AETNA PLAN OPTIONS	OK HMO 500 - 08††	OK CPOS 1000 - 08		OK CPOS 1500 100% - 08††	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis	N/A	N/A	Recognized*	N/A	Recognized*
Referrals Required	Yes	No	N/A	No	N/A
Network	HMO	Choice POS	N/A	Choice POS	N/A
MEMBER BENEFITS					
Member Coinsurance (Applies to most services)	20% after deductible	20% after deductible	40% after deductible	0% after deductible	30% after deductible
Calendar-Year Deductible**	$500 3 member maximum	$1000 3 member maximum	$2000 3 member maximum	$1500 3 member maximum	$3000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	$3000 3 member maximum	$4000 3 member maximum	$8000 3 member maximum	N/A	$6000 3 member maximum
Lifetime Maximum Benefit	$5,000,000	$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	$25 copay	$30 copay	40% after deductible	$25 copay	30% after deductible
Specialist Office Visit Copay	$40 copay	$40 copay	40% after deductible	$40 copay	30% after deductible
Outpatient Lab	$0 copay	$0 copay	40% after deductible	$0 copay	30% after deductible
Outpatient X-ray — no copay applies if performed and billed with physician office visit	$25 copay	$30 copay	40% after deductible	$25 copay	30% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	20% after deductible	20% after deductible	40% after deductible	0% after deductible	30% after deductible
Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST	$40 copay	$40 copay	40% after deductible	0% after deductible	30% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	50% after deductible	50% after deductible	50% after deductible	0% after deductible	30% after deductible
Routine Adult Physical Exams	$25 copay	$30 copay	40% after deductible	$25 copay	30% after deductible
Annual Routine GYN & PAP	$40 copay	$40 copay	40% after deductible	$40 copay	30% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	$0 copay	30% after deductible	$0 copay	30% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	40% after deductible	0% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	40% after deductible	0% after deductible	30% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	20% after $100 Copay (Deductible waived)	20% after $150 Copay (Deductible waived)	Paid as In-Network	$200 Copay (Deductible waived)	Paid as In-Network
Urgent Care	$75 copay	$100 copay	40% after deductible	$75 copay	30% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$15/$35/$60 Mandatory Generics†	$15/$35/$60 Mandatory Generics†	Not covered	$15/$35/$60 Mandatory Generics†	Not covered

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year. Expenses accumulate separately toward the preferred and non-preferred deductibles.

***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

†If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.

††Insure Oklahoma plan eligible.

AETNA PLAN OPTIONS	OK CPOS 2500 100% - 08††		OK CPOS 4000 100% - 08	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis	N/A	Recognized*	N/A	Recognized*
Referrals Required	No	N/A	No	N/A
Network	Choice POS	N/A	Choice POS	N/A
MEMBER BENEFITS				
Member Coinsurance (Applies to most services)	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Calendar-Year Deductible**	$2500 3 member maximum	$5000 3 member maximum	$4000 3 member maximum	$8000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	N/A	$10,000 3 member maximum	N/A	$10,000 3 member maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	$25 copay	30% after deductible	$25 copay	30% after deductible
Specialist Office Visit Copay	$40 copay	30% after deductible	$40 copay	30% after deductible
Outpatient Lab	$0 copay	30% after deductible	$0 copay	30% after deductible
Outpatient X-ray — no copay applies if performed and billed with physician office visit	$25 copay	30% after deductible	$25 copay	30% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Routine Adult Physical Exams	$25 copay	30% after deductible	$25 copay	30% after deductible
Annual Routine GYN & PAP	$40 copay	30% after deductible	$40 copay	30% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible	$0 copay	30% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	$200 Copay (Deductible waived)	Paid as In-Network	$200 Copay (Deductible waived)	Paid as In-Network
Urgent Care	$100 copay	30% after deductible	$100 copay	30% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$15/$35/$60 Mandatory Generics†	Not covered	$15/$35/$60 Mandatory Generics†	Not covered

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**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year. Expenses accumulate separately toward the preferred and non-preferred deductibles.

***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

†If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.

††Insure Oklahoma plan eligible.

AETNA PLAN OPTIONS	OK OAMC 500V - 08[††]		OK OAMC 1000E - 08		OK OAMC 1000V - 08	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis	N/A	Recognized*	N/A	Recognized*	N/A	Recognized*
Referrals Required	No	N/A	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS						
Member Coinsurance (Applies to most services)	20% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Calendar-Year Deductible**	$500 3 member maximum	$1,000 3 member maximum	$1,000 3 member maximum	$2,000 3 member maximum	$1,000 3 member maximum	$2,000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	$3,000 3 member maximum	$6,000 3 member maximum	$4,000 3 member maximum	$8,000 3 member maximum	$4,500 3 member maximum	$9,000 3 member maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	$25 copay	50% after deductible	$25 copay	40% after deductible	$25 copay	50% after deductible
Specialist Office Visit Copay	$35 copay	50% after deductible	$35 copay	40% after deductible	$40 copay	50% after deductible
Outpatient Lab and X-ray — no copay applies if performed and billed with physician office visit	$25 copay	50% after deductible	$25 copay	40% after deductible	$25 copay	50% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	20% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST Network and OON combined	20% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	50% after deductible		50% after deductible		50% after deductible	
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$25 copay	50% after deductible	$0 copay	30% after deductible	$25 copay	50% after deductible
Annual Routine GYN & PAP	$35 copay	50% after deductible	$0 copay	30% after deductible	$40 copay	50% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible	$0 copay	30% after deductible	$0 copay	30% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	20% after $150 Copay (Deductible waived)	Paid as In-Network	20% after $150 Copay (Deductible waived)	Paid as In-Network	20% after $200 Copay (Deductible waived)	Paid as In-Network
Urgent Care	$75 copay	50% after deductible	$75 copay	40% after deductible	$100 copay	50% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$15/$35/$60 Mandatory Generics[†]	Retail copay, plus 20%	$10/$30/$60	Retail copay, plus 20%	$15/$35/$60 Mandatory Generics[†]	Retail copay, plus 20%

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***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

[†]If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.

[††]Insure Oklahoma plan eligible.

AETNA PLAN OPTIONS	OK OAMC 1500E - 08		OK OAMC 1500V - 08		OK OAMC 2500V - 08	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis	N/A	Recognized*	N/A	Recognized*	N/A	Recognized*
Referrals Required	No	N/A	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS						
Member Coinsurance (Applies to most services)	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Calendar-Year Deductible**	$1,500 3 member maximum	$3,000 3 member maximum	$1,500 3 member maximum	$3,000 3 member maximum	$2,500 3 member maximum	$4,000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	$5,000 3 member maximum	$10,000 3 member maximum	$5,000 3 member maximum	$10,000 3 member maximum	$6,500 3 member maximum	$12,000 3 member maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	$30 copay	40% after deductible	$30 copay	50% after deductible	$30 copay	50% after deductible
Specialist Office Visit Copay	$40 copay	40% after deductible	$40 copay	50% after deductible	$40 copay	50% after deductible
Outpatient Lab and X-ray — no copay applies if performed and billed with physician office visit	$30 copay	40% after deductible	$30 copay	50% after deductible	$30 copay	50% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	50% after deductible		50% after deductible		50% after deductible	
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$0 copay	30% after deductible	$30 copay	50% after deductible	$30 copay	50% after deductible
Annual Routine GYN & PAP	$0 copay	30% after deductible	$40 copay	50% after deductible	$40 copay	50% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible	$0 copay	30% after deductible	$0 copay	30% after deductible
Inpatient Hospital	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	20% after $200 Copay (Deductible waived)	Paid as In-Network	20% after $200 Copay (Deductible waived)	Paid as In-Network	20% after $200 Copay (Deductible waived)	Paid as In-Network
Urgent Care	$100 copay	40% after deductible	$100 copay	50% after deductible	$100 copay	50% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$15/$35/$60	Retail copay, plus 20%	$20/$40/$60 Mandatory Generics†	Retail copay, plus 20%	$20/$40/$60 Mandatory Generics†	Retail copay, plus 20%

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***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

†If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.

AETNA PLAN OPTIONS	OK OAMC 2000 100% - 08††		OK OAMC 3000 100% - 08††		OK OAMC 5000 100% - 08	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis*	N/A	Recognized*	N/A	Recognized*	N/A	Recognized*
Referrals Required	No	NA	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS						
Member Coinsurance (Applies to most services)	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Calendar-Year Deductible**	$2,000 3 member maximum	$4,000 3 member maximum	$3,000 3 member maximum	$5,000 3 member maximum	$5,000 3 member maximum	$6,000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	N/A	$12,000 3 member maximum	N/A	$15,000 3 member maximum	N/A	$18,000 3 member maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	$25 copay	30% after deductible	$25 copay	30% after deductible	$25 copay	30% after deductible
Specialist Office Visit Copay	$40 copay	30% after deductible	$40 copay	30% after deductible	$40 copay	30% after deductible
Outpatient Lab and X-ray — no copay applies if performed and billed with physician office visit	$25 copay	30% after deductible	$25 copay	30% after deductible	$25 copay	30% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST Net and Out-of-Network combined	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$25 copay	30% after deductible	$25 copay	30% after deductible	$25 copay	30% after deductible
Annual Routine GYN & PAP	$40 copay	30% after deductible	$40 copay	30% after deductible	$40 copay	30% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible	$0 copay	30% after deductible	$0 copay	30% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	$200 copay	Paid as In-Network	$250 copay	Paid as In-Network	$250 copay	Paid as In-Network
Urgent Care	$100 copay	30% after deductible	$100 copay	30% after deductible	$100 copay	30% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$15/$35/$60	Retail copay, plus 20%	$15/$35/$60	Retail copay, plus 20%	$15/$35/$60	Retail copay, plus 20%

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***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

††Insure Oklahoma plan eligible.

AETNA PLAN OPTIONS	OK Limited Benefit 50/50 - 08	
	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis*	N/A	Recognized*
Referrals Required	No	N/A
Network	Managed Choice	N/A
MEMBER BENEFITS		
Member Coinsurance (Applies to most services)	50% after deductible	50% after deductible
Calendar-Year Deductible**	$1,500 3 member maximum	$3,000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	$5,500 3 member maximum	$11,000 3 member maximum
Benefit Maximum	$25,000 annual benefit maximum per member	
Physician Office Visit — Non-Specialist	50% after deductible	50% after deductible
Specialist Office Visit Copay	50% after deductible	50% after deductible
Outpatient Lab, X-ray and Complex Imaging Limitation - maximum benefit of $500 per calendar year, all services combined	50% after deductible	50% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST Net and Out-of-Network combined	50% after deductible	50% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	Not covered	
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$25 copay	50% after deductible
Annual Routine GYN & PAP	$25 copay	50% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible
Inpatient Hospital	50% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	50% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	50% after deductible	50% after deductible
Urgent Care	50% after deductible	50% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	$10/30%/50% after medical plan deductible Mandatory Generics†	Retail copay, plus 20% after medical plan deductible

Note: The Limited Benefit 50/50 plan does not cover mental health, substance abuse rehabilitation, DME and other medical services. Refer to the Limitations and Exclusions section of the plan documents for a complete list of exclusions.

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***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, pharmacy and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

†If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.

AETNA PLAN OPTIONS	CDHP 2500-08 HSA compatible		CDHP 4000-08 HSA compatible		CDHP 2000-08	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Reimbursement Basis*	N/A	Recognized*	N/A	Recognized*	N/A	Recognized*
Referrals Required	No	N/A	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS						
Member Coinsurance (Applies to most services)	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Calendar-Year Deductible**	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Out-of-Pocket Maximum*** (Certain payments do not apply)	$2,500 Individual $5,000 Family	$8,000 Individual $16,000 Family	$4,000 Individual $8,000 Family	$16,000 Individual $32,000 Family	$4,000 Individual $8,000 Family+	$8,000 Individual $16,000 Family+
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Non-Specialist (Primary Physician) Office Visit Copay	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Specialist Office Visit Copay	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Lab and X-ray	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST Net and Out-of-Network combined	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$0 copay Deductible waived	30% after deductible	$0 copay Deductible waived	30% after deductible	20% after deductible	40% after deductible
Annual Routine GYN & PAP	$0 copay Deductible waived	30% after deductible	$0 copay Deductible waived	30% after deductible	20% after deductible	40% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay Deductible waived	30% after deductible	$0 copay Deductible waived	30% after deductible	$0 copay Deductible waived	30% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	0% after deductible	Paid as In-Network	0% after deductible	Paid as In-Network	20% after deductible	Paid as In-Network
Urgent Care	0% after deductible	30% after deductible	0% after deductible	30% after deductible	20% after deductible	40% after deductible
Prescription Drugs Retail: 30-day supply Mail Order: 3X retail copay 90-day supply	0% after medical plan deductible	30% after medical plan deductible	0% after medical plan deductible	30% after medical plan deductible	$10/$30/$60	Retail copay, plus 20%

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. Expenses accumulate separately toward the preferred and non-preferred deductibles. No one family member may contribute more than the Individual Deductible amount toward the Family Deductible.

***All covered expenses accumulate separately toward the preferred and non-preferred 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. The Out-of-Pocket maximum for HSA-compatible plans includes all expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts). No one family member may contribute more than the Individual Deductible amount toward the Family Deductible.

+All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

AETNA PLAN OPTIONS	PPO 1000V-08		Indemnity 1000
	In-Network	Out-of-Network	
Out-of-Network Reimbursement Basis	N/A	Recognized*	Usual and Customary
Referrals Required	No	NA	No
Network	Managed Choice	N/A	N/A
MEMBER BENEFITS			
Member Coinsurance (Applies to most services)	20% after deductible	50% after deductible	30% after deductible
Calendar-Year Deductible**	$1,000 3 member maximum	$2,000 3 member maximum	$1,000 3 member maximum
Out-of-Pocket Maximum*** (Certain payments do not apply)	$4,500 3 member maximum	$9,000 3 member maximum	$4,000 3 member maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000
Non-Specialist (Primary Physician) Office Visit Copay	$25 copay	50% after deductible	30% after deductible
Specialist Office Visit Copay	$40 copay	50% after deductible	30% after deductible
Outpatient Lab and X-ray — no copay applies if performed and billed with physician office visit	$25 copay	50% after deductible	30% after deductible
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	20% after deductible	50% after deductible	30% after deductible
Outpatient Physical, Occupational, Speech Therapy Limitation: 20 visits per year PT/OT combined; 20 visits per year ST Net and Out-of-Network combined	20% after deductible	50% after deductible	30% after deductible
Durable Medical Equipment $2500 per calendar year maximum; Net and Out-of-Network combined	50% after deductible		30% after deductible
Routine Adult Physical Exams 1 exam/24 months; $300 max per exam	$25 copay	50% after deductible	30% after deductible
Annual Routine GYN & PAP	$40 copay	50% after deductible	30% after deductible
Routine Mammogram 1 exam age 35-39 1 annual exam age 40+	$0 copay	30% after deductible	30% after deductible
Inpatient Hospital	20% after deductible	50% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	30% after deductible
Emergency Room (Copay waived if admitted; non-emergent use of ER is not covered)	20% after $200 Copay (Deductible waived)	Paid as In-Network	30% after deductible
Urgent Care	$100 copay	50% after deductible	30% after deductible
Prescription Drugs **Retail: 30-day supply** **Mail Order: 3X retail copay** **90-day supply**	$15/$35/$60 Mandatory Generics†	Retail copay, plus 20%	$15/$35/$60 Mandatory Generics†

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year. Expenses accumulate separately toward the preferred and non-preferred deductibles.

***All covered expenses accumulate separately toward the preferred and non-preferred Out-of-Pocket maximums. Certain member cost-sharing elements including copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Out-of-Pocket maximum. Once 3 individual members of a family each satisfy their Out-of-Pocket maximum separately, all family members will be considered as having met their Out-of-Pocket maximum for the remainder of the calendar year.

†If generic is available and member or physician requires brand, member pays the copay amount plus the difference in cost between a brand-name and generic drug.