We want you to know®

Aetna®

Coldwater Creek Inc.
801169

BENEFITS SUMMARY
Aetna Affordable Health Choices® insurance plan

Plan design and benefits provided by Aetna Life Insurance Company (Aetna) and administered by Strategic Resource Company (SRC).

Unless otherwise indicated, all benefits and limitations are per covered person. Where a benefit is expressed as a percentage, the lower of the negotiated charge(s) or the recognized charge(s) will be the basis of payment.

Inside this Benefits Summary:

PLEASE READ CAREFULLY BEFORE DECIDING WHETHER THIS PLAN IS RIGHT FOR YOU:
• This plan will not pay more than the overall maximum benefit in a coverage year.
• This plan also limits what it will pay for particular kinds of services in addition to the overall annual maximum benefit.
• Once any of these limits have been reached, the plan will not pay any more towards the cost of the service in question, and your health care providers can bill you for what the plan does not pay. Many illnesses cost much more to treat than this plan will cover.
• This Benefits Summary explains these limits, the overall annual maximum benefit, and other cost sharing features of your plan, such as copayments and deductibles. See the full plan for more information.

Aetna will pay benefits only for expenses incurred while this coverage is in force, and only for the medically necessary treatment of injury or disease. The coverage displayed in this Benefits Summary reflects certain mandate(s) of the state in which this policy was written. However, certain federal laws or other mandate(s) in the state you live and/or work could also affect how this coverage pays.

If you have a pre-existing condition, this plan may not pay for the coverage of this condition for the first 365 days of coverage. For more information on pre-existing condition limitations, please see "Exclusions and Limitations" in this summary or refer to the plan documents.

Group limited benefit medical coverage is not available if you live and work in **New Hampshire**.
This limited health plan does not meet **Massachusetts** Minimum Creditable Coverage standards.

Basic Net

Coverage for Outpatient Charges	Preferred Provider (In network. Percentages refer to Negotiated Charge.)	Non-Preferred Provider (Out of network. Percentages refer to Recognized Charge.)
Doctors' office visits		
This is the charge for the visit itself. It may not include all services that happen in the doctor's office, such as diagnostic or surgical services.		
Maximum benefit per coverage year	5 visits	Same as preferred
Copay/deductible for each visit	$10 copay	$10 deductible
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%
Diagnostic, surgical, and other outpatient services and supplies		
Maximum benefit per coverage year	$400 or 5 services, whichever is used up first	Same as preferred
Copay/deductible for each visit	$15 copay	$15 deductible
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%
Emergency room visits and ambulance services		
Maximum benefit per coverage year	$1,000	Same as preferred
Deductible per coverage year	$100	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	Same as preferred

Coverage for Inpatient Charges	Preferred Provider (In network. Percentages refer to Negotiated Charge.)	Non-Preferred Provider (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per coverage year (Not all inpatient charges are paid up to the annual maximum. Carefully review the limit on other hospital services.)	$10,000	Same as preferred
Limit on other hospital services per coverage year	$1,000	Same as preferred
Once this limit has been reached, this benefit will no longer pay for many hospital-billed charges. The plan will continue to pay for room and board and inpatient professional services until the maximum benefit per coverage year is reached.		
Deductible per coverage year		
Individual	$250	Same as preferred
Family	$500	Same as preferred
Percentage of remaining charges you pay	20%	40%

Coverage for Prescription Drug Charges	Preferred Provider (In network. Percentages refer to Negotiated Charge.)	Non-Preferred Provider (Out of network. Percentages refer to Recognized Charge.)
Maximum benefit per coverage year (This does not count towards any other benefit limits or maximums.)	$500	Same as preferred
Deductible for each prescription	$10	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	Same as preferred

Covers only medical prescriptions, except for dental prescriptions issued in connection with treatment resulting from a covered accident.

Medicare Part D Notice: This prescription drug benefit does not meet the criteria for Medicare Part D coverage; it does not match up to the plan offered under Medicare Part D.

To use your prescription benefit:
A) Present your Aetna Affordable Health Choices® identification (ID) card to the pharmacist.
B) Participating pharmacies will apply a discount.
C) You pay the amount charged by the pharmacy.*
D) Submit a medical claim form to SRC for reimbursement.*
* If the pharmacy submits your claim(s) for you, then these steps do not apply.

Sometimes the plan will treat a service from a non-preferred provider as if that provider were a preferred provider for purposes of determining your copay, coinsurance and deductible. The plan will do this when you have a medical emergency or there is not a preferred provider in your area. You remain responsible, however, for any amount that a non-preferred provider may bill you above the recognized charge. Please note that if you travel to an area that has a preferred provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits.

If you get emergency care from a non-preferred provider, call us within two business days after you start receiving treatment. Member services is available Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682.**

To find out whether a provider is in Aetna's network (a **preferred provider**), use DocFind at **www.aetna.com/docfind.**

When you enroll in medical coverage, you also receive:

Aetna Vision℠ Discounts*

Aetna Vision℠ Discounts uses the nationwide EyeMed Select Network of vision care providers to offer you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at discounted prices. Plus, you can receive discounts on eye exams and LASIK eye surgery. For exams and eyewear call **1-800-793-8616**. For contacts call **1-800-391-5367**. For LASIK customer service call **1-800-422-6600**. You can also locate a local provider by visiting **www.aetna.com/docfind/custom/aahc**. This discount arrangement may not be available to Illinois residents.

Prescription drug discount program*

The prescription drug discount program gives you and your family access to over 59,000 retail pharmacies nationwide including major pharmacy chains and independent pharmacies (Aetna Network Pharmacy Database - 3/20/08). You can also use our Aetna Rx Home Delivery® service; a fast, easy way to fill the prescriptions you take regularly. To locate a participating pharmacy, call **1-888-772-9682** or visit **www.aetna.com/docfind/custom/aahc**.

*Discount programs provide access to discounted prices and are not insured benefits.

Medical Exclusions and Limitations

This plan does not cover all health care expenses and has exclusions and limitations. Members should refer to their booklet certificate to determine which health care services are covered and to what extent. The following is a **partial list** of services and supplies that are generally *not covered* . **However, your plan may contain exceptions to this list based on state mandates or the plan design purchased.**

Medical Pre-existing Condition Limitation:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 180 days prior to your enrollment in this plan. Generally, this 180-day period ends on the day before the medical plan waiting period begins (for example, on your date of hire). The pre-existing condition exclusion does not apply to pregnancy, a newborn child or a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 365 days from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion period if you have not experienced a break in coverage of at least 63 days. To reduce the 365-day exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate but you have had prior health coverage, we will help you obtain a certificate from your prior plan or insurer. There are also other ways to show you have had creditable coverage. Please contact us at **1-888-772-9682** if you need help demonstrating creditable coverage.

Medical Exclusions:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents.
- Any eye surgery mainly to correct refractive errors.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and X-rays, unless medically necessary to repair an injury to the mouth, jaw or teeth resulting from an accident.
- Donor egg retrieval.
- Experimental and investigational procedures.
- Hearing aids.
- Immunizations for travel or work.
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling.
- Special duty nursing.

Terms defined

A service or supply is ***medically necessary*** if it is determined by Aetna to be appropriate for the diagnosis, care or treatment of the disease or injury involved. See the plan documents for the complete definition.

A ***copayment*** (or ***copay***) is a fixed amount that you must pay for a medical service after you have met any deductible. In some cases, you may be responsible for paying a copay as well as a percentage of the remaining charges.

In many instances, the plan requires that a deductible is met before a benefit is paid. A **deductible** is the amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. All covered expenses accumulate toward both the preferred and non-preferred deductible per coverage year.

Once the family deductible per coverage year is met, all family members will be considered to have met their deductible. You will have met your ***family deductible*** either when two covered family members have each fully paid their own deductibles in a coverage year or when the amounts paid by all family members add up to the family deductible amount.

Inpatient charges are all charges incurred when you are admitted as an inpatient at a hospital or other inpatient facility, including hospital room and board charges (daily room rate), inpatient professional services, and other hospital services.

> ***Other hospital services*** are charges for certain services and supplies billed by a hospital when you are admitted as an inpatient, other than those charges for room and board. These charges may be significant and may include, but are not limited to: pharmaceutical, medical and surgical supplies and devices; lab tests and x-rays; and operating and recovery room expenses.
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> ***Inpatient professional services*** are charges billed by surgeons, physicians, radiologists, pathologists and anesthesiologists for services provided during an inpatient stay.

Outpatient charges are charges billed for services and supplies provided at doctors' offices, free-standing clinics and outpatient facilities. They also include charges at a hospital when you are not admitted as an inpatient, including emergency room charges.

A ***Negotiated Charge*** is the maximum amount that a preferred provider has agreed to charge for a covered the visit, service, or supply. After your plan limits have been reached, the provider may require that you pay the full charge rather than the negotiated charge.

A ***Recognized Charge*** is the amount that Aetna recognizes as payable by the plan for a visit, service, or supply. For non-preferred providers (except inpatient and outpatient facilities and pharmacies), the **Recognized Charge** generally equals the 80th percentile of what providers in that geographic area charge for that service, based on the MDR database from Ingenix. This means that 80% of the charges in the database for geographic area charge that amount or less – and 20% charge more – for that service or supply. For preferred providers, the **Recognized Charge** equals the **Negotiated Charge**. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would be your responsibility.

Percentage of remaining charges you pay refers to the percentage of negotiated or **Recognized Charges** you pay after you have fulfilled the deductible and/or copay and before the benefit maximum is reached. This is also known as member coinsurance. A non-preferred provider may require that you pay more than the **Recognized Charge**, and this additional amount would also be your responsibility. Once the applicable benefit maximum has been reached, you will be responsible for 100% of the remaining balance.

Preventive visits are those visits to the doctor for services that are not for the purpose of diagnosing or treating an injury or disease. Some common types of preventive visits are annual physical exams, gynecological exams, well-baby or well-child visits, mammograms, some cancer screenings, and bone mass density measurements. Included as part of the preventive visit are x-rays, lab and other tests, and materials for the administration of immunizations and testing for tuberculosis.
Your plan might not offer a preventive visit(s) benefit. Please refer to the benefits chart in this Benefits Summary. Some federal and state laws mandate certain preventive exams that are to be covered by, or in addition to, this benefit if offered under your plan. If a preventive visit(s) benefit is not offered under your plan (see the benefits chart), these mandates will be covered by other benefits under your plan. Please refer to the plan documents for more information.

Questions and answers

How do benefit limits work?
They put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services for that service or supply. Because there are limits on what is paid for certain kinds of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum. **Before you enroll in the plan, please read the benefits chart in the previous pages carefully to understand these limits and consider what effects they may have.**

Will the plan always pay up to the maximum benefits per coverage year?
No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for certain types of charges you continue to have, even though the overall maximum benefit has not been reached. Please read the benefits chart in the previous pages carefully to understand what types of charges may be limited before the overall maximums in question are reached.

How does this limited benefits insurance plan differ from a traditional major medical health plan?
There are important differences in what the plan will pay and what the premium costs. Both types of plans cover many types of services and supplies. However, this limited benefits insurance plan has a lower maximum benefit and places limits how much it will pay for categories of services or supplies. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket costs if you have a serious or chronic medical condition. Because traditional major medical health plans provide more coverage, they cost more.

What will I pay up front when I go to a healthcare provider?
A preferred doctor, hospital or other healthcare provider may require you to pay charges for which you are responsible in advance. This could include your copay, deductible, percentage of charges the plan does not pay (coinsurance), charges for services excluded under the plan, and charges in excess of your coverage limits. A non-preferred provider may require that you pay all charges in advance, and it would be up to you to submit a claim for reimbursement for any charges the plan may pay.

What are my rights for childbirth?
Under the Newborns' and Mothers' Health Protection Act (NMHPA), your plan will treat your hospital stay for the first 48 hours after a vaginal deliver (or 96 hours after cesarean section) as **medically necessary**. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding childbirth. Please refer to the plan documents.

What are my rights for reconstructive surgery after a mastectomy?
Under the Women's Health and Cancer Rights Act, your plan will consider as **medically necessary** post-mastectomy reconstruction of the same breast, or reconstruction of the other breast to achieve symmetry, prostheses, and treatment of physical complications of all stages of mastectomy including lymphedema. Your plan's overall benefit maximum, limits and deductibles will determine how much the plan will pay. The state in which you live, you work, or your plan was underwritten may have additional mandated rights regarding a mastectomy. Please refer to the plan documents.

What if I don't understand something I've read here, or have more questions?
Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, by calling toll free **1-888-772-9682**. We're here to answer questions before and after you enroll.

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE DESCRIBED IN THIS BENEFITS SUMMARY.

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL (1-877-623-6765) or visit the Connector website (www.mahealthconnector.org). THIS HEALTH PLAN, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.

This material is for information only and is not an offer or invitation to contract. Insurance plans contain exclusions and limitations. 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. 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. 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. Discount programs provide access to discounted prices and are not insured benefits. Information is believed to be accurate as of the production date; however, it is subject to change.

Insurance plans are underwritten by Aetna Life Insurance Company.
Plans are administered by Strategic Resource Company (SRC).

For OK residents only, policy forms issued include GR-9/GR-9N and GR-29/GR-29N.