

**BENEFITS SUMMARY**

**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.

IMPORTANT DISCLOSURE: This plan has a number of specific limits and other restrictions on visits, services and/or the dollar amounts covered under the plan in addition to the overall dollar limit of the policy. Once these limits have been reached, the plan will not pay any more towards the cost of the service in question and you will be responsible for the remaining unpaid charges or expenses. This Benefits Summary explains these visit and service limits, the overall annual benefit maximum, and other cost sharing features of your plan, such as co-payments and deductibles. Please read it carefully so that you understand the limits to what the plan will pay before you enroll.

Medical: Option 1

Coverage for Outpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Doctors' office visits		
Maximum benefit per coverage year	5 visits	Same as preferred
Copay for each visit	\$10	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%
Preventive visits		
Maximum benefit per coverage year	\$100	Same as preferred
Copay for each visit	\$15	None
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	50%
Emergency room visits		
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
Diagnostic & surgical services		
Maximum benefit per coverage year	\$400 or 5 services, whichever is used up first	Same as preferred
Copay for each visit	\$15	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%



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Coverage for Inpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Maximum benefit per coverage year	\$2,000	Same as preferred
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)	Non-Preferred Provider (out of network)
Maximum benefit per coverage year	\$200	Same as preferred
Copay 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.

If you live in an area that does not have a preferred health care provider, you will be considered **out-of-area** and receive benefits for eligible expenses as if you were using a preferred provider. Please note that if you travel to an area that has a preferred health care provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits. However, if you have a life-threatening medical emergency and use a non-preferred provider, you can call member services within two business days of the medical emergency treatment and your claim for the covered expenses will be treated as if presented by a preferred provider. Call member services Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682**.



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Medical: Option 2

Coverage for Outpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Doctors' office visits		
Maximum benefit per coverage year	5 visits	Same as preferred
Copay for each visit	\$10	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%
Preventive visits		
Maximum benefit per coverage year	\$100	Same as preferred
Copay for each visit	\$15	None
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	50%
Emergency room visits		
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
Diagnostic & surgical services		
Maximum benefit per coverage year	\$400 or 5 services, whichever is used up first	Same as preferred
Copay for each visit	\$15	Same as preferred
Percentage of remaining charges you pay	None (plan pays 100% up to benefit maximum)	20%



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Coverage for Inpatient Charges	Preferred Provider (in network)	Non-Preferred Provider (out of network)
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 <i>Once this limit is reached, this benefit will no longer pay for hospital-billed charges other than room and board and inpatient professional services.</i>	\$1,000	Same as preferred
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)	Non-Preferred Provider (out of network)
Maximum benefit per coverage year	\$500	Same as preferred
Copay 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.

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- 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.

If you live in an area that does not have a preferred health care provider, you will be considered **out-of-area** and receive benefits for eligible expenses as if you were using a preferred provider. Please note that if you travel to an area that has a preferred health care provider but use a non-preferred health care provider, you will not be eligible for preferred provider benefits. However, if you have a life-threatening medical emergency and use a non-preferred provider, you can call member services within two business days of the medical emergency treatment and your claim for the covered expenses will be treated as if presented by a preferred provider. Call member services Monday through Friday between 8 a.m. and 8 p.m. ET, at **1-888-772-9682**.



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Terms defined

A **copayment** (or **copay**) is an initial amount of a medical provider's fee that you are responsible for paying each time you incur certain covered charges from a provider and it is usually paid when the charges are incurred. 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 of money you must pay for eligible expenses during each coverage year before the plan begins to pay benefits. All covered expenses accumulate toward both the preferred and non-preferred deductible.

Once the family deductible 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.

Other hospital services are charges for certain services and supplies billed by a hospital in addition to those charges for room occupancy. These charges may be significant and may include, but are not limited to: pharmacy; medical and surgical supplies and devices; lab and x-rays; and operating and recovery room expenses. They do not include charges for services such as surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient professional services are charges for surgeon, physician and anesthesiologist services, private duty nursing, or special duty nursing.

Inpatient charges are charges billed by a hospital or provider when you are admitted as an inpatient and charged for at least one day's room and board (24-hour hospital confinement). Inpatient charges are comprised of: room and board charges (daily room rate), professional charges billed by a provider (such as charges by a physician who does not work directly for the hospital), and hospital charges other than room and board.

Outpatient charges are charges billed at doctors' offices, free-standing clinics and facilities, and pharmacies. They also include charges at a hospital when you are not admitted as an inpatient, and you are not billed for room and board charges.

A **negotiated charge** is the maximum amount that a preferred provider has agreed to charge for the visit, service, or supply. You should not have to pay more than your portion of the discounted PPO charge (subject to your plan limits).

A **recognized charge** is the amount that Aetna recognizes that a visit, service, or supply should cost, whether from a preferred or non-preferred provider. 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.



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Questions and answers:

How do benefit limits work?

This plan has limits on the amount of money it will pay per coverage year. These limits differ for each type of charge and, depending on your plan design as explained in the benefits chart above, may be a maximum number of visits or services, a maximum dollar amount, or both. 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 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 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?

This limited benefits insurance plan, like a traditional major medical health plan, covers a range of health care services both in and out of the hospital. However, this limited benefits insurance plan places limits on how much it will pay or how many services or visits it will cover. 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 considerable out-of-pocket costs if you have a serious or chronic medical condition that requires hospitalization or continuing outpatient care.

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.



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Your medical benefits also include:

Aetna VisionSM Discounts program*

Aetna VisionSM Discounts program 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 55,000 retail pharmacies nationwide including major pharmacy chains and independent pharmacies (Aetna Region Network Profile - 3/10/06). 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.

Informed Health[®] Line

Aetna's Informed Health[®] Line gives you and your family access to registered nurses 24 hours a day, 7 days a week. This toll-free line connects you to a team of nurses experienced in providing information on a variety of health topics. Informed Health Line nurses use the Healthwise[®] Knowledgebase to provide information about health issues, medical procedures and treatment options, and help you and your family communicate more effectively with your doctors. You can also choose to listen to certain health topics of interest through Aetna's new audio health library, which is available in English and Spanish. Contact Aetna's Informed Health Line at **1-800-556-1555**.

Employee Assistance Program

Aetna's Employee Assistance Program is a service that provides support in managing stress, and balancing work and life. This telephonic and web based program includes resources related to emotional support, as well as childcare, and legal and financial guidance. These services are convenient and confidential, available 24 hours a day, 7 days a week by calling **1-888-AETNA-EAP (1-888-238-6232)** or visiting www.AetnaEAP.com.



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Supplemental Plans

Hospital Indemnity

Lump-sum benefit \$1,000 for one stay in the hospital as an inpatient per coverage year; plus
Daily benefit \$100 per day, for up to 100 days that you are an inpatient in a hospital per coverage year.
 This benefit applies if you or a covered dependent are admitted to the hospital as an inpatient.

Vision

Eye Exams Reimbursements of \$25 for an exam once every 12 months
Aetna VisionSM Discounts program* Aetna VisionSM Discounts program 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**.

Fees for other services must be paid by you. Benefit period is 12 consecutive months beginning on the later of your effective date or your most recent eye exam covered under this plan.
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Dental

Maximum benefit per coverage year	\$500
Deductible per coverage year	\$50
Preventive services (includes checkups and cleanings)	You are responsible for up to 20% [†] of the recognized charges. These services have no waiting period.
Basic services (includes fillings, oral surgery, and denture, crown and bridge repair)	You are responsible for up to 40% [†] of the recognized charges. You need to be enrolled in the dental plan without interruption for 3 months before the plan begins to pay for these services.
Major services (includes Perio and Endodontics, crowns, bridges, and dentures)	You are responsible for up to 50% [†] of the recognized charges. You need to be enrolled in the dental plan without interruption for 12 months before the plan begins to pay for these services.

[†] You may receive additional savings by using a participating PPO network dentist. The percentage of the cost that you are responsible for could be lower based on provider and location. The dental PPO network is not available in Alabama, Arkansas, Idaho, Hawaii, Louisiana, Mississippi, New Mexico, or Puerto Rico. To locate a preferred provider, call toll-free 1-888-772-9682 or visit www.aetna.com/docfind/custom/aahc.

Short Term Disability (STD)

Benefit Period	Weekly benefits for up to 6 months while you are disabled.
Benefit Amount	50% of base pay received from the employer that sponsors this program (includes reported tips, but not overtime) up to \$125 maximum weekly benefit.
Waiting Period	Benefits begin after 14 days (plan pays immediately if hospitalized)
Coverage for employee only; coverage not available in California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico.	

Term Life and Accidental Death Insurance

Employee term life benefit	\$20,000
Employee accidental death benefit	\$20,000
Optional dependents coverage	\$2,500 in term life for dependents over 6 months of age \$500 for children from birth through 6 months of age

Benefits paid to the beneficiary of your choice; benefits reduced by 50% when you reach age 70.



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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:

For the first 365 days after an insured person enrolls, the plan will not pay for medical expenses for pre-existing conditions. Pre-existing conditions are those conditions for which the insured person received diagnosis, care or treatment within 180 days before that person enrolled in the plan.

The plan will reduce the pre-existing condition period by the number of days of "prior creditable coverage" as of the enrollment date. "Creditable coverage" means prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act of 1996. Please provide us with a copy of any certificates of creditable coverage or, if you need help in obtaining one or have questions about creditable coverage, please contact member services at **1-888-772-9682**.

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.
- 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.
- Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions.



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Hospital Indemnity Plan Limitations and Exclusions:

The same limitations and exclusions apply as those listed for the medical and/or dental coverage (if offered under your plan).

Vision Care Exclusions:

- Orthoptic vision training, subnormal vision aids, any associated supplemental testing.
- Medical and/or surgical treatment of the eyes or supporting structure.
- Any eye or vision examination, or any corrective eyewear, required by an employer as a condition of employment.

Dental Exclusions:

In addition to the medical exclusions and limitations listed above, the following charges are not covered under the dental plan coverage, and they will not be recognized toward satisfaction of any deductible amount.

- Cosmetic procedures unless needed as a result of injury.
- Any procedure, service or supplies that are included as covered medical expenses under another group medical expense benefit plan.
- Prescribed drugs, pre-medication, analgesia or general anesthesia.
- Services provided for any type of temporomandibular (TMJ) or related structures, or myofascial pain.
- Charges in excess of the Recognized Charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

Short Term Disability Exclusions:

- Attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness, unless as the result of a medical condition.
- Commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
- Substance abuse.
- Occupational injury or sickness.

Term Life Exclusions:

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).

Accidental Death Benefit Exclusions:

- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A disease, ptomaine or bacterial infection except for that which results directly from an injury.
- Medical or surgical treatment except for that which results directly from an injury.
- Voluntarily inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.



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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.

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. Material 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.