress, family or marital conflicts, major life changes, depression, effective parenting, chronic illness, and child and elder care.
- You can get help for **legal** concerns including buying a home, divorce, or adoption.
- **Financial planning** is available to you for retirement planning, budgets, saving for college, debt, and more.

DETACH WALLET ID CARD.

ABILITY ASSIST®

Getting support *to help you manage life* is simple.

Call 1-800-96-HELPS
(1-800-964-3577)

The Hartford

Online – The point is simplicity.

An award-winning online resource, called GuidanceResources Online℠ (offered by ComPsych), is available to you to provide trusted, expert information, resources, referrals and answers to everyday questions at your convenience. Ongoing support from The Hartford – now as simple as going online.

- Chat sessions with expert moderators.
- Research hundreds of personal health topics or search for childcare, eldercare, schools, attorneys or financial planners.
- First-time users enter the Company ID, HLF902 and create their own confidential Username and Password at **www.guidanceresources.com**.

An Expanded Network – Additional help minus the complications.

To help you access additional help, Ability Assist makes referrals to local resources and services, such as self-help groups, senior centers, Certified Financial Planners and advocacy programs.

Confidentiality – A Must.

Use of these services is completely confidential. Your employer is not given personal information about who has used the service without written consent, except where required by law.

Trouble-free support.

We know what it takes to help you stay on your feet. You want support without the hassle. You need simple answers. Clear choices. For the twists and turns of life, know you can turn to The Hartford.

1 The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company, and Hartford Life Group Insurance Company. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

2 ComPsych is the largest provider of employee assistance programs, managed behavioral health, work/life, and crisis intervention services. Source: Business Insurance, Largest EAP Provider 2005 Survey, June 2006 edition.

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ABILITY ASSIST®

Ability Assist is offered through ComPsych®, a leading provider of employee assistance programs. Services include:

- Emotional, financial, and legal counseling
- Substance abuse information
- Child and elder care information and resources
- Marital and family counseling
- Work-life consultation

ComPsych®
THE GUIDANCE RESOURCE COMPANY

We deliver on our promises every day.

The Hartford