

Election Form

Complete this form and make a copy for yourself. Give the original to your employer.

IF YOU ARE NOT CHANGING YOUR EXISTING COVERAGE, YOU DO NOT NEED TO COMPLETE THIS FORM.

A. INFORMATION ABOUT YOU

Print Your Name (First, Middle Initial, Last)

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Date of Birth (MM/DD/YYYY) _____ Social Security Number _____

B. YOUR ELECTION

(Check the appropriate box.)

I am not currently enrolled and I elect to....

- Enroll** in the coverage choice selected below. ❶
- Decline** this opportunity to participate.

I am currently enrolled and I elect to....

- Change** my current coverage with the choice selected below. ❶
- Change** my personal and/or dependent information.
- Drop** my current coverage choice.

❶ By selecting the coverage choice(s) below, I authorize my employer to deduct from my paycheck any required contributions (Choose One):
 Before taxes are deducted. **After** taxes are deducted.

Your Signature _____ Today's Date (MM/DD/YYYY) _____

C. YOUR COVERAGE CHOICES

For each coverage you wish to adjust: 1) Check the appropriate box () for the action you wish to make (add/drop/change to); and
 2) Check the appropriate box () for whom this action applies.

MEDICAL	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	(List Dependents on the back of this form)	Monthly Cost
	<input type="checkbox"/>	Yourselves Only	\$ 85.28
	<input type="checkbox"/>	Yourselves Plus One	\$216.52
	<input type="checkbox"/>	Yourselves and Family	\$308.00

QUALIFYING LIFE EVENTS

A. LOSS OF OTHER COVERAGE (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be allowed to enroll yourself and your dependents. You must submit this form, together with documentation, to your employer within 31 days of the LOC. If you are entitled to this special enrollment, complete **sections A & B** (above) then go to the list on the right and check the box next to your LOC, supply the date of the LOC, and finish completing the form through **section D**. When finished, make a copy of this form and give it to your employer with your documentation attached.

- Check the box of the description that identifies your **LOC**.
- Divorce, legal separation or death
 - Termination of employment of a dependent
 - Reduction of a dependent's hours
 - Termination of your or your dependents' COBRA rights
 - Loss of employer's contribution to spouse's coverage
 - Dependent child losing eligibility as a dependent
 - Other loss of coverage

Date of the LOC: _____

B. FAMILY STATUS CHANGES (FSC): Whether you are currently enrolled or previously declined coverage, you may be allowed to add, increase, decrease or drop coverage when you experience certain FSC events. You must submit this form, together with documentation, to your employer within 31 days of the FSC. If you are so entitled because of a recent FSC, complete **sections A & B** (above) then go to the list on the right and check the box next to your FSC, supply the date of the FSC, and finish completing this form through **section D**. When finished, make a copy of this form and give it to your employer with your documentation attached.

- Check the box of the description that identifies your **FSC**.
- Divorce, legal separation or death
 - Marriage
 - Birth or adoption of a dependent
 - Other

Date of the FSC: _____

FOR YOUR EMPLOYER'S USE ONLY

Employee ID: _____	Hire Date (MM/DD/YYYY): _____	Pay Type: _____	Total Deduction: \$ _____
Location or Site Code: _____	Authorized Signature: _____	Today's Date (MM/DD/YYYY): _____	



D. DEPENDENT INFORMATION

Check here if you have more dependents and provide all requested information on a separate sheet and attach it to this form.

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change To	Print Dependent's Name (First, Middle Initial, Last) _____	Social Security Number _____
	Sex _____ Relationship _____ Date of Birth _____	If over 18, is your child: <input type="checkbox"/> Full-time student? <input type="checkbox"/> Disabled?
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street Address _____	
	If this dependent has a different address than you, list it here: _____	
	City _____ State _____ Zip Code _____	



Record keeping by Strategic Resource Company (SRC).

Insurance plan is underwritten by Aetna Life Insurance Company.



Professional Business Solutions, Inc.

**Open Enrollment:
January 15 - January 31, 2007**

**Newly-hired employees will have
30 days from their date of
eligibility to enroll.**

RE: Aetna Affordable Health ChoicesSM insurance plans

Professional Business Solutions knows how important you are to our success. We also know that finding affordable health care isn't always easy; that's why we have teamed up with Aetna* to offer health insurance.

This limited accident and sickness insurance plan offers you and your dependents medical coverage.

Premium payments for your benefits will be deducted directly from your paycheck.

Enclosed Materials (Your enrollment kit includes:)



- Temporary Member Identification (bottom of this letter): Once you enroll, you should use this until you receive your permanent IDs. This Temporary Identification is valid following your first payroll deduction.
- How to Enroll Guide (back of letter): Use this guide to walk you through the enrollment process.
- Plan Brochure (color): Contains information on available tools and discounts that you receive for participating.
- Benefits Summary: Describes the specific benefits associated with your plan.
- Election Form: Use to capture your benefit elections.
- Important Disclosure Information: Provides information on the rules associated with your plan.

If you are missing any of the contents of this kit, please see your site manager or call Customer Service at **1-888-772-9682**.

Remember, you only have a limited time to enroll; if you choose not to enroll, you cannot participate until the next open enrollment, unless you have a qualifying life event.

*Si necesita ayuda en español, por favor llame al Centro del Servicio al Cliente al **1-888-772-9682** (presione el número dos) de lunes a viernes de 8:00 a.m. a 8:00 p.m. horario del Este.*

Cut out your Temporary Member Identification along the dotted line.

 MEDICAL PPO PROFESSIONAL BUSINESS SOLUTIONS, INC. COMPANY NO.: 800563	 An Aetna Company AETNA AFFORDABLE HEALTH CHOICES SM PPO BIN# 610502 RX
EMPLOYEE NAME: _____ AND COVERED DEPENDENTS	
FOR MEMBER SERVICES CALL 1-888-772-9682	
PAYOR NUMBER 57604 0039	

Key Terms:

Deductible: the amount you pay annually for covered services before your plan starts paying.

Member Coinsurance: your portion of the cost of covered services after the deductible has been met.

Preferred Provider Organization (PPO): a network of doctors and facilities who provide discount services to plan members.

Copayment (Copay): The set amount you pay for each covered service – for example: doctor's office visits and prescription drugs.

Inpatient: services that require a minimum of 24 hours in the hospital; all other services are considered 'outpatient.'



* Insurance Plans are underwritten by Aetna Life Insurance Company.
Plans are administered by Strategic Resource Company (SRC).
Material is subject to change.
For OK residents only, policy forms issued include GR-9 and GR-29.



Enrolling is easy!

Enrollment in this limited accident and sickness insurance plan is quick and easy – review the following steps to sign up today.

Step One - Review the enclosed materials and ask questions – if you need more information or don't completely understand something, give us a call. We're here to answer questions before you enroll!

Step Two - Make your decisions and complete the Election Form .

Step Three - Turn in your completed Election Form to your employer.

Employees electing medical will receive plastic identification (ID) cards at their home address along with important membership information. ID Cards are not needed to access any of the other benefit elections.

Making changes:

If you are within your open enrollment period, you may make changes to your elections by completing and turning in an Election Form to your employer. If you are outside of your open enrollment period, there are certain events that will allow you to make changes to your elections. Log in to the SRC website or see your employer. You will be provided with the information to determine if you are eligible to make such changes.

Contact us:

1-888-772-9682 (Monday-Friday, 8 a.m. to 8 p.m. ET) or
www.src-web.com

www.aetna.com/docfind/custom/aabc

HEALTH CARE PROVIDER: The person listed on the front of this card has been enrolled under a limited major medical plan sponsored by the employer listed on the front of this card. Covered members are entitled to benefits under the applicable plan, subject to exclusions and limitations. This card does not guarantee coverage. For verification of coverage, filing a claim or for questions other than the discount programs, contact us at the number printed on the front of this card or mail us at the address below.

INSURED: Network physicians, hospitals, and other health care providers are independent contractors and are neither agents nor employees of Aetna Life Insurance Company.

EMERGENCY URGENT CARE: Call your local emergency hotline (ex.911) or go to the nearest emergency facility. For VISION ONE call 1-800-793-8616. For LASIK call 1-800-422-6600. For CONTACTS DIRECT call 1-800-391-5367.

Strategic Resource Company
P.O. Box 23759
Columbia, SC 29224-3759

Notice to Members Concerning Health Care Services: Your share of the payment for health care services may be based on the agreement between your health plan and your provider. Under certain circumstances, this agreement may allow your provider to bill you for amounts up to the provider's regular billed charges.

Aetna Affordable Health ChoicesSM

Professional Business Solutions, Inc.

Enroll Today!

Call SRC toll-free at **1-888-772-9682**

Monday-Friday, 8 a.m. to 8 p.m. ET

**Affordable
Premiums**

**Family Coverage
Available**

**Guaranteed
Acceptance**

We want you to know[®]



006461685LOS/ATTACH1LOS

Your employer is giving you the opportunity to enroll in this payroll-deducted insurance coverage.

Medical

A Limited Major Medical Insurance Plan.

The table on the right will give you a quick overview of the Medical Coverage.

- Use any licensed provider for covered expenses or any certified hospital. You can save even more money by using a network provider or facility through the discounted PPO network.
- Chiropractic visits are covered.
- Maternity is a covered expense and covered the same as any other expenses, up to the annual benefit maximum.
- If you live in an area that is not served by the PPO network and you use a nonparticipating provider that is also located outside a network area, your covered expenses would be reimbursed according to the in network provisions of the plan.

Exclusions and limitations apply. Refer to the Exclusions and Limitations section for details.

BENEFIT	IN NETWORK	OUT OF NETWORK
Annual Deductible - Individual	\$100	\$200
Annual Deductible - Family *	\$200	\$400
Annual Benefit Maximum (per covered person)	\$10,000 in or out of network	
Percentage of charges paid by plan ^{1,2,3}	80%	60%
Subject to these annual limits:		
Outpatient expenses ³	\$1,000 in or out of network	
Other inpatient hospital services ^{3,6}	\$1,000 in or out of network	
Doctors' Office Visits		
Per visit copay or base deductible	\$15 copay	\$15 base deductible
Percentage of remaining charges paid by plan ^{1,4,5}	100%	80%
Outpatient Care ^{1,3,4,5}	80%	60%
Prescription Drugs ^{1,2,4,5}	80% in or out of network	

Footnotes

1. Where benefit is expressed as a percentage, the lower of the recognized charge(s) or the discounted PPO charge(s) will be the basis of payment.
2. You will have met your "family deductible" when two covered family members have each paid their own deductibles in a coverage year.
3. Subject to the annual deductible.
4. Subject to the outpatient expenses benefit limit.
5. Subject to the annual benefit maximum.
6. Other inpatient hospital services are certain hospital charges other than room and board. They include, but are not limited to, pharmacy, medical and surgical supplies and devices, lab and x-rays and operating and recovery room expenses.

Additional Benefits

- **The prescription drug discount program*** gives you and your family access to more than 52,000 retail pharmacies across the continental U.S., Puerto Rico, and the Virgin Islands (as of 1/1/05). You can also use our Aetna Rx Home Delivery® service; a fast, easy way to fill the prescriptions you take regularly.
- **Aetna's Vision One® discount program,*** a nationwide network of vision care providers, offers you and your family glasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories at a discounted price. Plus, you can receive discounts on eye exams and LASIK eye surgery.

* Discount programs provide access to discounted prices and are not insured benefits.

Exclusions and Limitations

This is a summary list. Coverages, features, limitations and exclusions may vary by state. This is not a contract. Only the insurance policy can provide the actual terms, coverages, amounts, conditions, limitations and exclusions. Except to the extent coverage for such benefit is specifically provided in your Booklet-Certificate, coverage is not provided for the following charges:

Medical Preexisting Condition Limitation:

Medical expenses for a preexisting condition are not covered (full postponement rule) for the first 365 days after the enrollee's effective date. Lookback period for determining a preexisting condition (conditions for which diagnosis, care and treatment was recommended or received) is 180 days prior to the effective date. The preexisting limitation period will be reduced by the number of days of prior creditable coverage the member has as of the effective date. The preexisting condition limitation does not apply to newborn or adopted children, or to any pregnancy.

As used above, "creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Medical Exclusions:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved;
- Service or supply rendered by someone who is related to a covered person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the covered persons household.
- Injury arising out of or in the course of employment; or which is compensable under any Workers' Compensation or Occupational Disease Act or Law;
- Care, treatment, services or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist;
- Experimental or investigational services, drugs or supplies except to the extent required by law;
- Cosmetic or Reconstructive Surgery: This does not apply to reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or because of congenital disease or anomaly of a covered person; or reconstructive surgery on a non-diseased breast to restore and achieve symmetry between two breasts following a mastectomy;
- Dental Care and treatment, except that required by injury and rendered within 6 months of the injury;
- Educational testing, or training related to learning disabilities or developmental delays;
- Services of a resident physician or intern rendered in that capacity;
- Charges made only because there is insurance or a person is not legally obligated to pay;
- Custodial care;
- Any expense incurred before the effective date of the policy or after the date the policy terminates;
- Eye surgery mainly to correct refractive errors;
- Education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy;
- Performance, or lifestyle enhancement drugs or supplies;
- Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered;
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet-Certificate;
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling;
- Acupuncture therapy, except when its performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan;
- Speech therapy, except to restore speech to a person who has lost existing speech function as the result of a disease or injury;
- Inpatient or outpatient treatment of alcoholism, drug abuse and mental disorders;
- Private duty nursing;
- An injury sustained while the covered person was legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the injury occurred;
- An injury sustained while the covered person was voluntarily using any drug, narcotic or controlled substance unless as prescribed by a physician;
- Charges made by a hospital or treatment facility owned or run by the U.S. government unless a charge is made for such services in the absence of insurance;
- Charges made to treat an illness or injury sustained while flying as a pilot or crew member of any aircraft or travel or flight. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by; for; or under; the direction of any military authority other than the Military Airlift Command of the United States or similar air transport service of any other country;
- Charges made by a hospital which does not unconditionally require payment (this does not apply to charges billed by Veterans Administration Hospitals);
- Charges made by a physician for non-surgical medical treatment given to a covered person while confined in an inpatient facility;
- Charges made for outpatient services and supplies that are not deemed to be physician office visits; emergency room visits; diagnostic and surgical services; or prescription drugs and medicines;
- Voluntary sterilization procedure or the reversal of a sterilization procedure;
- Weight Control services including: surgical procedures, medical treatments, weight control/loss programs; food supplements; or exercise programs;
- Charges furnished, paid for, or for which benefits are provided or required under any law of a government;
- Charges made for prescription drugs and medicines prescribed by a physician [on an inpatient and/or outpatient basis].
- Charges in excess of the Recognized Charge, based on the 80th percentile of the Medicode Medical Data Research Tables.

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. 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).**

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