



**Group Insurance Plan of Benefits for
VEDICSOFT (Control # 835655)
Administered by Aetna Global Benefits®
Effective Date: August 1, 2010**

| Eligibility Provision | | | |
|--|--|--|---|
| Employee | Regular full-time employees of VEDICSOFT participating in this plan working a minimum of 25 hours per week. | | |
| Dependent | Wife or husband; same or opposite sex domestic partner; unmarried children under age 19; to age 25 if attending school. | | |
| PPO | | | |
| PLAN FEATURES | OUTSIDE THE U.S. | In the U.S. | |
| | | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Individual deductible | \$3,500 per calendar year | \$1,250 per calendar year | \$3,500 per calendar year |
| Family deductible | \$7,000 per calendar year | \$2,500 per calendar year | \$7,000 per calendar year |
| Prior Plan Deductible Credit | Prior plan deductible credit accrued within the last calendar year from previous carrier applies to the current year deductible. | | |
| Individual Payment Limit <i>(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)</i> | \$10,000 per calendar year | None | \$10,000 per calendar year |
| Family Payment Limit <i>(Does not include deductibles, copays, benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US)</i> | \$20,000 per calendar year | None | \$20,000 per calendar year |
| Lifetime Maximum | \$5,000,000 | Unlimited | \$5,000,000 |
| Plan Payment Percentages | | | |
| Hospital Services | | | |
| Inpatient | 70% after deductible and \$250 Inpatient Per Confinement deductible | 100% after deductible and \$250 Inpatient Per Confinement deductible | 70% after deductible and \$250 Inpatient Per Confinement deductible |
| Outpatient | 70% after deductible | 100% after deductible | 70% after deductible |
| Private Room Limit | The institution's semiprivate rate | | |
| Pre-certification Penalty | No Penalty | No Penalty | \$400 |
| Non-Emergency Use of the Emergency Room | 70% after deductible | 100% after \$50 co-pay | 70% after deductible |
| Emergency Room | 100% after deductible | 100% after \$100 co-pay | 100% after \$100 co-pay |
| Urgent Care | 70% after deductible | 100% after \$50 co-pay | 70% after deductible |
| Physician Services | | | |
| PCP Office Visit | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Specialist Office Visit | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Mental Health Services | | | |
| Mental Health Inpatient Coverage <i>(Unlimited days per calendar year combined with Alcoholism and Drug Abuse)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Mental Health Outpatient Coverage <i>(Unlimited visits per calendar year combined with Alcoholism and Drug Abuse)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Summary of Coverage and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.



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| | | Preferred Benefits (In-Network) | Non-Preferred Benefits (Out-of-Network) |
| Plan Payment Percentages | | | |
| Alcohol/Drug Abuse Services | | | |
| Substance Abuse Inpatient Coverage <i>(Unlimited days per calendar year combined with Mental Health)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Substance Abuse Outpatient Coverage <i>(Unlimited visits per calendar year combined with Mental Health)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Other Services | | | |
| Skilled Nursing Facility <i>(60 days per calendar year)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Hospice Care Facility Inpatient <i>(30 Days lifetime maximum)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Hospice Care Facility Outpatient <i>(\$5,000 lifetime maximum)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Home Health Care <i>(60 visits combined, includes Private Duty Nursing per calendar year)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Spinal Disorder Treatment <i>(Unlimited visits per calendar year)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Short Term Rehabilitation <i>(Includes coverage for Occupational, Physical and Speech Therapies; 20 combined maximum visits per calendar year)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Ostomy | 70% after deductible | 100% after deductible | 70% after deductible |
| Transplants <i>(\$200,000 maximum per transplant; does not apply to bone marrow or peripheral blood stem cell.)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Diagnostic Outpatient X-ray | 70% after deductible | 100% after deductible | 70% after deductible |
| Diagnostic Outpatient Lab | 70% after deductible | 100% after deductible | 70% after deductible |
| Base Infertility Services <i>(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Hearing Aids <i>1 hearing aid per ear to \$1,000 maximum per ear every 3 years for child to age 24</i> | 70% after deductible | 100% after deductible | 70% after deductible |
| Wellness Benefits | | | |
| Routine Physical Exams: Children <i>Children age 0-18: 7 exams first year of life; 3 visits second year of life; 3 visits third year of life and 1 exam per year thereafter (includes immunizations)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Routine Physical Exams: Adult <i>Adults age 18+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months (includes immunizations)</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |

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| Plan Payment Percentages | | | |
| Routine Gynecological Exams <i>Includes 1 exam and pap smear per calendar year</i> | 70% - not subject to deductible | 100% after \$20 co-pay | 70% after deductible |
| Mammograms <i>(Unlimited visits per calendar year)</i> | 70% - not subject to deductible | 100% - not subject to deductible | 70% after deductible |
| Prostate Specific Antigen (PSA) <i>Includes 1 PSA per calendar year for males 40+</i> | 70% - not subject to deductible | 100% after \$20 co-pay | 70% after deductible |
| Digital Rectal Exam (DRE) <i>Includes 1 DRE per calendar year for males 40+</i> | 70% - not subject to deductible | 100% after \$20 co-pay | 70% after deductible |
| Cancer Screening <i>Includes 1 flex sigmoid and double barium contrast every 5 years; and at age 50+ 1 colonoscopy every 10 years</i> | 70% - not subject to deductible | 100% after \$20 co-pay | 70% after deductible |
| Prescription Drug Coverage Here | | | |
| Generic Drugs <i>(365 day maximum supply) Includes contraceptives</i> | 70% after deductible | 100% after \$10 co-pay per month supply (includes Mail Order Drugs) | 70% after deductible |
| Formulary Brand Name Drugs <i>(365 day maximum supply) Includes contraceptives</i> | 70% after deductible | 100% after \$30 co-pay per month supply (includes Mail Order Drugs) | 70% after deductible |
| Non Formulary Brand Name Drugs <i>(365 day maximum supply) Includes contraceptives</i> | 70% after deductible | 100% after \$50 co-pay per month supply (includes Mail Order Drugs) | 70% after deductible |
| Vision Expenses | | | |
| Routine Eye Exam <i>(Covered under medical) Includes one routine exam every 12 months.</i> | 70% after deductible | 100% after \$20 co-pay | 70% after deductible |
| Services and Programs | | | |
| Informed Health Line (24-hour nurse line) International Disease Management International Maternity Management Program Weight Watchers® Program On-Line Global Health and Travel Information through HTH Worldwide (http://www.aetnaglobalbenefits.com) | | | |

Other Health Care (Out-of-Area): When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out-of-pocket maximum(s).

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