An at-a-glance comparison of Aetna's plans

Which one of our plans is right for you? A lot depends on your priorities. Do you want to keep your payments, or "premiums," as low as possible? Or are you willing to pay a little more each month to help minimize your out-of-pocket costs for services?

This chart gives you a quick, at-a-glance look at all of Aetna's Advantage Plans for individuals in Colorado. It will help you determine your priorities and compare three key features across all the plans:

- Your payments, or premiums
- What you can expect to pay out of your pocket for services and treatment (as opposed to what the plan pays for)
- Your annual deductible — that is, how much you'll pay out-of-pocket before the plan begins covering your expenses

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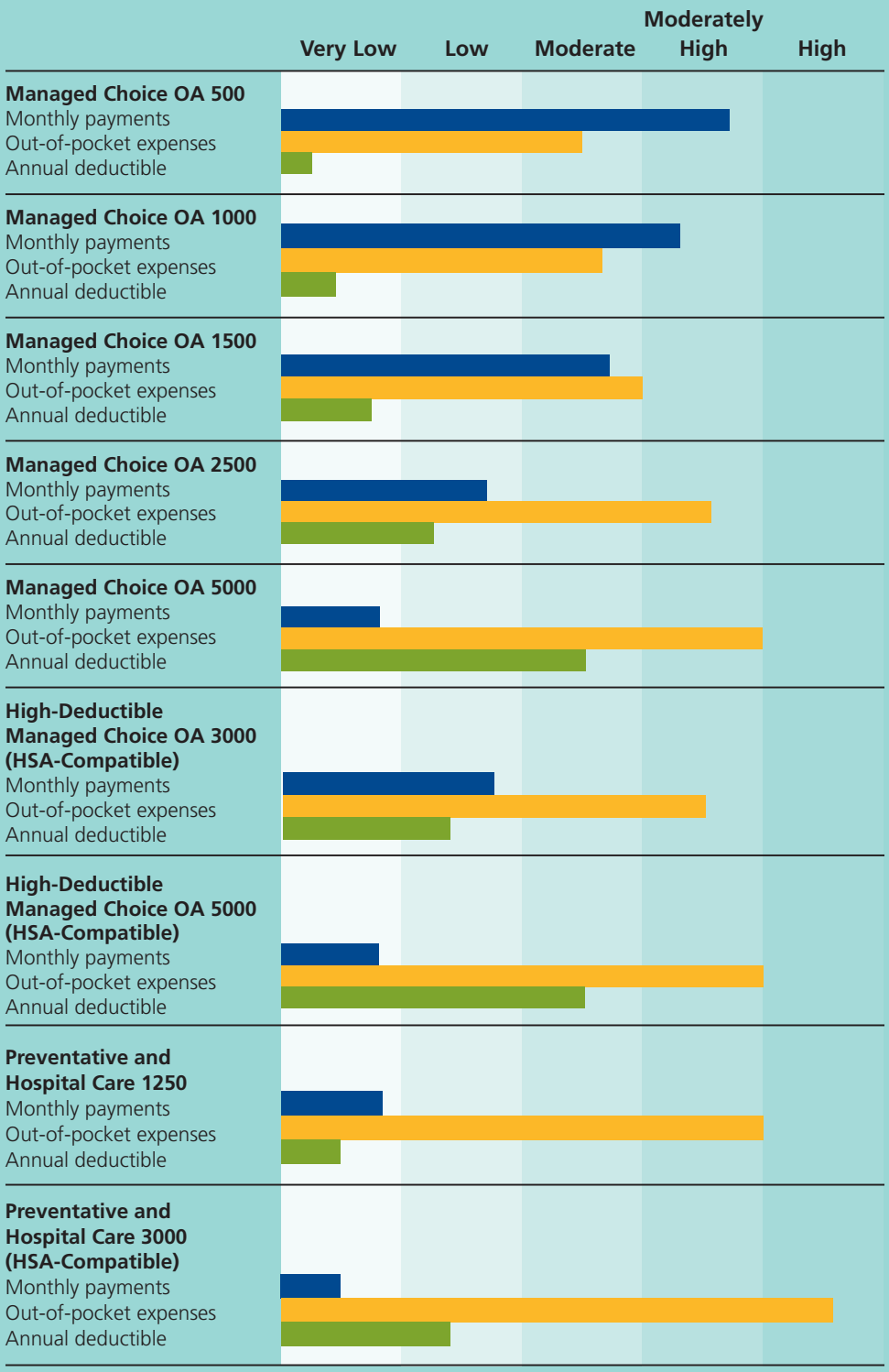
FEATURES/BENEFITS COMPARISON*



*Feature/Benefits Comparison is based on analysis of Aetna Advantage Plans with 12/1/06 effective dates. For more information on benefit levels, please refer to the benefit pages and/or the plan design documents.

	Managed Choice OA 500		Managed Choice OA 1000		Managed Choice OA 1500	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual	$500	$1,000	$1,000	$2,000	$1,500	$3,000
Deductible Family	$1,000	$2,000	$2,000	$4,000	$3,000	$6,000
Coinsurance (Member's Responsibility)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000
Out of Pocket Maximum Individual Family	 $2,000 $4,000	 $2,500 $5,000	 $2,500 $5,000	 $3,500 $7,000	 $3,000 $6,000	 $4,500 $9,000
Lifetime Maximum*	$5,000,000		$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	$20 copay – not subject to the deductible	50% after deductible	$20 copay – not subject to the deductible	50% after deductible	$25 copay – not subject to the deductible	50% after deductible
Specialist Visit	$30 copay – not subject to the deductible	50% after deductible	$30 copay – not subject to the deductible	50% after deductible	$35 copay – not subject to the deductible	50% after deductible
Hospital Admission	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room	$100 copay (waived if admitted) 20% after deductible		$100 copay (waived if admitted) 20% after deductible		$100 copay (waived if admitted) 20% after deductible	
Annual Routine Gyn Exam (Annual Pap / Mammogram)	No Copay – not subject to deductible	50% after deductible	No Copay – not subject to deductible	50% after deductible	No Copay – not subject to deductible	50% after deductible
Maternity	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Health (Annual*) ($200 per exam)	$20 copay – not subject to the deductible	50% after deductible	$20 copay – not subject to the deductible	50% after deductible	$25 copay – not subject to the deductible	50% after deductible
Lab/X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/Occupational/Subluxation (Aetna will pay $25 Max – 24 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment ($2000 per calendar year *)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
PHARMACY						
Pharmacy Deductible per Individual (does not apply to generic)*	$250	$250	$250	$250	$250	$250
Generic (Oral Contraceptives included)	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible
Preferred Brand Name	$25 copay after deductible	$25 copay plus 50% after deductible	$25 copay after deductible	$25 copay plus 50% after deductible	$25 copay after deductible	$25 copay plus 50% after deductible
Non-Preferred Brand (Oral Contractives Included)	$40 copay after deductible	$40 copay plus 50% after deductible	$40 copay after deductible	$40 copay plus 50% after deductible	$40 copay after deductible	$40 copay plus 50% after deductible
Self-Injectables	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Calendar Year Maximum per Individual*	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* Maximum applies to combined in and out-of-network benefits.
+ 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.
A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

COLORADO AETNA ADVANTAGE PLAN OPTIONS

	Managed Choice OA 2500		Managed Choice OA 5000	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual	$2,500	$5,000	$5,000	$10,000
Deductible Family	$5,000	$10,000	$10,000	$20,000
Coinsurance (Member's Responsibility)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $2,500 $5,000	 $2,500 $5,000	 $2,500 $5,000	 $2,500 $5,000
Out of Pocket Maximum Individual Family	 $5,000 $10,000	 $7,500 $15,000	 $7,500 $15,000	 $12,500 $25,000
Lifetime Maximum *	$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	$30 copay – not subject to the deductible	50% after deductible	$40 copay – not subject to the deductible	50% after deductible
Specialist Visit	$40 copay – not subject to the deductible	50% after deductible	$50 copay – not subject to the deductible	50% after deductible
Hospital Admission	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room	$100 copay (waived if admitted) 20% after deductible		$100 copay (waived if admitted) 20% after deductible	
Annual Routine Gyn Exam (Annual Pap / Mammogram)	No Copay – not subject to deductible	50% after deductible	No Copay – not subject to deductible	50% after deductible
Maternity	Not covered	Not covered	Not covered	Not covered
Preventive Health (Annual*) ($200 per exam)	$30 copay not subject to the deductible	50% after deductible	$40 copay – not subject to the deductible	50% after deductible
Lab / X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/Occupational/Subluxation (Aetna will pay $25 Max – 24 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment ($2000 per calendar year *)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
PHARMACY				
Pharmacy Deductible per Individual (does not apply to generic)*	$500	$500	$500	$500
Generic (Oral Contraceptives included)	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible
Preferred Brand Name	$25 copay after deductible	$25 copay plus 50% after deductible	$25 copay after deductible	$25 copay plus 50% after deductible
Non-Preferred Brand (Oral Contractives Included)	$40 copay after deductible	$40 copay plus 50% after deductible	$40 copay after deductible	$40 copay plus 50% after deductible
Self-Injectables	20% after deductible	Not Covered	20% after deductible	Not Covered
Calendar Year Maximum per Individual*	Unlimited	Unlimited	Unlimited	Unlimited

* Maximum applies to combined in and out-of-network benefits.
+ 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.
A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

COLORADO AETNA ADVANTAGE PLAN OPTIONS

	PPO High Deductible 3000 (HSA Compatible)		PPO High Deductible 5000 (HSA Compatible)	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual	$3,000	$6,000	$5,000	$10,000
Deductible Family	$6,000	$12,000	$10,000	$20,000
Coinsurance (Member's Responsibility)	10% after deductible 0% Once out-of-pocket max is satisifed	50% after deductible 0% Once out-of-pocket max is satisifed	0% after deductible	20% after deductible
Coinsurance Maximum Individual Family	 $2,000 $4,000	 $4,000 $8,000	 $0 $0	 $2,500 $5,000
Out of Pocket Maximum Individual Family	 $5,000 $10,000	 $10,000 $20,000	 $5,000 $10,000	 $12,500 $25,000
Lifetime Maximum *	$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Specialist Visit	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Hospital Admission	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Emergency Room	$100 copay (waived if admitted) 10% after deductible		$0 copay after deductible	$0 copay after deductible
Annual Routine Gyn Exam (Annual Pap / Mammogram)	No Copay – not subject to deductible	50% after deductible	No Copay – not subject to deductible	20% after deductible
Maternity	Not covered	Not covered	Not covered	Not covered
Preventive Health (Annual*) ($200 per exam)	$25 copay – not subject to the deductible	50% after deductible	No copay – not subject to deductible	20% after deductible
Lab / X-Ray	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Physical/Occupational/Subluxation (Aetna will pay $25 Max – 24 visits per calendar year*)	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Home Health Care (30 visits per calendar year*)	10% after deductible	50% after deductible	0% after deductible	20% after deductible
Durable Medical Equipment ($2000 per calendar year *)	10% after deductible	50% after deductible	0% after deductible	20% after deductible
PHARMACY				
Pharmacy Deductible per Individual	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible
Generic (Oral Contraceptives included)	$15 copay after deductible	$15 copay plus 50% after deductible	0% after Medical Deductible	20% after Medical Deductible
Preferred Brand Name	$25 copay after deductible	$25 copay plus 50% after deductible	0% after Medical Deductible	20% after Medical Deductible
Non-Preferred Brand (Oral Contractives Included)	$40 copay after deductible	$40 copay plus 50% after deductible	0% after Medical Deductible	20% after Medical Deductible
Self-Injectables	20% after deductible	Not Covered	0% after Medical Deductible	Not Covered
Calendar Year Maximum per Individual*	Unlimited	Unlimited	$5,000	$5,000

* Maximum applies to combined in and out-of-network benefits.
+ 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.

A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

COLORADO AETNA ADVANTAGE PLAN OPTIONS

	Preventative and Hospital Care 1250		Preventative and Hospital Care 3000 (HSA compatible)	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual Family	 $1,250 $2,500	 $2,500 $5,000	 $3,000 $6,000	 $6,000 $12,000
Coinsurance (Member's Responsibility)	20% after deductible	50% after deductible	20% after deductible 0% Once out-of-pocket max is satisfied	50% after deductible 0% Once out-of-pocket max is satisfied
Coinsurance Maximum Individual Family	 $2,500 $5,000	 $5,000 $10,000	 $2,000 $4,000	 $4,000 $8,000
Out-of-Pocket Maximum Individual Family	 $3,750 $7,500	 $7,500 $15,000	 $5,000 $10,000	 $10,000 $20,000
Lifetime Maximum *	$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	Not Covered	Not Covered	Not Covered	Not Covered
Specialist Visit	Not Covered	Not Covered	Not Covered	Not Covered
Hospital Admission	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room	$100 copay (waived if admitted) 20% after deductible		$100 copay (waived if admitted) 20% after deductible	
Annual Routine Gyn Exam (Annual Pap / Mammogram)	No Copay – not subject to deductible	50% after deductible	No Copay – not subject to deductible	50% after deductible
Maternity	Not covered	Not covered	Not covered	Not covered
Preventive Health (Physical – every 24 months*) ($200 per exam)	$25 copay – not subject to the deductible	50% after deductible	$35 copay – not subject to the deductible	50% after deductible
Lab / X-Ray	Not Covered	Not Covered	Not Covered	Not Covered
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/Occupational/Subluxation	Not Covered	Not Covered	Not Covered	Not Covered
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Durable Medical Equipment	Not Covered	Not Covered	Not Covered	Not Covered
PHARMACY				
Pharmacy Deductible per Individual (does not apply to generic)*	Not Applicable	Not Applicable	No Coverage**	No Coverage**
Generic (Oral Contraceptives included)	$15 copay not subject to deductible	$15 copay plus 50% not subject to deductible	No Coverage**	No Coverage**
Preferred Brand Name	Not Covered**	Not Covered**	No Coverage**	No Coverage**
Non-Preferred Brand (Oral Contractives Included)	Not Covered**	Not Covered**	No Coverage**	No Coverage**

* Maximum applies to combined in and out-of-network benefits.
** Aetna discount applies.
\+ 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.

A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

INDIVIDUAL DENTAL PPO MAX PLAN		
MEMBER BENEFITS	**PREFERRED**	**NONPREFERRED**
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100% not subject to deductible	50% not subject to deductible
Comprehensive oral exam	100% not subject to deductible	50% not subject to deductible
Problem-focused oral exam	100% not subject to deductible	50% not subject to deductible
X-rays		
Bitewing — single film	100% not subject to deductible	50% not subject to deductible
Complete series	100% not subject to deductible	50% not subject to deductible
PREVENTIVE SERVICES		
Adult cleaning	100% not subject to deductible	50% not subject to deductible
Child cleaning	100% not subject to deductible	50% not subject to deductible
Sealants — per tooth	Discount	Not Covered
Fluoride application — with cleaning	100% not subject to deductible	50% not subject to deductible
Space maintainers	Discount	Not Covered
BASIC SERVICES		
Amalgam filling — 2 surfaces	100% after deductible	50% after deductible
Resin filling — 2 surfaces anterior	Discount	Not Covered
Oral Surgery	Discount	Not Covered
Extraction – exposed root or erupted tooth	Discount	Not Covered
Extraction of impacted tooth —soft tissue	Discount	Not Covered
MAJOR SERVICES		
Complete upper denture	Discount	Not Covered
Partial upper denture (resin base)	Discount	Not Covered
Crown — Porcelain with noble metal	Discount	Not Covered
Pontic — Porcelain with noble metal	Discount	Not Covered
Inlay — Metallic (3 or more surfaces)	Discount	Not Covered
Oral Surgery		
Removal of impacted tooth — partially bony	Discount	Not Covered
Endodontic Services		
Bicuspid root canal therapy	Discount	Not Covered
Molar root canal therapy	Discount	Not Covered
Periodontic Services		
Scaling & root planing — per quadrant	Discount	Not Covered
Osseous surgery — per quadrant	Discount	Not Covered
ORTHODONTIC SERVICES	Discount	Not Covered

Access to negotiated discounts: members are eligible to receive non covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist at any time.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.
All products not available in all counties. Please refer to the state map located on page 2 of the Aetna Advantage Brochure.

A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.