### PLAN FEATURES

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$500 Individual</td>
<td>$1,000 Individual</td>
</tr>
<tr>
<td>(per calendar year)</td>
<td>$1,000 Family</td>
<td>$2,000 Family</td>
</tr>
</tbody>
</table>

Unless otherwise indicated, the deductible must be met prior to benefits being payable. Applicable covered expenses accumulate toward both the in-network and out-of-network providers 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. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

| **Out-of-Pocket Maximum** | $1,500 Individual                | $3,000 Individual               |
| (per calendar year)       | $3,000 Family                  | $6,000 Family                   |

Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. All applicable covered expenses accumulate toward both 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, deductible and copays. Penalty amounts do not apply. Pharmacy expenses do not apply towards the Out-of-Pocket-Maximum. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

| **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: *225% of Medicare Facility: *300% 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

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Adult Physical Exams/Immunizations</strong></td>
<td>Covered 100%; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>1 exam every 12 months for members age 18 and older.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Routine Well Child Exams/Immunizations

Covered 100%; deductible waived

40% for children from birth through age 6; Not Covered age 7 and over.

(Age and frequency schedules apply)

### Routine Gynecological Care Exams

Covered 100%; deductible waived

40%; after deductible

1 exam per 12 months

Includes routine tests and related lab fees.

### Routine Mammograms

Covered 100%; deductible waived

40%; after deductible

Recommended: one baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.

### Routine Digital Rectal Exams / Prostate Specific Antigen Test

Covered 100%; deductible waived

40%; after deductible

Recommended for males age 40 and over.
Colorectal Cancer Screening
Covered 100%; deductible waived
For all members age 50 and over. Frequency schedule applies.

Routine Eye Exams
Covered 100%; deductible waived
1 routine exam per 12 months.

Routine Hearing Screening
Subject to Routine Physical Exam benefit.

For covered dependent children under age 1; subject to $1,400 non-disposable hearing aid maximum for each hearing impaired ear in any 36 month period.

PHYSICIAN SERVICES

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician Visits</td>
<td></td>
</tr>
<tr>
<td>Office Hours: $20 copay; After</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Office Hours/Home: $25 copay;</td>
<td></td>
</tr>
<tr>
<td>deductible waived</td>
<td></td>
</tr>
</tbody>
</table>

Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits
$25 copay; deductible waived

Prenatal OB Care
$25 copay for initial visit only, thereafter covered 100%; deductible waived

Allergy Treatment
Same as applicable participating provider office visit member cost sharing

Allergy Testing
Same as applicable participating provider office visit member cost sharing

DIAGNOSTIC PROCEDURES

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Laboratory</td>
<td></td>
</tr>
<tr>
<td>Covered 100%; deductible waived</td>
<td>40%; after deductible</td>
</tr>
</tbody>
</table>

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
Covered 100%; deductible waived

Diagnostic X-ray for Complex Imaging Services
$50 copay; deductible waived

EMERGENCY MEDICAL CARE

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Provider</td>
<td></td>
</tr>
<tr>
<td>$50 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
</tbody>
</table>

Non-Urgent Use of Urgent Care Provider
Not Covered

Emergency Room
$100 copay; deductible waived

Non-Emergency Care in an Emergency Room
Not Covered

Emergency Use of Ambulance
Covered 100%; deductible waived

Non-Emergency Use of Ambulance
Not Covered

HOSPITAL CARE

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Coverage</td>
<td></td>
</tr>
<tr>
<td>20% per admission; after deductible</td>
<td>40% per admission; after deductible</td>
</tr>
</tbody>
</table>

The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
**Inpatient Maternity Coverage**
20%; after deductible
```
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.
```

**Outpatient Hospital**
20%; after deductible
```
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.
```

**MENTAL HEALTH SERVICES**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Non-Biologically Based Mental Illness</td>
<td>20% per admission; after deductible</td>
<td>40% per admission</td>
</tr>
<tr>
<td>Outpatient Non-Biologically Based Mental Illness</td>
<td>$25 per visit; deductible waived</td>
<td>40% per visit; after deductible</td>
</tr>
</tbody>
</table>

**ALCOHOL/DRUG ABUSE SERVICES**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detoxification</td>
<td>20% per admission; after deductible</td>
<td>40% per admission; after deductible</td>
</tr>
<tr>
<td>Outpatient Detoxification</td>
<td>$25 per visit</td>
<td>40% per visit</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>20% per admission; after deductible</td>
<td>40% per admission; after deductible</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>20% per admission; after deductible</td>
<td>40% per admission; after deductible</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>$25 per visit</td>
<td>40% per visit</td>
</tr>
</tbody>
</table>

**OTHER SERVICES**

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>20%; after deductible</td>
<td>40% per admission; after deductible</td>
</tr>
<tr>
<td>Limited to 100 days; per calendar year</td>
<td>Limited to 100 days; per calendar year</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered 100%; deductible waived</td>
<td>20%; after deductible</td>
</tr>
<tr>
<td>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care - Inpatient</td>
<td>20%; after deductible</td>
<td>40% per admission; after deductible inpatient stay.</td>
</tr>
<tr>
<td>Hospice Care - Outpatient</td>
<td>Covered 100%</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Hospice care includes bereavement counseling and respite care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Therapy</td>
<td>$25 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Limited to 60 visits; per calendar year</td>
<td>Limited to 60 visits; per calendar year</td>
<td></td>
</tr>
<tr>
<td>Includes speech, physical, occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation Therapy</td>
<td>$25 copay; deductible waived</td>
<td>40%; after deductible</td>
</tr>
<tr>
<td>Limited to 36 visits; per calendar year</td>
<td>Limited to $1,000; per calendar year</td>
<td></td>
</tr>
</tbody>
</table>
### Autism
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 6 years of age. Includes coverage for Applied Behavioral Analysis. Once the limit has been met, Applied Behavioral Analysis will be covered under Mental Health services.

### Durable Medical Equipment
<table>
<thead>
<tr>
<th>Plan Design</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>40%; after deductible (must precertify if over $1,500)</td>
</tr>
</tbody>
</table>

### Diabetic Supplies
Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies. 40%; after deductible.

### Transplants
20% per admission; after deductible. Preferred coverage is provided at an IOE contracted facility only. Non-Preferred coverage is provided at a Non-IOE facility. 40% per admission; after deductible.

### Bariatric Surgery
20% per admission; after deductible. Not Covered.

### FAMILY PLANNING
**IN-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.

**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; after deductible.

### Comprehensive Infertility Services
* Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived.

* Limited to 6 cycles per lifetime.
Comprehensive Infertility includes Artificial Insemination and Ovulation Induction.

### Advanced Reproductive Technology (ART)
* Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived.

* Limited to $25,000 per calendar year.
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.

### Voluntary Sterilization
Member cost sharing is based on the type of service performed and the place of service where it is rendered.

Including tubal ligation and vasectomy.

### PRESCRIPTION DRUG BENEFITS
**IN-NETWORK**
- **Retail**
  - $10 copay for formulary generic drugs, $25 copay for formulary brand-name drugs, and $40 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.

**OUT-OF-NETWORK**
- **Retail**
  - Not Covered

* 2 times retail copay for 31-90 day supply at participating pharmacies. Percentage copays will not be multiplied.
**Mail Order**  
$20 copay for formulary generic drugs, $50 copay for formulary brand-name drugs, and $80 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.

**Aetna Specialty CareRx™**  
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®.

**No Mandatory Generic (NO MG)** - The member pays the applicable copay only. Oral fertility drugs included.

<table>
<thead>
<tr>
<th>GENERAL PROVISIONS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependents Eligibility</td>
<td>Spouse, domestic partner, children from birth to age 26 regardless of student status.</td>
<td></td>
</tr>
<tr>
<td>Pre-existing Conditions Exclusion</td>
<td>On effective date: Waived After effective date: Waived</td>
<td></td>
</tr>
</tbody>
</table>

* Notice: In accordance with Maine law 24-A section 4207, this benefit summary provides information about any provisions in this health benefit plan that are different than those from last year. If any provisions are different, they are identified by an asterisk (*).

**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. This amount is based on the out-of-network plan you or your employer picks.

- For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.
- For hospitals and other facilities, the amount is based on "prevailing" charges. We get this data from an external database.

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.
Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. 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.

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 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 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.

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.

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PRESIDENT AND TRUSTEES OF BATES COLLEGE
Proposed Effective Date: 01-01-2012
HMO - Maine

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