Enrollment Summary

California

Choices Designed for Small Groups with 2-50 Eligible Employees

Pick-A-Plan

PLANS EFFECTIVE
APRIL 1, 2006

14.02.011.1-CA (4/06)

MEDICAL PLANS

NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	MC $250 90/70*		MC $0 90/60**	
PCP/Referrals Required	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance (Applies to most services)	90%	70%	90%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$250 per mem. two-mem. max	$500 per mem. two-mem. max	None	$250 per mem. two-mem. max
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$2,500 per mem. two-mem. max	$5,000 per mem. two-mem. max	$2,000 per mem. two-mem. max	$5,000 per mem. two-mem. max
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	$15 copay (deductible waived)	70% after deductible	$10 copay (deductible waived)	60% after deductible
Specialist Office Visit	$15 copay (deductible waived)	70% after deductible	$10 copay (deductible waived)	60% after deductible
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT
Outpatient Lab and X-ray	90%	70%	90%	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	80%	60%	80%	50%
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	90%	70%; Aetna pays up to $25 per visit	90%	60%; Aetna pays up to $25 per visit
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	$15 copay (deductible waived)	70%	$10 copay (deductible waived)	60%
Well-Child Exams (Age and frequency schedules apply)	$15 copay (deductible waived)	70%	$10 copay (deductible waived)	60%
Routine GYN (Frequency schedules apply)	$15 copay (deductible waived)	70%	$10 copay (deductible waived)	60%
Hospital — Inpatient	90%	70% after $250 copay per admission	90%	60% after $250 copay per admission; Aetna pays up to $750 per day
Outpatient Surgery — OP Hospital Department	80% after deductible	60% after $150 copay	80% after $150 copay	50% after $150 copay; Aetna pays up to $400 per surgery
Outpatient Surgery — Freestanding Facility	90% (deductible waived)	70% after $150 copay	90%	60% after $150 copay; Aetna pays up to $400 per surgery
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	90% after $100 copay	Paid as In-Network	90% after $100 copay	Paid as In-Network
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$10/$25/$50/70% $______________	Not Covered	$10/$25/$50/70% $______________	Not Covered

* Payment for out-of-network care is determined based upon the lowest of the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan documents as "reasonable" or "recognized" charges.

** 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 or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

*** Deductibles for MC HDHP do apply to the coinsurance maximum.

\+ This plan provides limited benefit only and does not constitute a comprehensive health insurance plan. As such it may not cover all the expenses associated with your health care needs.

++ Available to members residing in California, but outside of the PPO service area.

+++ Three-visit limit applies to all types of office visits combined (primary, specialist, chiropractic, physical therapy, preventive services, etc.) Any lab or routine X-ray provided in the physician's office and billed with the office visit is included.

† The four Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Nonformulary, Tier 4: Self-Injectable.

All services subject to deductible, unless noted otherwise.

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 nonemergency hospital care.

The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance amounts indicate what Aetna is required to pay.

For a summary list of Limitations and Exclusions, refer to page 10.

NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	MC $250 80/60*		MC $500 80/60**	
PCP/Referrals Required	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance (Applies to most services)	80%	60%	80%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$250 per mem. two-mem. max	$500 per mem. two-mem. max	$500 per mem. two-mem. max	$500 per mem. two-mem. max
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$3,000 per mem. two-mem. max	$6,000 per mem. two-mem. max	$3,500 per mem. two-mem. max	$7,000 per mem. two-mem. max
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	$20 copay (deductible waived)	60% after deductible	$25 copay (deductible waived)	60% after deductible
Specialist Office Visit	$20 copay (deductible waived)	60% after deductible	$25 copay (deductible waived)	60% after deductible
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT
Outpatient Lab and X-ray	80%	60%	80%	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	70%	50%	70%	50%
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	80%	60%; Aetna pays up to $25 per visit	80%	60%; Aetna pays up to $25 per visit
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	$20 copay (deductible waived)	60%	$25 copay (deductible waived)	60%
Well-Child Exams (Age and frequency schedules apply)	$20 copay (deductible waived)	60%	$25 copay (deductible waived)	60%
Routine GYN (Frequency schedules apply)	$20 copay (deductible waived)	60%	$25 copay (deductible waived)	60%
Hospital — Inpatient	80%	60% after $250 copay per admission	80%	60% after $250 copay per admission; Aetna pays up to $750 per day
Outpatient Surgery — OP Hospital Department	70% after deductible	50% after $150 copay	70% after $150 copay	50% after $150 copay; Aetna pays up to $400 per surgery
Outpatient Surgery — Freestanding Facility	80% (deductible waived)	60% after $150 copay	80%	60% after $150 copay; Aetna pays up to $400 per surgery
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	80% after $100 copay	Paid as In-Network	80% after $100 copay	Paid as In-Network
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% $______________________	Not Covered	$15/$35/$50/70% $______________________	Not Covered

* Payment for out-of-network care is determined based upon the lowest of the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan documents as "reasonable" or "recognized" charges.

** 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 or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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MEDICAL PLANS

NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	MC $500 80/50**		MC $1,000 80/50**	
PCP/Referrals Required	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance (Applies to most services)	80%/50%	50%	80%/50%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$500 per mem. two-mem. max	$500 per mem. two-mem. max	$1,000 per mem. two-mem. max	$1,000 per mem. two-mem. max
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$4,000 per mem. two-mem. max	$8,000 per mem. two-mem. max	$4,000 per mem. two-mem. max	$8,000 per mem. two-mem. max
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	$30 copay (deductible waived)	50% after deductible	$20 copay (deductible waived)	50% after deductible
Specialist Office Visit	$30 copay (deductible waived)	50% after deductible	$20 copay (deductible waived)	50% after deductible
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT
Outpatient Lab and X-ray	50% (deductible waived)	50%	50% (deductible waived)	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	50%	50%	50%	50%
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	80%	50%; Aetna pays up to $25 per visit	80%	50%; Aetna pays up to $25 per visit
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	$30 copay (deductible waived)	50%	$20 copay (deductible waived)	50%
Well-Child Exams (Age and frequency schedules apply)	$30 copay (deductible waived)	50%	$20 copay (deductible waived)	50%
Routine GYN (Frequency schedules apply)	$30 copay (deductible waived)	50%	$20 copay (deductible waived)	50%
Hospital — Inpatient	50% facility; 80% professional	50%; Aetna pays up to $750 per day	50% facility; 80% professional	50%; Aetna pays up to $750 per day
Outpatient Surgery — OP Hospital Department	50% facility; 70% professional	50%; Aetna pays up to $400 per surgery	50% facility; 70% professional	50%; Aetna pays up to $400 per surgery
Outpatient Surgery — Freestanding Facility	50% facility; 80% professional	50%; Aetna pays up to $400 per surgery	50% facility; 80% professional	50%; Aetna pays up to $400 per surgery
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	50% facility; 80% professional after $100 copay	Paid as In-Network	50% facility; 80% professional after $100 copay	Paid as In-Network
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% $______________	Not Covered	$15/$35/$50/70% $______________	Not Covered

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NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	MC $2,000 80/50**		MC Basic**+	
PCP/Referrals Required	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance (Applies to most services)	80%/50%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$2,000 per mem. two-mem. max	$2,000 per mem. two-mem. max	$1,500 per mem. two-mem. max	$1,500 per mem. two-mem. max
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$4,000 per mem. two-mem. max	$8,000 per mem. two-mem. max	$3,000 per mem. two-mem. max	$5,000 per mem. two-mem. max
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	$25 copay (deductible waived)	50% after deductible	$20 copay (deductible waived); limited to 3 visits per mem. per year+++	Not Covered
Specialist Office Visit	$25 copay (deductible waived)	50% after deductible	$20 copay (deductible waived); limited to 3 visits per mem. per year+++	Not Covered
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	See Office Visit Benefit+++	Not Covered
Outpatient Lab and X-ray	50% (deductible waived)	50%	$20 copay (deductible waived); limited to $300 per mem. per year+++	Not Covered
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	50%	50%	Not Covered	Not Covered
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	80%	50%; Aetna pays up to $25 per visit	See Office Visit Benefit+++	Not Covered
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	$25 copay (deductible waived)	50%	80%	Not Covered
Well-Child Exams (Age and frequency schedules apply)	$25 copay (deductible waived)	50%	80%	Not Covered
Routine GYN (Frequency schedules apply)	$25 copay (deductible waived)	50%	80%	Not Covered
Hospital — Inpatient	50% facility; 80% professional	50%; Aetna pays up to $750 per day	80%	50%; Aetna pays up to $750 per day
Outpatient Surgery — OP Hospital Department	50% facility; 70% professional	50%; Aetna pays up to $400 per surgery	70% after $150 copay	50%; Aetna pays up to $400 per surgery
Outpatient Surgery — Freestanding Facility	50% facility; 80% professional	50%; Aetna pays up to $400 per surgery	80%	50%; Aetna pays up to $400 per surgery
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	50% facility; 80% professional after $100 copay	Paid as In-Network	80% after $100 copay	Paid as In-Network
Urgent Care	$50 copay	$50 copay	Not Covered	Not Covered
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% $________	Not Covered	Rx Discount Card $________	Not Covered

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NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	MC HSA-Compatible HDHP $2,100 80/50**		MC HSA-Compatible HDHP $3,000 80/50**	
PCP/Referrals Required	No	N/A	No	N/A
Network	Managed Choice	N/A	Managed Choice	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance (Applies to most services)	80%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$2,100 individual $4,200 family	$2,100 individual $4,200 family	$3,000 per mem. $6,000 family.	$3,000 per mem. $6,000 family
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$3,000 individual $6,000 family	$5,000 individual $10,000 family	$5,000 per mem. $10,000 family	$5,000 per mem. $10,000 family
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Specialist Office Visit	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT	Covered under PT/OT
Outpatient Lab and X-ray	80%	50%	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	70%	50%	70%	50%
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	80%	50%; Aetna pays up to $25 per visit	80%	50%; Aetna pays up to $25 per visit
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	$15 copay (deductible waived)	50%	$15 copay (deductible waived)	50%
Well-Child Exams (Age and frequency schedules apply)	$15 copay (deductible waived)	50%	$15 copay (deductible waived)	50%
Routine GYN (Frequency schedules apply)	$15 copay (deductible waived)	50%	$15 copay (deductible waived)	50%
Hospital — Inpatient	80%	50%; Aetna pays up to $750 per day	80%	50%; Aetna pays up to $750 per day
Outpatient Surgery — OP Hospital Department	70% after $150 copay	50%; Aetna pays up to $400 per surgery	70% after $150 copay	50%; Aetna pays up to $400 per surgery
Outpatient Surgery — Freestanding Facility	80%	50%; Aetna pays up to $400 per surgery	80%	50%; Aetna pays up to $400 per surgery
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	80% after $100 copay	Paid as In-Network	80% after $100 copay	Paid as In-Network
Urgent Care	80%	50%	80%	50%
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% (Integrated Medical/ Rx Deductible) $______________	Not Covered	$15/$35/$50/70% (Integrated Medical/ Rx Deductible) $______________	Not Covered

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NONREFERRAL-BASED PLAN DESIGNS (IN-NETWORK & OUT-OF-NETWORK)

AETNA PLAN OPTIONS	PPO $500 90/70*		Aetna Indemnity+++
PCP/Referrals Required	No	N/A	No
Network	Open Choice	N/A	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	
Plan Coinsurance (Applies to most services)	90%	70%	80%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	$500 per mem. two-mem. max	$500 per mem. two-mem. max	$500 per mem. two-mem. max
Coinsurance Maximum/ Out-of-Pocket Maximum (Deductible and certain payments do not apply)***	$3,000 per mem. two-mem. max	$6,000 per mem. two-mem. max	$3,500 per mem. two-mem. max
Lifetime Maximum Benefit	$5,000,000		$5,000,000
Primary Physician Office Visit	$15 copay (deductible waived)	70% after deductible	80%
Specialist Office Visit	$25 copay (deductible waived)	70% after deductible	80%
Chiropractic Services	Covered under PT/OT	Covered under PT/OT	Covered Under PT/OT
Outpatient Lab and X-ray	90%	70%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	80%	60%	70%
Outpatient Physical, Occupational, Chiropractic Therapy (24 visits per calendar year combined)	90%	70%; Aetna pays up to $25 per visit	80%
Physical Exams — Adults (Age and frequency schedules apply; MC and PPO plans: $300 max benefit every 12 months, in-network and out-of-network combined)	Applicable office visit copay (deductible waived)	70%	80%
Well-Child Exams (Age and frequency schedules apply)	Applicable office visit copay (deductible waived)	70%	80%
Routine GYN (Frequency schedules apply)	Applicable office visit copay (deductible waived)	70%	80%
Hospital — Inpatient	90% after $250 copay	70% after $250 copay	80% after $250 copay
Outpatient Surgery — OP Hospital Department	80% after $150 copay	60% after $150 copay	70% after $250 copay
Outpatient Surgery — Freestanding Facility	90%	70% after $150 copay	80%
Emergency Room (Copay waived if admitted, Non-emergency use of ER is not covered)	90% after $100 copay	Paid as In-Network	80%
Urgent Care	$50 copay	$50 copay	80%
Prescription Drugs† Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% $________	Not Covered	$10/$25/$50/70% after $150 brand and brand nonformulary deductible $________

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\+ This plan provides limited benefit only and does not constitute a comprehensive health insurance plan. As such it may not cover all the expenses associated with your health care needs.

++ Available to members residing in California, but outside of the PPO service area.

+++ Three-visit limit applies to all types of office visits combined (primary, specialist, chiropractic, physical therapy, preventive services, etc.) Any lab or routine X-ray provided in the physician's office and billed with the office visit is included.

† The four Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Nonformulary, Tier 4: Self-Injectable.

All services subject to deductible, unless noted otherwise.

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 nonemergency hospital care.

The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance amounts indicate what Aetna is required to pay.

For a summary list of Limitations and Exclusions, refer to page 10.

REFERRAL-BASED PLAN DESIGNS (IN-NETWORK)

AETNA PLAN OPTIONS	HMO $10/$20	HMO $10/$30	HMO $20/$40	HMO $30/$40	EPO 90
PCP/Referrals Required	Yes	Yes	Yes	Yes	Yes
Network	HMO	HMO	HMO	HMO	Elect Choice
MEMBER BENEFITS	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Plan Coinsurance (Applies to most services)	N/A	N/A	N/A	N/A	90%
Calendar Year Deductible	None	None	None	None	None
Copay Maximum — HMO/AVN HMO Coinsurance Maximum — EPO (Certain payments do not apply)	$1,500 per mem. $3,000 family	$2,000 per mem. $4,000 family	$2,000 per mem. $4,000 family	$3,000 per mem. $6,000 family	$2,500 per mem. two-mem. max
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	$5,000,000
Primary Physician Office Visit	$10 copay	$10 copay	$20 copay	$30 copay	$15 copay
Specialist Office Visit	$20 copay	$30 copay	$40 copay	$40 copay	$30 copay
Chiropractic Services	$15 copay (20 visits per CY)	$15 copay (20 visits per CY)	$15 copay (20 visits per CY)	$15 copay (20 visits per CY)	Covered under PT/OT
Outpatient Lab and X-ray	$20 copay	$30 copay	$40 copay	$40 copay	90%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	$20 copay	$30 copay	$40 copay	$40 copay	80%
Outpatient Physical, Occupational, Speech Therapy — HMO/AVN HMO Outpatient Physical, Occupational, Chiropractic Therapy — EPO	$20 copay (20 visits per calendar year combined)**	$30 copay (20 visits per calendar year combined)**	$40 copay (20 visits per calendar year combined)**	$40 copay (20 visits per calendar year combined)**	90% (24 visits per calendar year combined)
Physical Exams — Adults (Age and frequency schedules apply)	$10 copay	$10 copay	$20 copay	$30 copay	$15 copay
Well-Child Exams (Age and frequency schedules apply)	$10 copay	$10 copay	$20 copay	$30 copay	$15 copay
Routine GYN (Frequency schedules apply)	$20 copay	$30 copay	$40 copay	$40 copay	$30 copay
Hospital — Inpatient	$0 copay	$300 copay	$750 copay	$1,000 copay	90%
Outpatient Surgery — OP Hospital Department	$0 copay	$250 copay	$250 copay	$250 copay	$300 copay
Outpatient Surgery — Freestanding Facility	$0 copay	$50 copay	$50 copay	$50 copay	$100 copay
Emergency Room (Copay waived if admitted, Non-Emergency use of ER is not covered)	$100 copay	$100 copay	$100 copay	$100 copay	90% after $100 copay
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs*** Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$10/$25/$50 $_______________	$15/$35/$50 $_______________	$15/$35/$50 $_______________	$15/$35/$50 $_______________	$15/$35/$50/70% $_______________

*In-Network for these plans refers to the Aetna Value Network.

**Coverage will continue after this period if approved by Aetna.

***For HMO and Aetna Value Network HMO, the three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Generic & Brand Nonformulary.
For EPO, the four Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Nonformulary, Tier 4: Self-Injectable.

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.

The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance amounts indicate what Aetna is required to pay.

For a summary list of Limitations and Exclusions, refer to page 10.

REFERRAL-BASED PLAN DESIGNS (IN-NETWORK)

AETNA PLAN OPTIONS	EPO 80	Aetna Value Network HMO $10/$20	Aetna Value Network HMO $15/$30	Aetna Value Network HMO $25/$40
PCP/Referrals Required	Yes	Yes	Yes	Yes
Network	Elect Choice	Aetna Value Network HMO	Aetna Value Network HMO	Aetna Value Network HMO
MEMBER BENEFITS	**In-Network**	**In-Network***	**In-Network***	**In-Network***
Plan Coinsurance (Applies to most services)	80%	N/A	N/A	N/A
Calendar Year Deductible	None	None	None	None
Copay Maximum — HMO/AVN HMO Coinsurance Maximum — EPO (Certain payments do not apply)	$3,500 per mem. two-mem. max	$1,500 per member $3,000 family	$2,500 per member $5,000 family	$3,000 per member $6,000 family
Lifetime Maximum Benefit	$5,000,000	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	$20 copay	$10 copay	$15 copay	$25 copay
Specialist Office Visit	$40 copay	$20 copay	$30 copay	$40 copay
Chiropractic Services	Covered under PT/OT	$15 copay (20 visits per CY)	$15 copay (20 visits per CY)	$15 copay (20 visits per CY)
Outpatient Lab and X-ray	80%	$20 copay	$30 copay	$40 copay
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	70%	$20 copay	$30 copay	$40 copay
Outpatient Physical, Occupational, Speech Therapy — HMO/AVN HMO Outpatient Physical, Occupational, Chiropractic Therapy — EPO	80% (24 visits per calendar year combined)	$20 copay (30 visits per calendar year)**	$30 copay (30 visits per calendar year)**	$40 copay (30 visits per calendar year)**
Physical Exams — Adults (Age and frequency schedules apply)	$20 copay	$10 copay	$15 copay	$25 copay
Well-Child Exams (Age and frequency schedules apply)	$20 copay	$10 copay	$15 copay	$25 copay
Routine GYN (Frequency schedules apply)	$40 copay	$20 copay	$30 copay	$40 copay
Hospital — Inpatient	80%	$0 copay	$500 copay	$1,000 copay
Outpatient Surgery — OP Hospital Department	$300 copay	$0 copay	$125 copay	$250 copay
Outpatient Surgery — Freestanding Facility	$100 copay	$0 copay	$125 copay	$250 copay
Emergency Room (Copay waived if admitted, Non-Emergency use of ER is not covered)	80% after $100 copay	$100 copay	$100 copay	$100 copay
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs*** Retail: per 30-day supply Mail Order: two times retail copay (31 to 90-day supply available)	$15/$35/$50/70% $______________	$10/$25/$50 $_______________	$15/$35/$50, after $150 Rx deductible on brand formulary and brand nonformulary only $_______________	$15/$35/$50, after $150 Rx deductible on brand formulary and brand nonformulary only $_______________

*In-Network for these plans refers to the Aetna Value Network.

**Coverage will continue after this period if approved by Aetna.

***For HMO and Aetna Value Network HMO, the three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Generic & Brand Nonformulary. For EPO, the four Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Nonformulary, Tier 4: Self-Injectable.

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.

The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance amounts indicate what Aetna is required to pay.

For a summary list of Limitations and Exclusions, refer to page 10.

Limitations and Exclusions

Medical

These plans do not cover all health care expenses and include exclusions and limitations. Members should refer to their plan documents 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 documents may contain exceptions to this list based on state mandates or the plan design purchased.

Aetna HMO, Aetna Value Network℠ HMO

- All medical and hospital services not specifically covered, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval.
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial).
- Hearing aids.
- Home births.
- Immunizations for travel or work.*
- Implantable drugs and certain injectable drugs, including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Nonmedically necessary services or supplies.
- Orthotics, except as specified in the plan.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling.
- Special-duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.

Aetna EPO, MC, PPO & Indemnity

- All medical or hospital services not specifically covered, or which are limited or excluded in the plan documents.
- Charges related to 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 such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Nonmedically necessary services or supplies.
- Orthotics, as specified in the plan.
- 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.
- Those for or related to treatment of obesity or for diet or weight control.

Pre-Existing Conditions Exclusion Provision

These plans impose a pre-existing conditions exclusion which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within six months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to six months from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period.

If you had less than six months of group or three months of individual (including Medicare, Medicaid and Medi-Cal) of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

If you had no prior creditable coverage within the six months for group or three months for individual prior to your enrollment date (either because you had no prior coverage or because there was more than a six months of group or three months of individual gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-802-3862 for PPO and 1-888-702-3862 for HMO if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

* California members are covered for all indicated or medically necessary immunizations.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include Aetna Health of California Inc., Aetna Dental of California Inc. and/or Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of healthcare/dental services. However, Aetna itself is not a provider of healthcare/dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither employees nor agents of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations) and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Health benefit and insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. If your plan covers outpatient prescription drugs, your plan may include a Preferred Drug List (formulary). A preferred drug list is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the Preferred Drug List. The medications listed on the Preferred Drug List are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the Preferred Drug List, and information about other pharmacy programs such as precertification and step therapy, please refer to Aetna's website at www.aetna.com, or the Preferred Drug List. Many drugs, including many of those listed on the Preferred Drug List are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, your costs may be higher for a "preferred drug" than they would be for a "nonpreferred drug." You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services.

Aetna Health Savings Accounts (HSA) are administered by Aetna Life Insurance Company. HSA fees, interest rates and investment options are subject to change without notice. Investment options are not insured by Aetna or the FDIC and may result in loss of principal. This document is not intended to provide tax or investment advice. Please consult your independent financial advisor before opening an HSA or making an investment selection.

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