



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.

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.

CORE NET

MEDICAL EXPENSE BENEFIT	Preferred Provider (in network)	Non-Preferred Provider (out of network)
Maximum Annual Benefit		\$1,000 in or out of network
Additional Annual Benefit for Cancer Treatment		\$1,000 in or out of network
Member Coinsurance³	20%	40%
Deductible (per coverage year)¹	\$50	\$100
Doctors' Office Visits²		
Per Visit Copay	\$10 copay	not applicable; Medical Expense Benefit Deductible applies
Member Coinsurance³ for the visit	Covered 100%	20%
Member Coinsurance³ for related covered services (Routine exams are not covered)	20% after the Medical Expense Benefit Deductible is met	40% after the Medical Expense Benefit Deductible is met
Additional Accident Benefit (You first have to exhaust the Medical Expense Benefit)		
Per Occurrence Deductible		\$50 in or out of network
Member Coinsurance³	20% after the Medical Expenses Benefit Deductible is met	
Maximum Benefit per Occurrence		\$5,000 in or out of network
Maximum Number of Occurrences Annually		2 occurrences in or out of network
Expenses must be for treatment relating to an accident and must be incurred within 90 days of the injury to be covered.		
Additional Death Benefit (no network requirement)		
Maximum Benefit (Paid to the beneficiary if insured dies due to, or resulting from, a covered accident, on or off the job, within 365 days after the date of the accident.)		\$25,000



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¹ 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.

² Benefits paid count towards the Medical Expense Benefit maximum annual benefit.

³ 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. 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.

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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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.



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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.

Medical Accidental Death Benefit Exclusions:

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

* These do not apply if the loss is caused by an infection which results directly from the injury or surgery needed because of the injury.



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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.