PLAN DESIGN

Customer Name: The Romine Group

Proposed Effective Date: 01-01-2015

Policy Period: 12

Data Source ID: Q3188722 - 1 - All Employees/NC/250/4629MIPP#2139

Option: $250 PPO Plan Option

Plan: PPO Plan

Location(s): Michigan

Specialty Networks Included: None Quoted

Organization Name: Aetna

Prepared: 09/25/2014 03:21 PM

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The Romine Group
Proposed Effective Date: 01-01-2015
Open Choice® (PPO) - Michigan

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$250 Individual $500 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. 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.		
Member Coinsurance	10%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$750 Individual $1,500 Family	$12,000 Individual $24,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Payment for Non-Preferred Care**	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	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; 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 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.		
Women's Health	Covered 100%; deductible waived	50%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.		

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Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered under Routine Adult Exams	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay; deductible waived	50%; after deductible
Specialist Office Visits	$30 office visit copay; deductible waived	50%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
E-visit to Non-Specialist 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 our authorized internet E-visit service vendor.	$30 copay; deductible waived	50%; after deductible
E-visit to Specialist 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 our authorized internet E-visit service vendor.	$30 copay; deductible waived	50%; after deductible
Walk-in Clinics 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.	$30 office visit copay; deductible waived	50%; after deductible
Allergy Testing	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
Allergy Injections	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; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray 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.	10%; after deductible	50%; after deductible
Diagnostic Laboratory 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.	10%; after deductible	50%; after deductible
Diagnostic Outpatient Complex Imaging	10%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
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Emergency Room	$150 copay; deductible waived	Same as preferred care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	$100 copay; after deductible	$100 copay; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	50%; 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	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$30 copay; deductible waived	50%; 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	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	10%; after deductible	50%; after deductible
Treatment Facility	10%; after deductible	50%; after deductible
Outpatient	$30 copay; deductible waived	50%; 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**
Convalescent Facility	10%; after deductible	50%; after deductible
Limited to 60 days per calendar year.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	10%; after deductible	50%; after deductible
Limited to 60 visits per calendar year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	50%; 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
Outpatient Short-Term Rehabilitation	$30 copay; deductible waived	50%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	$30 copay; deductible waived	50%; after deductible
Limited to 20 visits per calendar year.		

PLAN DESIGN & BENEFITS
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Autism Behavioral Therapy	$30 copay; deductible waived	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	$30 copay; deductible waived	50%; after deductible
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.		
Autism Physical Therapy	$30 copay; deductible waived	50%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Occupational Therapy	$30 copay; deductible waived	50%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Speech Therapy	$30 copay; deductible waived	50%; after deductible
Visits combined with Short Term Rehabilitation.		
Durable Medical Equipment	10%; after deductible	50%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; 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	**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	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
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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; after deductible.
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Voluntary Abortion	Not Covered	Not Covered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Open Formulary; with mid year changes	
Retail	$10 copay for generic drugs, $40 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	50% of submitted cost after the applicable preferred copay

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Mail Order	$20 copay for generic drugs, $80 copay for formulary brand-name drugs, and $120 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®.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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 with 90 day Transition of Care. Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		
GENERAL PROVISIONS		
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 we pay 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 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, we limit 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 we "recognize" 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 we "recognize" 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 plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 our website.

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 Navigator member site.

PLAN DESIGN & BENEFITS
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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 us 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 us 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.

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 our agents. Provider participation may change without notice. We do 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.

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• 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.

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

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

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

For more information about Aetna plans, refer to **www.aetna.com.**

The Romine Group
Proposed Effective Date: 01-01-2015
Open Choice® (PPO) - Michigan

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PLAN DESIGN

Customer Name: The Romine Group

Proposed Effective Date: 01-01-2015

Policy Period: 12

Data Source ID: Q3188722 - 2 - All Employees/NC/250/4629MIPP#2148

Option: $3000 PPO Plan

Plan: PPO Plan

Location(s): Michigan

Specialty Networks Included: None Quoted

Organization Name: Aetna

Prepared: 09/25/2014 03:23 PM

aetna®

The Romine Group
Proposed Effective Date: 01-01-2015
Open Choice® (PPO) - Michigan

PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	20%
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$11,000 Individual $22,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Payment for Non-Preferred Care**	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	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 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 22.	Covered 100%; deductible waived	20%; after deductible
Routine Gynecological Care Exams Recommended: One exam per calendar year. Includes routine tests and related lab fees.	Covered 100%; deductible waived	20%; after deductible
Routine Mammograms Recommended: One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	20%; after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.	Covered 100%; deductible waived	20%; after deductible

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Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Colorectal Cancer Screening Recommended: For all members age 50 and over.	Covered under Routine Adult Exams	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$40 office visit copay; deductible waived	20%; after deductible
Specialist Office Visits	$40 office visit copay; deductible waived	20%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
E-visit to Non-Specialist 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 our authorized internet E-visit service vendor.	Not Covered	Not Covered
E-visit to Specialist 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 our authorized internet E-visit service vendor.	Not Covered	Not Covered
Walk-in Clinics 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.	$40 office visit copay; deductible waived	20%; after deductible
Allergy Testing	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
Allergy Injections	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; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray 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.	Covered 100%; after deductible	20%; after deductible
Diagnostic Laboratory 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.	Covered 100%; after deductible	20%; after deductible
Diagnostic Outpatient Complex Imaging	Covered 100%; after deductible	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered

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Emergency Room	$150 copay; deductible waived	Same as preferred care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	$100 copay; after deductible	$100 copay; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	Covered 100%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	Covered 100%	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	Covered 100%; after deductible	20%; 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	Covered 100%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$40 copay; deductible waived	20%; 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	Covered 100%; after deductible	20%; 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	20%; after deductible
Treatment Facility	Covered 100%; after deductible	20%; after deductible
Outpatient	$40 copay; deductible waived	20%; 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**
Convalescent Facility	Covered 100%; after deductible	20%; after deductible
Limited to 60 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%; after deductible	20%; after deductible
Limited to 60 visits per calendar year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	Covered 100%; after deductible	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%; after deductible	20%; 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
Outpatient Short-Term Rehabilitation	$40 copay; deductible waived	20%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	$40 copay; deductible waived	20%; after deductible
Limited to 20 visits per calendar year.		

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PROVIDED BY AETNA LIFE INSURANCE COMPANY

Autism Behavioral Therapy	$40 copay; deductible waived	20%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis	$40 copay; deductible waived	20%; after deductible
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.		
Autism Physical Therapy	$40 copay; deductible waived	20%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Occupational Therapy	$40 copay; deductible waived	20%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Speech Therapy	$40 copay; deductible waived	20%; after deductible
Visits combined with Short Term Rehabilitation.		
Durable Medical Equipment	Covered 100%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Transplants	Covered 100%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; 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	**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	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
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
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; after deductible.
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Voluntary Abortion	Not Covered	Not Covered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Open Formulary; with mid year changes	
Retail	$15 copay for generic drugs, $35 copay for formulary brand-name drugs, and $60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost after the applicable preferred copay

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Mail Order	$30 copay for generic drugs, $70 copay for formulary brand-name drugs, and $120 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®.	
Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
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 with 90 day Transition of Care. Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		
GENERAL PROVISIONS		
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 we pay 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 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, we limit 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 we "recognize" 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 we "recognize" 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 plan "recognizes." Your doctor may bill you for the dollar amount that we don'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 our website.

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 Navigator member site.

PLAN DESIGN & BENEFITS
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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 us 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 us 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.

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 our agents. Provider participation may change without notice. We do 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
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• 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.

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

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

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

For more information about Aetna plans, refer to **www.aetna.com.**

The Romine Group
Proposed Effective Date: 01-01-2015
Open Choice® (PPO) - Michigan

PLAN DESIGN & BENEFITS
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Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Vision℠ Preferred

visit www.aetnavision.com

Summary of Benefits for The Romine Group

Effective Date: 01-01-2015
Plan 19a External Plan ID 9849662419
Line Value 366
12 12 12

	In Network	Out of Network*
Exam	**Aetna Vision Network**	
Use your Exam coverage once every rolling 12 months		
Routine/Comprehensive Eye Exam	**$10 Copay**	$25 Reimbursement
Standard Contact Lens Fit/Follow-up	**Member pays discounted fee of $40**	Not Covered
Premium Contact Lens Fit/Follow-up	**Member pays 90% of retail**	Not Covered
Eyeglass Lenses /Lens options		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single vision lenses	**$10 Copay**	$20 Reimbursement
Bifocal vision lenses	**$10 Copay**	$40 Reimbursement
Trifocal vision lenses	**$10 Copay**	$65 Reimbursement
Lenticular vision lenses	**$10 Copay**	$65 Reimbursement
Standard Progressive vision lenses	**$75 Copay**	$40 Reimbursement
Premium Progressive vision lenses[1]	**20% Discount off retail minus $120 plan allowance plus $75 Copay = member out-of-pocket**	$40 Reimbursement
UV treatment	**Member pays discounted fee of $15**	Not Covered
Tint (Solid and Gradient)	**Member pays discounted fee of $15**	Not Covered
Standard plastic scratch coating	**$0 Copay**	$15 Reimbursement
Standard polycarbonate lenses - Adult	**Member pays discounted fee of $40**	Not Covered
Standard polycarbonate lenses - Children to age 19	**$0 Copay**	$35 Reimbursement
Standard anti-reflective coating	**Member pays discounted fee of $45**	Not Covered
Polarized	**Member pays 80% of retail**	Not Covered
Contact Lenses		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional contact lenses	**$130 Allowance** Additional 15% off balance over allowance**	$90 Reimbursement
Disposable contact lenses	**$130 Allowance**	$90 Reimbursement
Medically necessary contact lenses	**$0 Copay**	$200 Reimbursement
Frames		
Use your Frame coverage once every rolling 12 months		
Any Frame available, including frames for prescription sunglasses	**$130 allowance Additional 20% off balance over allowance**	$65 Reimbursement
Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.		
Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances have been exhausted.	**Up to a 40% Discount**	No Discount
Non-covered items such as cleaning cloths and contact lens solution[2]	**20% Discount**	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] only. Call 1-800-422-6600	**15% discount off retail or 5% discount off the promotional price**	No Discount
Retinal Imaging[4]	**Member pays a discounted fee up to $39**	No Discount
Replacement contact lenses	**Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit www.aetnavision.com for details**	No Discount

Partial list of Exclusions and Limitations

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

[1]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.

[2]Non covered discounts may not be available in all states.

[3]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

[4]Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

This material is for information only, and is not an offer or invitation to contract.
Extraterritorial state requirements may apply to members residing in specific States. If your plan covers members in other states, impacts to your plan of benefits and rates adjustments (if any) will be evaluated and communicated to you at the point of sale.

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DENTAL INSURANCE BENEFITS SUMMARY

For Employees of The Romine Group

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility).
Minimum Work Hours	You must be working a minimum of 30 hours per week to be eligible for coverage.
Coverage Payment	Your employer pays 100% of the premium for this coverage.

LATE ENTRANTS WAITING PERIODS	
Type A	Waived
Type B	12 Months
Type C	12 Months
Orthodontia	12 Months

CALENDAR YEAR DEDUCTIBLES AND MAXIMUMS	PARTICIPATING PROVIDERS[2]	NON-PARTICIPATING PROVIDERS[2]*
Type A Deductible	Waived	Waived
Type B & C Deductible		
▪ Each Insured Person	$0	$0
▪ Family	3 times Individual	3 times Individual
Maximum(s) (For Each Insured Person)		
▪ Type A, B & C Combined	$1,000	$1,000
▪ Orthodontia	$1,000 (Lifetime[1])	$1,000 (Lifetime[1])

[1]Reference to "Lifetime" indicates an amount that applies or is available only once while insured under this policy.
[2]The same expense(s) may be used to satisfy the deductibles for participating and non-participating providers.

COVERED SERVICES	PARTICIPATING	NON-PARTICIPATING*
Type A Services ▪ Examination(s)/Evaluation(s) ▪ Bitewing X-ray(s) ▪ Other X-ray(s) ▪ Fluoride Treatment(s) ▪ Cleaning(s) (Prophylaxis) ▪ Sealant(s) ▪ Space Maintainer(s) (Including Recementation) ▪ Emergency Treatment ▪ Brush Biopsy/Cancer Screening	100%	50%
Type B Services ▪ Periodontal Maintenance (Following Active Periodontal Treatment) ▪ Filling(s) ▪ Stainless Steel Crowns ▪ Extraction(s) ▪ Oral Surgery ▪ General Anesthesia or Intravenous (I.V.) Sedation ▪ Endodontics ▪ Periodontics ▪ Repair of Removable Dentures ▪ Adjustments, Tissue Conditioning, Rebasing or Relining of Removable Dentures ▪ Repair and Re-Cementation of Bridges ▪ Crowns, Inlays, Onlays ▪ Repair and Re-cementation of Cast Crowns/Inlays/Onlays	75%	50%

COVERED SERVICES (CONTINUED)	PARTICIPATING	NON-PARTICIPATING*
Type C Services ▪ Full or Partial Removable Dentures ▪ Bridgework (Fixed Dentures) ▪ Endosteal Implant(s)	50%	50%
Orthodontia ▪ Available for dependent children	50%	40%

The plan pays the percentage shown after the deductible is satisfied, up to the maximum. *Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.*
This plan provides different coverage levels for participating and non-participating providers. By using a participating provider, plan members will save more through the predetermined fee arrangement and better benefit coverage.
**The Maximum Allowance for non-participating providers is based on the 90th percentile of prevailing fee data for the geographical area. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.*

LIMITATIONS AND EXCLUSIONS

Information about the limitations and exceptions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have any questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions and limitations. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Dental insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.