

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx OAMC 500-08		Tx OAMC 1000-08		Tx OAMC 1500-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
<b>Out-of-Network Reimbursement Basis*</b>	N/A	Recognized	N/A	Recognized	N/A	Recognized
<b>Referrals Required</b>	No	No	No	No	No	No
<b>Network</b>	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>						
<b>Member Coinsurance (Applies to most services)</b>	20%	40%	20%	40%	20%	40%
<b>Calendar-Year Deductible**</b>	\$500 Individual 3 Individuals per Family	\$1,000 Individual 3 Individuals per Family	\$1,000 Individual 3 Individuals per Family	\$2,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family
<b>Coinsurance Maximum*** (Deductible and certain payments do not apply)</b>	\$2,500 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family	\$3,500 Individual 3 Individuals per Family	\$7,000 Individual 3 Individuals per Family
<b>Lifetime Maximum Benefit</b>	\$5,000,000		\$5,000,000		\$5,000,000	
<b>Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance</b>	\$20 copay Deductible waived	40%	\$25 copay Deductible waived	40%	\$30 copay Deductible waived	40%
<b>Specialist Office Visit Copay</b>	\$30 copay Deductible waived	40%	\$35 copay Deductible waived	40%	\$40 copay Deductible waived	40%
<b>Outpatient — Lab</b>	\$0 copay Deductible waived	40%	\$0 copay Deductible waived	40%	\$0 copay Deductible waived	40%
<b>Outpatient — X-ray</b>	\$20 copay Deductible waived	40%	\$25 copay Deductible waived	40%	\$30 copay Deductible waived	40%
<b>Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)</b>	20%	40%	20%	40%	20%	40%
<b>Outpatient Physical, Occupational, Speech Therapy, Chiropractic (Professional Charges)</b>	20%	40%	20%	40%	20%	40%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
<b>Durable Medical Equipment \$2500 per calendar year maximum, Preferred &amp; Non-Preferred combined</b>	50%	50%	50%	50%	50%	50%
<b>Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)</b>	\$20 copay Deductible waived	40%	\$25 copay Deductible waived	40%	\$30 copay Deductible waived	40%
<b>Routine GYN (Frequency schedules apply)</b>	\$30 copay Deductible waived	40%	\$35 copay Deductible waived	40%	\$40 copay Deductible waived	40%
<b>Inpatient Hospital</b>	20%	40%	20%	40%	20%	40%
<b>Outpatient Surgery</b>	20%	40%	20%	40%	20%	40%
<b>Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)</b>	20% after \$150 Copay; Deductible waived	Paid as In-Network	20% after \$150 Copay, deductible waived	Paid as In-Network	20% after \$150 Copay, deductible waived	Paid as In-Network
<b>Urgent Care</b>	\$50 copay Deductible waived	40%	\$75 copay Deductible waived	40%	\$75 copay Deductible waived	40%
<b>Prescription Drugs: Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)</b>	\$15/\$35/\$50	\$15/\$35/\$50 + 30%	\$15/\$35/\$50	\$15/\$35/\$50 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%

\*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 Coinsurance maximum. Certain member cost sharing elements including deductible, copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Coinsurance maximum. Once 3 individual members of a family each satisfy their Coinsurance maximum separately, all family members will be considered as having met their Coinsurance maximum for the remainder of the calendar year.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx OAMC 2000-08		Tx OAMC 2500-08		Tx OAMC 3500-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
<b>Out-of-Network Reimbursement Basis*</b>	N/A	Recognized	N/A	Recognized	N/A	Recognized
<b>Referrals Required</b>	No	No	No	No	No	No
<b>Network</b>	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>						
<b>Member Coinsurance (Applies to most services)</b>	20%	50%	30%	50%	30%	50%
<b>Calendar-Year Deductible**</b>	\$2,000 Individual 3 Individuals per Family	\$4,000 Individual 3 Individuals per Family	\$2,500 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$3,500 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family
<b>Coinsurance Maximum*** (Deductible and certain payments do not apply)</b>	\$4,000 Individual 3 Individuals per Family	\$8,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$10,000 Individual 3 Individuals per Family	\$7,000 Individual 3 Individuals per Family	\$10,000 Individual 3 Individuals per Family
<b>Lifetime Maximum Benefit</b>	\$5,000,000		\$5,000,000		\$5,000,000	
<b>Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance</b>	\$35 copay Deductible waived	50%	\$40 copay Deductible waived	50%	\$40 copay Deductible waived	50%
<b>Specialist Office Visit Copay</b>	\$45 copay Deductible waived	50%	\$50 copay Deductible waived	50%	\$50 copay Deductible waived	50%
<b>Outpatient — Lab</b>	\$0 copay Deductible waived	50%	\$0 copay Deductible waived	50%	\$0 copay Deductible waived	50%
<b>Outpatient — X-ray</b>	\$35 copay Deductible waived	50%	\$40 copay Deductible waived	50%	\$40 copay Deductible waived	50%
<b>Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)</b>	20%	50%	30%	50%	30%	50%
<b>Outpatient Physical, Occupational, Speech Therapy, Chiropractic (Professional Charges)</b>	20%	50%	30%	50%	30%	50%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
<b>Durable Medical Equipment \$2500 per calendar year maximum, Preferred &amp; Non-Preferred combined</b>	50%	50%	50%	50%	50%	50%
<b>Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)</b>	\$35 copay Deductible waived	50%	\$40 copay Deductible waived	50%	\$40 copay Deductible waived	50%
<b>Routine GYN (Frequency schedules apply)</b>	\$45 copay Deductible waived	50%	\$50 copay Deductible waived	50%	\$50 copay Deductible waived	50%
<b>Inpatient Hospital</b>	20%	50%	30%	50%	30%	50%
<b>Outpatient Surgery</b>	20%	50%	30%	50%	30%	50%
<b>Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)</b>	20% after \$200 Copay, deductible waived	Paid as In-Network	30% after \$200 Copay, deductible waived	Paid as In-Network	30% after \$200 Copay, deductible waived	Paid as In-Network
<b>Urgent Care</b>	\$75 copay Deductible waived	50%	\$100 copay Deductible waived	50%	\$100 copay Deductible waived	50%
<b>Prescription Drugs: Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)</b>	\$15/\$40/\$60	\$15/\$40/\$60 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%

\*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 Coinsurance maximum. Certain member cost sharing elements including deductible, copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Coinsurance maximum. Once 3 individual members of a family each satisfy their Coinsurance maximum separately, all family members will be considered as having met their Coinsurance maximum for the remainder of the calendar year.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx OAMC1000 100%-08		Tx OAMC 2000 100%-08		Tx OAMC 3000 100%-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
<b>Out-of-Network Reimbursement Basis*</b>	N/A	Recognized	N/A	Recognized	N/A	Recognized
<b>Referrals Required</b>	No	No	No	No	No	No
<b>Network</b>	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>						
<b>Member Coinsurance</b> (Applies to most services)	0%	30%	0%	30%	0%	30%
<b>Calendar-Year Deductible**</b>	\$1,000 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family	\$2,000 Individual 3 Individuals per Family	\$4,000 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family
<b>Coinsurance Maximum***</b> (Deductible and certain payments do not apply)	N/A	\$5,000 Individual 3 Individuals per Family	N/A	\$6,000 Individual 3 Individuals per Family	N/A	\$7,000 Individual 3 Individuals per Family
<b>Lifetime Maximum Benefit</b>	\$5,000,000		\$5,000,000		\$5,000,000	
<b>Nonspecialist (Primary Physician) Office Visit</b> (office hours) Copay/Coinsurance	\$30 copay Deductible waived	30%	\$30 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Specialist Office Visit Copay</b>	\$40 copay Deductible waived	30%	\$40 copay Deductible waived	30%	\$35 copay Deductible waived	30%
<b>Outpatient — Lab</b>	0% Deductible waived	30%	0% Deductible waived	30%	0% copay Deductible waived	30%
<b>Outpatient — X-ray</b>	\$30 copay Deductible waived	30%	\$30 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans)	0%	30%	0%	30%	0%	30%
<b>Outpatient Physical, Occupational, Speech Therapy, Chiropractic</b> (Professional Charges)	0%	30%	0%	30%	0%	30%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
<b>Durable Medical Equipment</b> \$2500 per calendar year maximum, Preferred & Non-Preferred combined	0%	30%	0%	30%	0%	30%
<b>Routine Physical Exams — Adults and Well Child</b> (Age and frequency schedules apply)	\$30 copay Deductible waived	30%	\$30 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Routine GYN</b> (Frequency schedules apply)	\$40 copay Deductible waived	30%	\$40 copay Deductible waived	30%	\$35 copay Deductible waived	30%
<b>Inpatient Hospital</b>	0%	30%	0%	30%	0%	30%
<b>Outpatient Surgery</b>	0%	30%	0%	30%	0%	30%
<b>Emergency Room</b> (Copay waived if admitted; non-emergency use of ER is not covered)	\$150 copay Deductible waived	Paid as In-Network	\$200 copay Deductible waived	Paid as In-Network	\$250 copay Deductible waived	Paid as In-Network
<b>Urgent Care</b>	\$75 copay Deductible waived	30%	\$75 copay Deductible waived	30%	\$75 copay Deductible waived	30%
<b>Prescription Drugs:</b> Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)	\$15/\$40/\$60	\$15/\$40/\$60 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%

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

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx OAMC 4000 100%-08		Tx OAMC 5000 100%-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred
Out-of-Network Reimbursement Basis*	N/A	Recognized	N/A	Recognized
Referrals Required	No	No	No	No
Network	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>				
Member Coinsurance (Applies to most services)	0%	30%	0%	30%
Calendar-Year Deductible**	\$4,000 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family
Coinsurance Maximum*** (Deductible and certain payments do not apply)	N/A	\$8,000 Individual 3 Individuals per Family	N/A	\$8,000 Individual 3 Individuals per Family
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance	\$25 copay Deductible waived	30%	\$25 copay Deductible waived	30%
Specialist Office Visit Copay	\$40 copay Deductible waived	30%	\$40 copay Deductible waived	30%
Outpatient — Lab	0% Deductible waived	30%	0% Deductible waived	30%
Outpatient — X-ray	\$25 copay Deductible waived	30%	\$25 copay Deductible waived	30%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0%	30%	0%	30%
Outpatient Physical, Occupational, Speech Therapy, Chiropractic (Professional Charges)	0%	30%	0%	30%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
Durable Medical Equipment \$2500 per calendar year maximum, Preferred & Non-Preferred combined	0%	30%	0%	30%
Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)	\$25 copay Deductible waived	30%	\$25 copay Deductible waived	30%
Routine GYN (Frequency schedules apply)	\$40 copay Deductible waived	30%	\$40 copay Deductible waived	30%
Inpatient Hospital	0%	30%	0%	30%
Outpatient Surgery	0%	30%	0%	30%
Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)	\$250 copay Deductible waived	Paid as In-Network	\$250 copay Deductible waived	Paid as In-Network
Urgent Care	\$75 copay Deductible waived	30%	\$75 copay Deductible waived	30%
Prescription Drugs: Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)	\$15/\$40/\$60	\$15/\$40/\$60 + 30%	\$15/\$40/\$60	\$15/\$40/\$60 + 30%

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

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx HMO 30 Plus-08		Tx CPOS 1500 100%-08		Tx CPOS 2500 100%-08	
	Network/Referred	Non-Network / Non-Referred	Network	Non-Network	Network	Non-Network
Out-of-Network Reimbursement Basis*	N/A	Recognized	N/A	Recognized	N/A	Recognized
Referrals Required	Yes	No	No	No	No	No
Network	HMO	N/A	HMO	N/A	HMO	N/A
<b>MEMBER BENEFITS</b>						
Member Coinsurance (Applies to most services)	N/A	30%	0%	30%	0%	30%
Calendar-Year Deductible**	N/A	\$4,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family	\$2,500 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family
Out of Pocket Maximum*** (Deductible and certain payments do not apply)	\$4,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$10,000 Individual 3 Individuals per Family
Lifetime Maximum Benefit	Unlimited	\$2,000,000	\$5,000,000		\$5,000,000	
Primary Care Physician Office Visit (office hours) Copay/Coinsurance	\$30 copay	30%	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%
Specialist Office Visit Copay	\$50 copay	30%	\$45 copay Deductible waived	30%	\$45 copay Deductible waived	30%
Outpatient — Lab	\$0 copay	30%	0% Deductible waived	30%	0% Deductible waived	30%
Outpatient — X-ray	\$30 copay	30%	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	\$250 copay	30%	0%	30%	0%	30%
Outpatient Physical, Occupational, Speech Therapy, (Professional Charges)	\$50 copay	30%	0%	30%	0%	30%
Durable Medical Equipment \$2500 per calendar year maximum, Net and OON combined	50%	50%	0%	30%	0%	30%
Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)	\$30 copay	30%	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%
Routine GYN (Frequency schedules apply)	\$50 copay	30%	\$45 copay Deductible waived	30%	\$45 copay Deductible waived	30%
Inpatient Hospital	\$500 per day; 5 day maximum	30%	0%	30%	0%	30%
Outpatient Surgery	\$300 copay	30%	0%	30%	0%	30%
Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)	\$250 copay	Paid as In-Network	\$200 Copay, deductible waived	Paid as In-Network	\$250 Copay, deductible waived	Paid as In-Network
Urgent Care	\$75 copay	30%	\$75 copay Deductible waived	30%	\$75 copay Deductible waived	30%
Prescription Drugs: (Generic formulary/brand formulary/nonformulary) Retail: per 30-day supply; Mail Order: three times retail copay, (31 to 90 day supply available)	\$15/\$35/\$50	\$15/\$35/\$50 + 30%	\$15/\$40/\$60	Not covered	\$15/\$40/\$60	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 Deductible, 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.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx CPOS 3500 100%-08		Tx CPOS 5000 100%-08		Tx HMO Family Plus-08	
	Network	Non-Network	Network	Non-Network	Network/Referred	Non-Network/Non-Referred
<b>Out-of-Network Reimbursement Basis*</b>	N/A	Recognized	N/A	Recognized	N/A	Recognized
<b>Referrals Required</b>	No	No	No	No	Yes	No
<b>Network</b>	HMO	N/A	HMO	N/A	HMO	N/A
<b>MEMBER BENEFITS</b>						
<b>Member Coinsurance (Applies to most services)</b>	0%	30%	0%	30%	0%	30%
<b>Calendar-Year Deductible**</b>	\$3,500 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$6,000 Individual 3 Individuals per Family	\$10,000 Individual \$10,000 Family*	\$20,000 Individual \$20,000 Family*
<b>Out of Pocket Maximum*** (Deductible and certain payments do not apply)</b>	\$1,500 Individual 3 Individuals per Family	\$12,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$12,000 Individual 3 Individuals per Family	\$2,500 Individual \$2,500 Family*	\$20,000 Individual \$20,000 Family*
<b>Lifetime Maximum Benefit</b>	\$5,000,000		\$5,000,000		\$5,000,000	
<b>Primary Care Physician Office Visit (office hours) Copay/Coinsurance</b>	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Specialist Office Visit Copay</b>	\$45 copay Deductible waived	30%	\$45 copay Deductible waived	30%	0%	30%
<b>Outpatient — Lab</b>	0% Deductible waived	30%	0% Deductible waived	30%	0%	30%
<b>Outpatient — X-ray</b>	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%	0%	30%
<b>Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)</b>	0%	30%	0%	30%	0%	30%
<b>Outpatient Physical, Occupational, Speech Therapy, (Professional Charges)</b>	0%	30%	0%	30%	0%	30%
	20 visits per year PT/OT combined; 20 visits ST; Network and OON combined		20 visits per year PT/OT combined; 20 visits ST; Network and OON combined		20 visits per year PT/OT combined; 20 visits ST; Network and OON combined	
<b>Durable Medical Equipment \$2500 per calendar year maximum, Net and OON combined</b>	0%	30%	0%	30%	0%	30%
<b>Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)</b>	\$35 copay Deductible waived	30%	\$35 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Routine GYN (Frequency schedules apply)</b>	\$45 copay Deductible waived	30%	\$45 copay Deductible waived	30%	\$25 copay Deductible waived	30%
<b>Inpatient Hospital</b>	0%	30%	0%	30%	0%	30%
<b>Outpatient Surgery</b>	0%	30%	0%	30%	0%	30%
<b>Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)</b>	\$250 Copay, deductible waived	Paid as In-Network	\$250 Copay, deductible waived	Paid as In-Network	\$250 Copay, deductible waived	Paid as In-Network
<b>Urgent Care</b>	\$75 copay Deductible waived	30%	\$75 copay Deductible waived	30%	0%	30%
<b>Prescription Drugs: (Generic formulary/brand formulary/nonformulary) Retail: per 30-day supply; Mail Order: three times retail copay, (31 to 90 day supply available)</b>	\$15/\$40/\$60	Not covered	\$15/\$40/\$60	Not covered	\$15 copay for Generic meds Member pays 100% for Brand	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 Deductible, 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.

\*The Family Deductible and Out-of-Pocket maximum on the HMO Family Plus plan can be met by a combination of Family members or by any single Individual within the family. Once the Family Deductible or Out-of-Pocket maximum is met, all family members will be considered as having met their Deductible or Out-of-Pocket maximum for the remainder of the calendar year.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx Limited Benefit 50/50-08		Tx OAMC Basic 1500-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred
Out-of-Network Reimbursement Basis*	N/A	Recognized	N/A	Recognized
Referrals Required	No	No	No	No
Network	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>				
Member Coinsurance (Applies to most services)	50%	50%	20%	50%
Calendar-Year Deductible**	\$1,500 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family	\$1,500 Individual 3 Individuals per Family	\$3,000 Individual 3 Individuals per Family
Coinsurance Maximum*** (Deductible and certain payments do not apply)	\$5,000 Individual 3 Individuals per Family	\$10,000 Individual 3 Individuals per Family	\$5,000 Individual 3 Individuals per Family	\$10,000 Individual 3 Individuals per Family
Lifetime Maximum Benefit	\$5,000,000 Lifetime Maximum Benefit \$25,000 Annual Maximum Benefit		\$5,000,000	
Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance	50%	50%	\$35 - Deductible waived (3 visits per year, specialist & non-specialist combined at copay; additional visits subject to D&C)	50%
Specialist Office Visit Copay	50%	50%	See non-Specialist office visit	50%
Outpatient — Lab	50%	50%	20% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)	50% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)
Outpatient — X-ray	50%	50%	20% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)	50% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	50%	50%	20% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)	50% (\$500 max benefit lab, x-ray & complex combined; Net & non-Net combined)
Outpatient Physical, Occupational, Speech Therapy, (Professional Charges)	50%	50%	See non-Specialist office visit	50%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
Durable Medical Equipment \$2500 per calendar year maximum, Net and OON combined	50%	50%	Not covered	Not covered
Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)	\$35 copay Deductible waived	50%	See non-Specialist office visit	50%
Routine GYN (Frequency schedules apply)	\$35 copay Deductible waived	50%	See non-Specialist office visit	50%
Inpatient Hospital	50%	50%	20%	50%
Outpatient Surgery	50%	50%	20%	50%
Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)	50%	Paid as In-Network	20%	Paid as In-Network
Urgent Care	50%	50%	20%	50%
Prescription Drugs: Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)	\$15 copay for Generic meds Member pays 100% for Brand	\$15 copay + 30% for Generic meds Member pays 100% for Brand	\$15 copay for Generic meds Member pays 100% for Brand	\$15 copay + 30% for Generic meds Member pays 100% for Brand

Note: The Limited Benefit 50/50 and OAMC Basic 1500 plans may 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.

\*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 Coinsurance maximum. Certain member cost sharing elements including deductible, copays, pharmacy and penalties do not apply toward the Coinsurance maximum. Once 3 individual members of a family each satisfy their Coinsurance maximum separately, all family members will be considered as having met their Coinsurance maximum for the remainder of the calendar year.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx PPO 1000-08	
	Preferred	Non-Preferred
<b>Out-of-Network Reimbursement Basis*</b>	N/A	Recognized
<b>Referrals Required</b>	No	No
<b>Network</b>	PPO	N/A
<b>MEMBER BENEFITS</b>		
<b>Member Coinsurance</b> (Applies to most services)	20%	40%
<b>Calendar-Year Deductible**</b>	\$1,000 3 member maximum	\$2,000 3 member maximum
<b>Coinsurance Maximum***</b> (Deductible and certain payments do not apply)	\$3,000 3 member maximum	\$6,000 3 member maximum
<b>Lifetime Maximum Benefit</b>	\$5,000,000	
<b>Nonspecialist (Primary Physician) Office Visit</b> (office hours) Copay/Coinsurance	\$30 copay Deductible waived	40%
<b>Specialist Office Visit Copay</b>	\$40 copay Deductible waived	40%
<b>Outpatient — Lab</b>	0% Deductible waived	40%
<b>Outpatient — X-ray</b>	\$30 copay Deductible waived	40%
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans)	20%	40%
<b>Outpatient Physical, Occupational, Speech Therapy, Chiropractic</b> (Professional Charges)	20%	40% 20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined
<b>Durable Medical Equipment</b> \$2500 per calendar year maximum, Net and OON combined	50%	50%
<b>Routine Physical Exams — Adults and Well Child</b> (Age and frequency schedules apply)	\$30 copay Deductible waived	40%
<b>Routine GYN</b> (Frequency schedules apply)	\$40 copay Deductible waived	40%
<b>Inpatient Hospital</b>	20%	40%
<b>Outpatient Surgery</b>	20%	40%
<b>Emergency Room</b> (Copay waived if admitted; non-emergency use of ER is not covered)	20% after \$150 Copay, deductible waived	Paid as In-Network
<b>Urgent Care</b>	\$75 copay Deductible waived	40%
<b>Prescription Drugs:</b> (Generic formulary/brand formulary/nonformulary) Retail: per 30-day supply; Mail Order: three times retail copay, (31 to 90 day supply available)	\$15/\$35/\$50	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 Coinsurance maximum. Certain member cost sharing elements including deductible, copays, DME, pharmacy, mental health, substance abuse and penalties do not apply toward the Coinsurance maximum. Once 3 individual members of a family each satisfy their Coinsurance maximum separately, all family members will be considered as having met their Coinsurance maximum for the remainder of the calendar year.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Tx OAMC 3000 100% HSA-08		Tx OAMC 4000 100% HSA-08		Tx OAMC 5000 100% HSA-08	
	Preferred	Non-Preferred	Preferred	Non-Preferred	Preferred	Non-Preferred
Out-of-Network Reimbursement Basis*	N/A	Recognized	N/A	Recognized	N/A	Recognized
Referrals Required	No	No	No	No	No	No
Network	Managed Choice	N/A	Managed Choice	N/A	Managed Choice	N/A
<b>MEMBER BENEFITS</b>						
Member Coinsurance (Applies to most services)	0%	30%	0%	30%	0%	30%
Calendar-Year Deductible**	\$3,000 per member \$6,000 family	\$6,000 per member \$12,000 family	\$4,000 per member \$8,000 family	\$8,000 per member \$16,000 family	\$5,000 per member \$10,000 family	\$8,000 per member \$16,000 family
Out of Pocket Maximum***	\$4,000 per member \$8,000 family	\$12,000 per member \$24,000 family	\$5,000 per member \$10,000 family	\$16,000 per member \$32,000 family	\$5,000 per member \$10,000 family	\$16,000 per member \$32,000 family
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000		\$5,000,000	
Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance	0%	30%	0%	30%	0%	30%
Specialist Office Visit Copay	0%	30%	0%	30%	0%	30%
Outpatient — Lab	0%	30%	0%	30%	0%	30%
Outpatient — X-ray	0%	30%	0%	30%	0%	30%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0%	30%	0%	30%	0%	30%
Outpatient Physical, Occupational, Speech Therapy, Chiropractic (Professional Charges)	0%	30%	0%	30%	0%	30%
	20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined		20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined	
Durable Medical Equipment \$2500 per calendar year maximum, Net and OON combined	0%	30%	0%	30%	0%	30%
Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)	\$0 copay Deductible waived	30%	\$0 copay Deductible waived	30%	\$0 copay Deductible waived	30%
Routine GYN (Frequency schedules apply)	\$0 copay Deductible waived	30%	\$0 copay Deductible waived	30%	\$0 copay Deductible waived	30%
Inpatient Hospital	0%	30%	0%	30%	0%	30%
Outpatient Surgery	0%	30%	0%	30%	0%	30%
Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)	0%	Paid as In-Network	0%	Paid as In-Network	0%	Paid as In-Network
Urgent Care	0%	30%	0%	30%	0%	30%
Prescription Drugs: Retail 30-day supply; Mail Order Delivery: 3X retail copay, (90 day supply available)	\$10/\$30/\$50 after Integrated Medical Deductible	\$10/\$30/\$50 + 30% after Integrated Medical Deductible	\$10/\$30/\$50 after Integrated Medical Deductible	\$10/\$30/\$50 + 30% after Integrated Medical Deductible	0% after Integrated Medical Deductible	0% after Integrated Medical Deductible

\*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 Out of Pocket Maximum toward the Family Out of Pocket Maximum.

**TEXAS MEDICAL PLANS**

AETNA PLAN OPTIONS	Indemnity
Out-of-Network Reimbursement Basis*	N/A
Referrals Required	N/A
Network	N/A
<b>MEMBER BENEFITS**</b>	
Member Coinsurance (Applies to most services)	30%
Calendar-Year Deductible*	\$1,000 3 member maximum
Coinsurance Maximum (Deductible and certain payments do not apply)	\$3,000***† 3 member maximum
Lifetime Maximum Benefit	\$5,000,000
Nonspecialist (Primary Physician) Office Visit (office hours) Copay/Coinsurance	30%
Specialist Office Visit Copay	30%
Outpatient — Lab	30%
Outpatient — X-ray	30%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	40%
Outpatient Physical, Occupational, Speech Therapy, Chiropractic* (Professional Charges)	30% 20 visits per year Chiro/PT/OT combined; 20 visits ST; Preferred & Non-Preferred combined
Durable Medical Equipment \$2500 per calendar year maximum, Net and OON combined	50%
Routine Physical Exams — Adults and Well Child (Age and frequency schedules apply)	30%
Routine GYN (Frequency schedules apply)	30%
Inpatient Hospital	30%
Outpatient Surgery	30%
Emergency Room (Copay waived if admitted; non-emergency use of ER is not covered)	30%
Urgent Care	30%
Prescription Drugs: (Generic formulary/brand formulary/nonformulary) Retail: per 30-day supply; Mail Order: three times retail copay, (31 to 90 day supply available)	\$15/\$40/\$60 \$100 per member Rx deductible applicable to brand name medication

\*Not Covered.

\*\*Payment for out-of-network facility care is determined based upon Aetna’s allowable fee schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as “reasonable” or “recognized” charges.

\*\*\*Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

†Payment for Rx, mental disorders, DME, substance abuse and copayments do not apply and continue to be payable by the member after maximum is achieved. All other covered expenses accumulate separately toward the preferred and non-preferred coinsurance maximum. Three members must individually meet their coinsurance maximum before other family members will be considered to have met the maximum.

For a summary list of Limitations and Exclusions, refer to pages 36-37.