

AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions®

ARIZONA PLAN GUIDE



PLANS EFFECTIVE OCTOBER 1, 2009

14.02.970.1-AZ F (4/10)



Health care is a journey ...

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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As a small business owner, providing value to your customers and growing your business are your top priorities. Yet, today health care is a business issue for every entrepreneur.

Small businesses need insurance benefits plans that fit their workplace. Aetna Avenue provides employers with a choice of insurance benefits solutions. We know that choice, ease and reputation are as valuable to employers as they are to employees.

Aetna offers a variety of plans for small business — from medical plans, to dental, life and disability plans.

CHOICE

For business owners and employees

At Aetna, we provide employers a choice of insurance benefits plans. Within these benefits programs, employers can choose specific plan designs that fit business and employee needs. Employees have access to a wide network of doctors and other providers ensuring that they have a choice in how they receive their health care.

Medical Plans — supporting members on their health care journey.

- HMO
- PPO/POS
- Consumer-directed health plans (CDHP)

Dental, Life and Disability Plans — providing valuable protection.

- Dental
- Basic Term Life Insurance
- Disability Plans
- Packaged Life and Disability Plans

EASE

Allowing you to focus on your business

Employers want to focus on their customers and growing their business — not the insurance benefits program. Aetna makes sure that our plan designs are easy to set-up, administer, use and provide support to ensure your success.

Administration — making it work for your business

Aetna's plan designs automatically process health claim reimbursements, provide a password-protected website to keep track of accounts and are supported by knowledgeable service representatives. Our representatives are available to answer your questions and work with you when you need them.

Ready on Day-One — making it work for your employees.

Once employees are members of the Aetna health benefits and health insurance plans, they'll have access to our various tools and resources to help them use the plans effectively from the start.

Aetna Navigator® — our online resource for employers, members and providers

- DocFind® to locate doctors in the neighborhood
- Track medical claims online
- Discount programs for eye, dental and other health care
- Personal Health Record providing a complete picture of health
- Temporary ID cards available for members to print as needed

REPUTATION

In business it's everything

Your reputation is important to your business. At Aetna, our reputation is just as important. With 150 years of experience, we value our name, products and services and focus on delivering the right solution for your small business — our reputation depends upon it.

Our account executives, underwriters and customer service representatives are committed to providing your small business the valuable service it deserves.

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

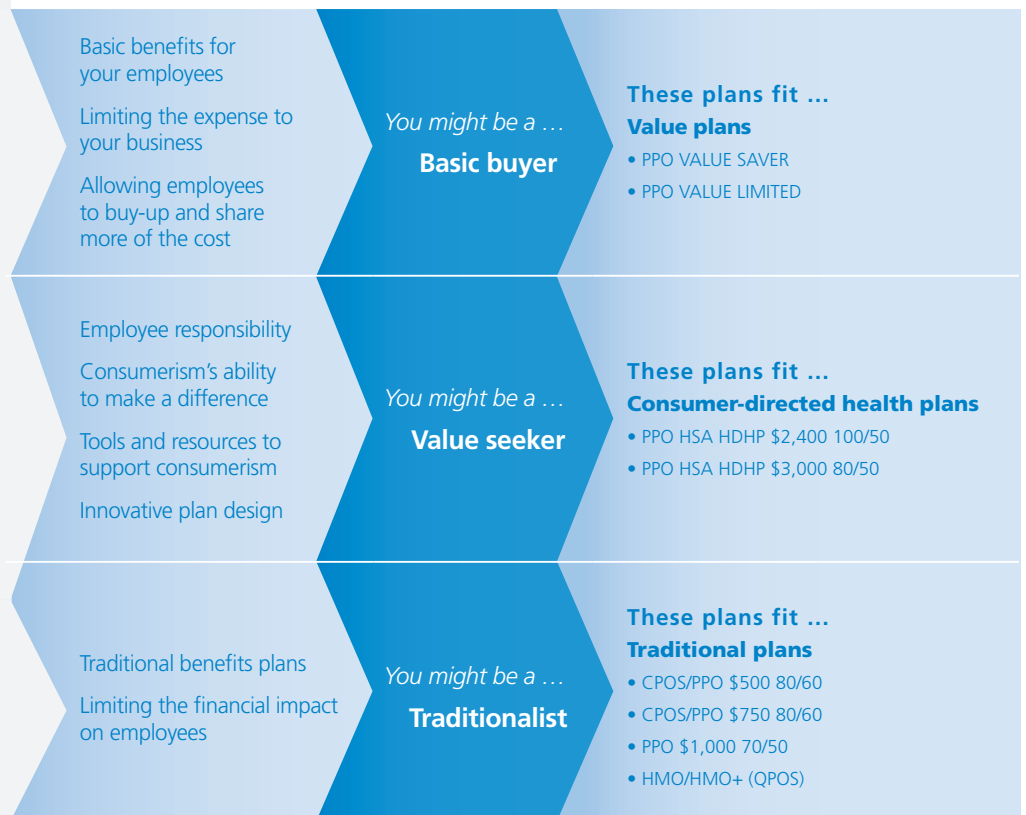
We know that small business owners' insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2 – 99 employees and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for your business and assist you through implementation.

AETNA'S MARKET MAP

Guiding your small business health care journey

Aetna's market map is a resource for brokers and employers to help determine the right insurance benefits plan for their business. Market map asks specific questions related to the business and employee need to narrow the field of plan design choices.

**DO
YOU
VALUE ...**





YOUNG SINGLES

CDHP
Traditional plans
Value plans

HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Includes singles and couples without children

Ready to conquer the world? Thinking big thoughts? Well, one of those thoughts should be about health coverage. Since they're probably on a budget, they might want an affordable policy with lower monthly payments and modest out-of-pocket costs that also provides for quality preventive care, prescription drug coverage and financial protection to help safeguard their assets.

ESTABLISHED FAMILIES

Includes married couples and single parents with teens and college-aged children

As the children get older, the entire family's needs change. Time management is important for active parents and children. Teenagers still need checkups and care for injuries and illness, while parents need to start thinking about their own needs, like plan designs that cover preventive care and screenings and promote a healthy lifestyle. And college brings financial concerns to the forefront, as well as the need for a national network.



YOUNG FAMILIES

Traditional plans
Value plans

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

Children tend to get sick more than adults — which means employees and their pediatricians get to know each other quite well. It also means they're probably looking for health coverage with lower fees for office visits, lower monthly payments and caps on their out-of-pocket expenses. And, of course, they can benefit from quality preventive care for the entire family.

EMPTY NESTERS

Includes men and women age 55 and over with no children at home

The kids are leaving home. It's a wistful time, but also an exciting one. What are the plans? Travel? Leisure? Reassessing health coverage needs? These employees are probably looking for a policy that combines financial security with quality coverage for prescriptions, hospital inpatient/outpatient services and emergency care.



ESTABLISHED FAMILIES

CDHP
Traditional plans



EMPTY NESTERS

CDHP
Traditional plans

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MEDICAL OVERVIEW

Arizona Network*

More than 9,500 Physicians and 78 Hospitals

**Aetna HMO/HMO+
(QPOS)/CPOS/PPO plans
are available in these counties:**

Cochise	Pinal**
Graham	Santa Cruz
Maricopa	Yavapai
Mohave	Yuma
Pima	

**PPO plans are available in
these counties:**

Apache	Greenlee
Coconino	La Paz
Gila	Navajo

*According to the Aetna Enterprise
Provider Database as of April 1, 2009.
Network subject to change.

**HMO/HMO+ (QPOS)/CPOS are available
in select areas of Pinal county. Contact
Aetna for more information.

AETNA HMO PLAN

*Members access care through
primary care physicians*

With this health benefits plan, members begin by selecting a primary care physician (PCP) from Aetna's participating network of providers. Members select a PCP who will coordinate their health care needs for covered benefits or services. Each covered member of the family may choose his or her own PCP.

AETNA HMO+ (QPOS)

The Aetna HMO+ (QPOS) is a two-tiered product that allows members to access care in one of two ways: Referred in-network (subject to copay) or self-referred, in or out of network (subject to deductible and coinsurance). Members have lower out-of-pocket costs when they use the HMO tier of the plan and follow the PCP referral process. Member cost sharing increases if members decide to self-refer in or out of network.

AETNA CPOS — NO REFERRALS

No need for referrals; freedom to select a provider of choice. Aetna CPOS offers all the health plan benefits of a point-of-service plan with two easy ways to access care when members need it. Members have the freedom to visit the participating doctor or hospital of their choice for covered services. Best of all, members seeking health care do not need referrals.

AETNA PPO

The Aetna PPO insurance plan offers members the freedom to go directly to any recognized provider for covered expenses, including specialists. The PPO network is suitable for in-state rural areas. No referrals are required.

Aetna will offer the in-state portfolio and rating structure to out-of-state employees who live in an out-of-state network area. Out-of-state employees who do not live in an out-of-state network area will be eligible for an in-state indemnity plan.

WHAT ARE PICK-A-PLAN 3* AND VALUEPICK?

Pick-A-Plan 3 is Aetna Small Group’s suite of plans designed specifically with small businesses in mind. These plans provide choice, flexibility and simplicity.

Pick-A-Plan 3 offers the following advantages:

Greater employee choice

Employers can offer any 3 of the 24 available plan designs.

Flexibility and affordability

Employers can create a customized benefits package from any of our plan types and plan designs. Aetna offers a variety of plans at different price points. Employers may designate a level of contribution that meets their budget.

Total freedom

Aetna offers 24 plan choices that range in price and benefits to help meet each individual employee’s needs, whether they are lower premiums or lower out-of-pocket costs at the time services are received.

Easy administration

Setting up this program is simple:

1. The employer chooses up to 3 plans to offer on the Employer Application
2. The employer chooses how much to contribute
3. Each employee chooses the plan that’s right for him or her

ValuePick offers reduced minimum participation and employer contribution requirements.

ValuePick offers the following advantages:

Lower participation and contribution requirements

Value plans have lower participation and contribution requirements, except when offered with a non-Value plan.**

Greater employee choice

Employers can offer up to 3 of the Value plans.

Flexibility and affordability

By choosing a Value plan, employers are now able to offer benefits to help meet the needs of their employees.

Total freedom

Aetna is committed to providing solutions to help meet the needs of small businesses. Employers can now offer quality coverage at affordable prices.

Easy administration

Setting up this program is simple:

1. The employer chooses up to 3 Value plans to offer on the Employer Application
2. The employer chooses how much to contribute
3. Each employee chooses the plan that’s right for him or her

	Pick-A-Plan 3	ValuePick
Target audience	Every small business with 5+ enrolled employees	Every small business with 5+ enrolled employees
Plan choices	Up to 3 of the 24 available plans	Up to 3 of the Value plans
Minimum participation		
2 – 4 enrolled employees	Single or Dual Option	Single or Dual Option
5 or more enrolled employees	Dual or Triple option available	Dual or Triple option available
Employer contribution	50% of the employee rate or \$120	25% of the employee rate or \$50
Rating options	2-9 employees — tabular; 10-99 employees — composite	2-9 employees — tabular; 10-99 employees — composite

*Available with five or more enrolled employees.

**If an employer chooses a ValuePick plan to offer with a non-Value plan, the standard participation and contribution requirements on the non-Value plan will apply to both plans offered.

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MEDICAL OVERVIEW

Embedded Aggregate Deductible

Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.

CONSUMER-DIRECTED HEALTH PLANS

Consumer-directed health plans are high-deductible health plans (HDHP) designed to give individuals greater flexibility and control when purchasing care. Aetna's HDHP's are paired with account-based funds that include health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending accounts (FSAs).

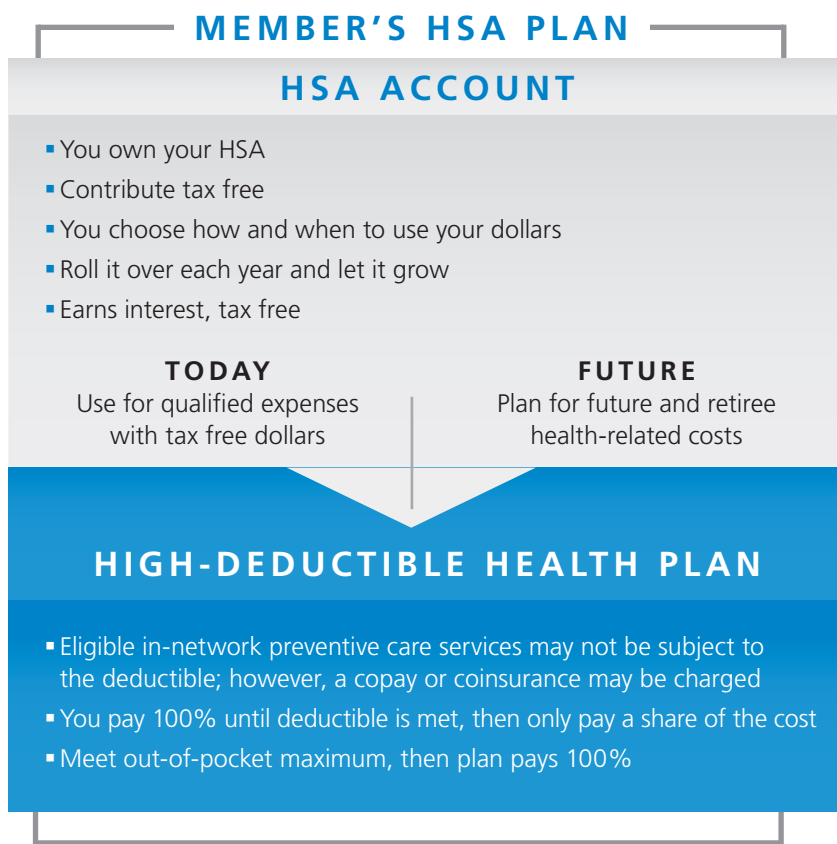
HDHP's increase the flexibility and control employers and employees have by putting them in the center of their health care. In more traditional scenarios, employees may have a higher premium associated with a low-deductible plan, and never use it. With an Aetna HDHP, the employer and employee can lower their monthly premium, and create a fund to pay for the services when needed. In an HSA or HRA fund, the monies can roll over from year to year and can be used toward future medical expenses.

When a HDHP is paired with an HSA, employers and their qualified employees have a tax-advantaged solution that allows them to manage their qualified medical and dental expenses. HRAs enable employers to use tax-deductible dollars to reimburse employees for predetermined types of medical expenses. While FSAs allow individuals to use pretax salary dollars to establish an account to help pay for health care and dependent care expenses.

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

HEALTH SAVINGS ACCOUNT (HSA)

The Aetna HealthFund® HSA, when coupled with a HSA-compatible high-deductible health benefits and health insurance plan, is a tax-advantaged savings account. Once enrolled, account contributions can be made by the employee and/or employer. The HSA can be used to pay for qualified expenses tax free.



Annual HSA contributions for 2010 are \$3,050 per individual / \$6,150 per family. Maximum will be adjusted for the cost of living in future years.

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

Administrative fees

FEE DESCRIPTION	FEE
HSA	
Initial Set-Up	\$0
Monthly Fees	\$0
POP*	
Initial Set-Up**	\$150
Renewal	\$75
HRA and FSA***	
Initial Set-Up*	
2 – 25 Employees	\$350
26 – 50 Employees	\$450
51 – 100 Employees	\$550
Renewal Fee	50% of the initial set-up fee
Monthly Fees ¹	\$5.00 per participant
Additional Set-Up Fee for “stacked” plans (those electing an Aetna HRA and FSA simultaneously)	\$150
Participation Fee for “stacked” participants	\$9.75 per participant
Minimum Fees	
0 – 25 Employees	\$10 per month minimum
26 – 299 Employees	\$50 per month minimum
TRA	
Annual Fee	\$350
Transit Monthly Fees	\$4.25 per participant
Parking Monthly Fees	\$3.15 per participant
COBRA	
20 – 50 Employees:	
Annual Fee	\$50
Per employee per month	\$0.85
51 – 100 Employees:	
Annual Fee	\$415
Per employee per month	\$0.98
Per employee per month	\$0.96 (Excludes initial notices for all employees at set-up.)

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Aetna HealthFund HRA combines the protection of a deductible-based health plan with a health fund that pays for eligible health care services. The member cannot contribute to the HRA, and employers have control over HRA plan designs and fund rollover. The fund is available to an employee for qualified expenses on the plan’s effective date.

The HRA and the HSA provide members with financial support for higher out-of-pocket health care expenses. Aetna’s consumer-directed health products and services give members the information and resources they need to help make informed health care decisions for themselves and their families while helping lower employers’ costs.

COBRA administration

Aetna COBRA administration offers a full range of notification, documentation and record-keeping processes that can assist employers with managing the complex billing and notification processes that are required for COBRA compliance, while also helping to save them time and money.

SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

Employees can reduce their taxable income, and employers can pay less in payroll taxes. There are three ways to save:

Premium Only Plans (POP)

Employees can pay for their portion of the group health insurance expenses on a pretax basis. First-year POP fees waived with the purchase of medical with 5-plus enrolled employees.

Flexible Savings Account (FSA)

FSAs give employees a chance to save for health expenses with pretax money. Health Care Spending Accounts allow employees to set aside pretax dollars to pay for out-of-pocket expenses as defined by the IRS. Dependent Care Spending Accounts allow participants to use pretax dollars to pay child or elder care expenses.

Transit Reimbursement Account (TRA)

TRAs allow participants to use pretax dollars to pay transportation and parking expenses for the purpose of commuting to and from work.

*First year POP fees waived with the purchase of medical with 5-plus enrolled employees.

**Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for \$75 fee. Non-discrimination testing only available for FSA and POP products.

***Aetna FSA pricing is inclusive for POP. Debit cards are available for FSA only. Contact Aetna for further information.

¹For HRA, if the employer opts out of Streamline, the fee is increased \$1.50 per participant.

Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules.

Aetna reserves the right to change any of the above fees and to impose additional fees upon prior written notice.

HMO PLAN OPTIONS	
PLAN OPTIONS	HMO \$15/\$30/\$250
PCP/Referrals Required	Yes
Member Benefits	In-Network
Plan Coinsurance	100%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	None
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum
Lifetime Maximum Benefit	\$5,000,000
Primary Physician Office Visit	\$15 copay
Specialist Office Visit	\$30 copay
Primary Physician E-Visit (Register at www.relayhealth.com)	\$15 copay
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$30 copay
Walk-In Clinics	\$30 copay
Outpatient Lab	\$0 copay
Outpatient X-ray	\$30 copay
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	\$100 copay
Chiropractic Services	\$30 copay (20 visits per CY)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay
Well-Child Exams (Age and frequency schedules apply)	\$15 copay
Routine GYN (Frequency schedules apply)	\$15 copay
Inpatient Hospital	\$250 copay per day up to 3 days per admit
Outpatient Surgery Freestanding Facility	\$125 copay
Outpatient Surgery Outpatient Hospital Department	\$250 copay
Emergency Services	\$100 copay
Urgent Care	\$50 copay
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included

HMO+ (QPOS) PLAN OPTIONS				
PLAN OPTIONS	HMO+ \$15/\$30/\$250 (QPOS)		HMO+ \$20/\$40/\$500 (QPOS)	
PCP/Referrals Required	Yes	N/A	Yes	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100%	60%	100%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	None	\$1,000 per member	None	\$1,500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,000 per member	\$3,000 per member	\$3,500 per member	\$3,500 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$15 copay	60%	\$20 copay	50%
Specialist Office Visit	\$30 copay	60%	\$40 copay	50%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$15 copay	Not Covered	\$20 copay	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$30 copay	Not Covered	\$40 copay	Not Covered
Walk-In Clinics	\$30 copay	Not Covered	\$40 copay	Not Covered
Outpatient Lab	\$0 copay	60%	\$0 copay	50%
Outpatient X-ray	\$30 copay	60%	\$40 copay	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	\$100 copay	50%	\$100 copay	50%
Chiropractic Services	\$30 copay (20 visits per CY)	60% (no visit limit)	\$40 copay (20 visits per CY)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay	60%	\$20 copay	50%
Well-Child Exams (Age and frequency schedules apply)	\$15 copay	60%	\$20 copay	50%
Routine GYN (Frequency schedules apply)	\$15 copay	60%	\$20 copay	50%
Inpatient Hospital	\$250 copay per day up to 3 days per admit	60%	\$500 copay per day up to 5 days per admit	50%
Outpatient Surgery Freestanding Facility	\$125 copay	60%	\$250 copay	50%
Outpatient Surgery Outpatient Hospital Department	\$250 copay	50%	\$500 copay	50%
Emergency Services	\$100 copay	Paid as in-network	\$100 copay	Paid as in-network
Urgent Care	\$50 copay	\$50 copay; ded waived	\$50 copay	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50	Not Covered	\$20 / \$40 / \$60	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%	Not Covered	80%	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

CPOS STANDARD PLAN OPTIONS				
PLAN OPTIONS	CPOS \$250 80/60 \$15/\$30		CPOS \$500 80/60 \$15/\$30	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	60%	80%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$250 per member	\$250 per member	\$500 per member	\$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,500 per member	\$5,000 per member	\$2,500 per member	\$5,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$15 copay; ded waived	60%	\$15 copay; ded waived	60%
Specialist Office Visit	\$30 copay; ded waived	60%	\$30 copay; ded waived	60%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$15 copay; ded waived	Not Covered	\$15 copay; ded waived	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$30 copay; ded waived	Not Covered	\$30 copay; ded waived	Not Covered
Walk-In Clinics	\$30 copay; ded waived	Not Covered	\$30 copay; ded waived	Not Covered
Outpatient Lab	\$30 copay; ded waived	60%	\$30 copay; ded waived	60%
Outpatient X-ray	\$30 copay; ded waived	60%	\$30 copay; ded waived	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services	\$30 copay, after ded (20 visits per CY)	60% (no visit limit)	\$30 copay, after ded (20 visits per CY)	60% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay; ded waived	60%	\$15 copay; ded waived	60%
Well-Child Exams (Age and frequency schedules apply)	\$15 copay; ded waived	60%	\$15 copay; ded waived	60%
Routine GYN (Frequency schedules apply)	\$15 copay; ded waived	60%	\$15 copay; ded waived	60%
Inpatient Hospital	80%	60%	80%	60%
Outpatient Surgery Freestanding Facility	80%	60%	80%	60%
Outpatient Surgery Outpatient Hospital Department	70%	50%	70%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50	Not Covered	\$15 / \$30 / \$50	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	Not Covered	80%; ded waived	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

For footnotes, see page 23.

CPOS STANDARD PLAN OPTIONS				
PLAN OPTIONS	CPOS \$500 90/70 \$10/\$20		CPOS \$750 80/60 \$20/\$40	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	90%	70%	80%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$500 per member	\$500 per member	\$750 per member	\$750 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,000 per member	\$4,000 per member	\$3,000 per member	\$6,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$10 copay; ded waived	70%	\$20 copay; ded waived	60%
Specialist Office Visit	\$20 copay; ded waived	70%	\$40 copay; ded waived	60%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$10 copay; ded waived	Not Covered	\$20 copay; ded waived	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$20 copay; ded waived	Not Covered	\$40 copay; ded waived	Not Covered
Walk-In Clinics	\$20 copay; ded waived	Not Covered	\$40 copay; ded waived	Not Covered
Outpatient Lab	\$20 copay; ded waived	70%	\$40 copay; ded waived	60%
Outpatient X-ray	\$20 copay; ded waived	70%	\$40 copay; ded waived	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	90%	60%	80%	50%
Chiropractic Services	\$20 copay, after ded (20 visits per CY)	70% (no visit limit)	\$40 copay, after ded (20 visits per CY)	60% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$10 copay; ded waived	70%	\$20 copay; ded waived	60%
Well-Child Exams (Age and frequency schedules apply)	\$10 copay; ded waived	70%	\$20 copay; ded waived	60%
Routine GYN (Frequency schedules apply)	\$10 copay; ded waived	70%	\$20 copay; ded waived	60%
Inpatient Hospital	90%	70%	80%	60%
Outpatient Surgery Freestanding Facility	90%	70%	80%	60%
Outpatient Surgery Outpatient Hospital Department	80%	60%	70%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50	Not Covered	\$20 / \$40 / \$60	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	Not Covered	80%; ded waived	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

CPOS STANDARD PLAN OPTIONS				
PLAN OPTIONS	CPOS \$1,000 80/60 \$25/\$50		CPOS \$1,500 70/50 \$25/\$50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	60%	70%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,000 per member	\$1,000 per member	\$1,500 per member	\$1,500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,000 per member	\$8,000 per member	\$5,000 per member	\$10,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$25 copay; ded waived	60%	\$25 copay; ded waived	50%
Specialist Office Visit	\$50 copay; ded waived	60%	\$50 copay; ded waived	50%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$25 copay; ded waived	Not Covered	\$25 copay; ded waived	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$50 copay; ded waived	Not Covered	\$50 copay; ded waived	Not Covered
Walk-In Clinics	\$50 copay; ded waived	Not Covered	\$50 copay; ded waived	Not Covered
Outpatient Lab	\$50 copay; ded waived	60%	\$50 copay; ded waived	50%
Outpatient X-ray	\$50 copay; ded waived	60%	\$50 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	70%	50%
Chiropractic Services	\$50 copay, after ded (20 visits per CY)	60% (no visit limit)	\$50 copay, after ded (20 visits per CY)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$25 copay; ded waived	60%	\$25 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$25 copay; ded waived	60%	\$25 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$25 copay; ded waived	60%	\$25 copay; ded waived	50%
Inpatient Hospital	80%	60%	70%	50%
Outpatient Surgery Freestanding Facility	80%	60%	70%	50%
Outpatient Surgery Outpatient Hospital Department	70%	50%	60%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	Not Covered	\$20 / \$40 / \$60	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	Not Covered	80%; ded waived	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

For footnotes, see page 23.

CPOS 100% PLAN OPTIONS				
PLAN OPTIONS	CPOS \$1,500 100/50 \$15/\$30		CPOS \$2,500 100/50 \$25/\$50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100%	50%	100%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,500 Individual \$4,500 Family	\$1,500 Individual \$4,500 Family	\$2,500 Individual \$7,500 Family	\$2,500 Individual \$7,500 Family
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$0 Individual \$0 Family	\$3,000 Individual \$9,000 Family	\$0 Individual \$0 Family	\$5,000 Individual \$15,000 Family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate ⁴		Embedded Aggregate ⁴	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$15 copay; ded waived	50%	\$25 copay; ded waived	50%
Specialist Office Visit	\$30 copay; ded waived	50%	\$50 copay; ded waived	50%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$15 copay; ded waived	Not Covered	\$25 copay; ded waived	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$30 copay; ded waived	Not Covered	\$50 copay; ded waived	Not Covered
Walk-In Clinics	\$30 copay; ded waived	Not Covered	\$50 copay; ded waived	Not Covered
Outpatient Lab	\$30 copay; ded waived	50%	\$50 copay; ded waived	50%
Outpatient X-ray	\$30 copay; ded waived	50%	\$50 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	100%	50%	100%	50%
Chiropractic Services	\$30 copay, after ded (20 visits per CY)	50% (no visit limit)	\$50 copay, after ded (20 visits per CY)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay; ded waived	50%	\$25 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$15 copay; ded waived	50%	\$25 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$15 copay; ded waived	50%	\$25 copay; ded waived	50%
Inpatient Hospital	100%	50%	100%	50%
Outpatient Surgery Freestanding Facility	100%	50%	100%	50%
Outpatient Surgery Outpatient Hospital Department	100%	50%	100%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	Not Covered	\$20 / \$40 / \$60	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	Not Covered	80%; ded waived	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

CPOS 100% PLAN OPTIONS		
PLAN OPTIONS	CPOS \$5,000 100/50 \$25/\$50	
PCP/Referrals Required	No	N/A
Member Benefits	In-Network	Out-of-Network ¹
Plan Coinsurance	100%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$0 Individual \$0 Family	\$10,000 Individual \$20,000 Family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate ⁴	
Lifetime Maximum Benefit	\$5,000,000	
Primary Physician Office Visit	\$25 copay; ded waived	50%
Specialist Office Visit	\$50 copay; ded waived	50%
Primary Physician E-Visit (Register at www.relayhealth.com)	\$25 copay; ded waived	Not Covered
Specialist Physician E-Visit (Register at www.relayhealth.com)	\$50 copay; ded waived	Not Covered
Walk-In Clinics	\$50 copay; ded waived	Not Covered
Outpatient Lab	\$50 copay; ded waived	50%
Outpatient X-ray	\$50 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	100%	50%
Chiropractic Services	\$50 copay, after ded (20 visits per CY)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$25 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$25 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$25 copay; ded waived	50%
Inpatient Hospital	100%	50%
Outpatient Surgery Freestanding Facility	100%	50%
Outpatient Surgery Outpatient Hospital Department	100%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	Not Covered
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included	

PPO STANDARD PLAN OPTIONS				
PLAN OPTIONS	PPO \$250 80/60 \$10/\$20		PPO \$500 90/70 \$10/\$20	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	60%	90%	70%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$250 per member	\$250 per member	\$500 per member	\$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,500 per member	\$5,000 per member	\$2,000 per member	\$4,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Specialist Office Visit	\$20 copay; ded waived	60%	\$20 copay; ded waived	70%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Walk-In Clinics	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Outpatient Lab	\$20 copay; ded waived	60%	\$20 copay; ded waived	70%
Outpatient X-ray	\$20 copay; ded waived	60%	\$20 copay; ded waived	70%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	90%	60%
Chiropractic Services	\$20 copay, after ded (no visit limit)	60% (no visit limit)	\$20 copay, after ded (no visit limit)	70% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Well-Child Exams (Age and frequency schedules apply)	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Routine GYN (Frequency schedules apply)	\$10 copay; ded waived	60%	\$10 copay; ded waived	70%
Inpatient Hospital	80%	60%	90%	70%
Outpatient Surgery Freestanding Facility	80%	60%	90%	70%
Outpatient Surgery Outpatient Hospital Department	70%	50%	80%	60%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50	\$15 / \$30 / \$50 plus 20%	\$15 / \$30 / \$50	\$15 / \$30 / \$50 plus 20%
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	60%	80%; ded waived	70%
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

PPO STANDARD PLAN OPTIONS				
PLAN OPTIONS	PPO \$500 80/60 \$15/\$30		PPO \$750 80/60 \$20/\$40	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	60%	80%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$500 per member	\$500 per member	\$750 per member	\$750 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,500 per member	\$5,000 per member	\$3,000 per member	\$6,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$15 copay; ded waived	60%	\$20 copay; ded waived	60%
Specialist Office Visit	\$30 copay; ded waived	60%	\$40 copay; ded waived	60%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 copay; ded waived	60%	\$10 copay; ded waived	60%
Walk-In Clinics	\$15 copay; ded waived	60%	\$20 copay; ded waived	60%
Outpatient Lab	\$30 copay; ded waived	60%	\$40 copay; ded waived	60%
Outpatient X-ray	\$30 copay; ded waived	60%	\$40 copay; ded waived	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services	\$30 copay, after ded (no visit limit)	60% (no visit limit)	\$40 copay, after ded (no visit limit)	60% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay; ded waived	60%	\$20 copay; ded waived	60%
Well-Child Exams (Age and frequency schedules apply)	\$15 copay; ded waived	60%	\$20 copay; ded waived	60%
Routine GYN (Frequency schedules apply)	\$15 copay; ded waived	60%	\$20 copay; ded waived	60%
Inpatient Hospital	80%	60%	80%	60%
Outpatient Surgery Freestanding Facility	80%	60%	80%	60%
Outpatient Surgery Outpatient Hospital Department	70%	50%	70%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$15 / \$30 / \$50	\$15 / \$30 / \$50 plus 20%	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	60%	80%; ded waived	60%
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

For footnotes, see page 23.

PPO STANDARD PLAN OPTIONS				
PLAN OPTIONS	PPO \$1,000 70/50 \$25/\$50		PPO \$2,000 70/50 \$25/\$50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	70%	50%	70%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,000 per member	\$1,000 per member	\$2,000 per member	\$2,000 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,000 per member	\$8,000 per member	\$4,500 per member	\$9,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Specialist Office Visit	\$50 copay; ded waived	50%	\$50 copay; ded waived	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 copay; ded waived	50%	\$10 copay; ded waived	50%
Walk-In Clinics	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Outpatient Lab	\$50 copay; ded waived	50%	\$50 copay; ded waived	50%
Outpatient X-ray	\$50 copay; ded waived	50%	\$50 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	70%	50%	70%	50%
Chiropractic Services	\$50 copay, after ded (no visit limit)	50% (no visit limit)	\$50 copay, after ded (no visit limit)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Inpatient Hospital	70%	50%	70%	50%
Outpatient Surgery Freestanding Facility	70%	50%	70%	50%
Outpatient Surgery Outpatient Hospital Department	60%	50%	60%	50%
Emergency Services	\$250 copay; ded waived	Paid as in-network	\$250 copay; ded waived	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived	50%	80%; ded waived	50%
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

PPO VALUE PLAN OPTIONS				
PLAN OPTIONS	PPO Value \$1,500 80/50		PPO Value Saver \$10,000 100/50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	50%	100%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,500 per member	\$2,500 per member	\$10,000 Individual \$10,000 Family	\$10,000 Individual \$10,000 Family
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$5,000 per member	\$10,000 per member	\$0 Individual \$0 Family	Unlimited Individual Unlimited Family
Deductible and Coinsurance Maximum Accumulation	Per Member		Embedded Aggregate ⁴	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	\$25 copay; ded waived ⁵ (office visit limit applies; see footnote for details)	50%	\$15 copay; ded waived	50%
Specialist Office Visit	\$25 copay; ded waived ⁵ (office visit limit applies; see footnote for details)	50%	100%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 copay; ded waived	50%	\$10 copay; ded waived	50%
Walk-In Clinics	See office visit benefit	50%	\$15 copay; ded waived	50%
Outpatient Lab	\$25 copay; ded waived	50%	\$30 copay; ded waived	50%
Outpatient X-ray	\$25 copay; ded waived	50%	\$30 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	50%	50%	Lab and X-ray limited to \$1,000 per member per calendar year	
	(limited to \$500 per member per calendar year; lab, X-ray and complex imaging combined)			
Chiropractic Services	See office visit benefit	See office visit benefit	100% after ded (no visit limit)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	See office visit benefit	50%	\$15 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	See office visit benefit	50%	\$15 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	See office visit benefit	50%	\$15 copay; ded waived	50%
Inpatient Hospital	80%	50%	100%	50%
Outpatient Surgery Freestanding Facility	80%	50%	100%	50%
Outpatient Surgery Outpatient Hospital Department	70%	50%	100%	50%
Emergency Services	\$250 copay; after ded	Paid as in-network	100%	Paid as in-network
Urgent Care	Not Covered	Not Covered	100%	100%
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%
	(Rx limited to \$500 per member per calendar year)			
Self-Injectable Drugs (Retail and mail order, excludes insulin)	70%; ded waived	50%	70%; ded waived	50%
	(Limit applies)			
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included		Included	

For footnotes, see page 23.

PPO VALUE PLAN OPTIONS		
PLAN OPTIONS	PPO Value Limited \$750 50/50	
PCP/Referrals Required	No	N/A
Member Benefits	In-Network	Out-of-Network ¹
Plan Coinsurance	50%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$750 per member	\$1,500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$5,000 per member	\$10,000 per member
Deductible and Coinsurance Maximum Accumulation	Per Member	
Lifetime Maximum Benefit	\$30,000 Annual Maximum	
Primary Physician Office Visit	50%	50%
Specialist Office Visit	50%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	50%	50%
Walk-In Clinics	50%	50%
Outpatient Lab	50%	50%
Outpatient X-ray	50%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	50%	50%
Chiropractic Services	50% (no visit limit)	50% (no visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$15 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$15 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$15 copay; ded waived	50%
Inpatient Hospital	50%	50%
Outpatient Surgery Freestanding Facility	50%	50%
Outpatient Surgery Outpatient Hospital Department	50%	50%
Emergency Services	\$250 copay; after ded	Paid as in-network
Urgent Care	50%	50%
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60	\$20 / \$40 / \$60 plus 20%
Self-Injectable Drugs (Retail and mail order, excludes insulin)	70%; ded waived	50%
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included	

CONSUMER-DIRECTED PLAN OPTIONS				
PLAN OPTIONS	PPO HSA HDHP \$2,400 100/50		PPO HSA HDHP \$3,000 80/50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$2,400 Individual \$4,800 Family	\$2,400 Individual \$4,800 Family	\$3,000 Individual \$6,000 Family	\$3,000 Individual \$6,000 Family
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$3,400 Individual \$6,800 Family	\$3,400 Individual \$6,800 Family	\$2,800 Individual \$5,600 Family	\$2,800 Individual \$5,600 Family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate ⁴		Embedded Aggregate ⁴	
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000	
Primary Physician Office Visit	100%	50%	80%	50%
Specialist Office Visit	100%	50%	80%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	100%	50%	80%	50%
Walk-In Clinics	100%	50%	80%	50%
Outpatient Lab	100%	50%	80%	50%
Outpatient X-ray	100%	50%	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	100%	50%	80%	50%
Chiropractic Services	100% (no visit limit)	50% (no-visit limit)	80% (no visit limit)	50% (no-visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	\$20 copay; ded waived	50%	\$20 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$20 copay; ded waived	50%	\$20 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$20 copay; ded waived	50%	\$20 copay; ded waived	50%
Inpatient Hospital	100%	50%	80%	50%
Outpatient Surgery Freestanding Facility	100%	50%	80%	50%
Outpatient Surgery Outpatient Hospital Department	100%	50%	80%	50%
Emergency Services	100%	Paid as in-network	\$250 copay; after ded	Paid as in-network
Urgent Care	100%	100%	80%	80%
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60 after integrated medical/rx deductible	\$20 / \$40 / \$60 plus 20% after integrated medical/rx deductible	\$20 / \$40 / \$60 after integrated medical/rx deductible	\$20 / \$40 / \$60 plus 20% after integrated medical/rx deductible
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80% after integrated medical/rx deductible	50% after integrated medical/rx deductible	80% after integrated medical/rx deductible	50% after integrated medical/rx deductible
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

For footnotes, see page 23.

INDEMNITY PLAN OPTION	
PLAN OPTIONS	Indemnity \$500 80%
PCP/Referrals Required	NA
Member Benefits	Out-of-Network ¹
Plan Coinsurance	80%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$3,000 per member
Deductible and Coinsurance Maximum Accumulation	Per Member
Lifetime Maximum Benefit	\$5,000,000
Primary Physician Office Visit	80%
Specialist Office Visit	80%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	80%
Walk-In Clinics	80%
Outpatient Lab	80%
Outpatient X-ray	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%
Chiropractic Services	80% (no-visit limit)
Physical Exams - Adults (Age and frequency schedules apply)	80%
Well-Child Exams (Age and frequency schedules apply)	80%
Routine GYN (Frequency schedules apply)	80%
Inpatient Hospital	80%
Outpatient Surgery Freestanding Facility	80%
Outpatient Surgery Outpatient Hospital Department	70%
Emergency Services	80%
Urgent Care	80%
Prescription Drugs² Retail: up to a 30-day supply Mail Order: 31 to 90-day supply; two-times retail copay	\$20 / \$40 / \$60
Self-Injectable Drugs (Retail and mail order, excludes insulin)	80%; ded waived
90-Day Rx Transition of Coverage (TOC) for Precertification³	Included

FOOTNOTES

The dollar amount indicates what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify for certain services such as outpatient complex imaging and non-emergency hospital care. All services are subject to deductible, unless noted otherwise.

Amounts over allowable charges, failure to precertify penalty, copays, payments for emergency/urgent care services, Rx (including self-injectables) and DME do not apply towards the CPOS/PPO Coinsurance Maximums and continue to be payable after the maximum is reached. Note: On PPO HSA HDHP plans only amounts over allowable charges and failure to precertify penalty do not apply toward the Out-of-Pocket maximum and continue to be payable after the maximum is reached.

For a summary list of Limitations and Exclusions, refer to pages 46-47.

¹Members may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, members will pay substantially more money out of their own pocket if they choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in the member's plan. The member may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills the member above Aetna's recognized charge does not count toward the member's deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network Rates), which are Aetna's standard rates for paying providers within the network. For out-of-network hospitals and other out-of-network facilities the recognized charge is based on the Aetna Facility Fee Schedule.

This benefit applies when members choose to get care out of network. When members have no choice in the doctors they see (for example, an emergency room visit after a car accident), they are generally not responsible for the extra out-of-network costs.

For Point of Service plans, because of state laws, the terms of the coverage for out-of-network claims will be different for members of this plan who are issued policies in CT and NY. Members of these plans will receive a separate contract for their out-of-network benefits, as required by state laws.

²The three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Non-Formulary.

³Transition of Coverage (TOC) applies to precertification and step therapy for prescription drugs. It helps members of newly enrolled groups to transition to the Aetna drug formulary by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time precertification and step therapy will not apply to certain drugs as listed in the formulary guide. Once the 90 calendar days has expired, precertification and step therapy will apply to all drugs requiring precertification and step therapy as listed in the formulary guide. Members who have claims paid for a drug requiring precertification or step therapy during the TOC period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a precertification or step therapy approval for a medical exception to this drug.

⁴Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.

⁵This plan provides limited benefits only and does not constitute a comprehensive insurance plan. As such, it may not cover all the expenses associated with your health care needs. Office visits are limited to three per member per calendar year (in-network and out-of-network) for all types of office visits combined (primary physician, specialist physician, preventive care, chiropractic, PT/OT/ST, mental health etc.). Routine X-rays and lab provided by the provider during a covered office visit and billed with the office visit is included in the office visit copay. Preventive care (adult routine physicals, routine child exams and routine GYN) are included in the three office visit benefit. If the member uses all of his or her three office visits, preventive care is still covered after the deductible.

Aetna Avenue

DENTAL OVERVIEW

AETNA DENTAL® PLANS

With a variety of plan options to choose from, employers will now be able to offer employees a dental benefits and dental insurance plan to help meet their needs, with rates that will give them a reason to smile. Choose the dental plan that works best from options consisting of various DMO®, PPO and Voluntary Dental plan designs and packages.

The Mouth MattersSM

Research shows that more than 90 percent of all medical illnesses are detectable in the mouth and that 75 percent of people over the age of 35 have periodontal (gum) disease.¹ Untreated oral diseases can have a big impact on the quality of life. This means that a dentist may be the first health care provider to diagnose a health problem!

Aetna Dental/Medical IntegrationSM program, available at no additional charge to plan sponsors that have both medical and dental coverages with Aetna, focuses on those who are pregnant or have diabetes, coronary artery disease (heart disease) or cerebrovascular disease (stroke) and have not had a recent dental visit. We proactively educate those at-risk members about the impact oral health care can have on their condition. Our member outreach has been proven to successfully motivate those at-risk members who do not normally seek dental care to visit the dentist. Once at the dentist, these at-risk members will receive enhanced dental benefits including an extra cleaning and full coverage for certain periodontal services.

The Dental Maintenance Organization (DMO[®])

Members select a primary care dentist to coordinate their care from the available managed dental network. Each family member may choose a different primary care dentist and may switch dentists at any time via Aetna Navigator[®] or with a call to Member Services. If specialty care is needed, a member's primary care dentist can refer the member to a participating specialist. However, members may visit orthodontists without a referral. There are virtually no claim forms to file, and benefits are not subject to deductibles or annual maximums.

Preferred Provider Organization (PPO) plan

Members can choose a dentist who participates in the network or choose a licensed dentist who does not. Participating dentists have agreed to offer our members services at a negotiated rate and will not balance-bill members.

PPO Max plan

While the PPO Max dental insurance plan uses the PPO network, when members use out-of-network dentists the service will be covered based on the PPO fee schedule, rather than the reasonable and customary charge. The member will share in more of the costs and may be balance-billed. This plan offers members a quality dental insurance plan with a significantly lower premium that encourages in-network usage.

Freedom-of-Choice plan design option

Get maximum flexibility with our two-in-one dental plan design. The Freedom-of-Choice plan design option provides the administrative ease of one plan, yet members get to choose between the DMO and PPO Max plans on a monthly basis. One blended rate is paid. Members may switch between the plans on a monthly basis by calling Member Services. Plan changes must be made by the 15th of the month to be effective the following month.

Dual Option plan design

In the Dual Option plan design,* the DMO may be packaged with any one of the PPO plans. Employees may choose between the DMO and PPO offerings at annual enrollment.

Voluntary Dental option

The Voluntary Dental option provides a solution to meet the individual needs of members in the face of rising health care costs. Administration is easy, and members benefit from low group rates and the convenience of payroll deductions. Employers choose how the plan is funded. It can be entirely member-paid or employers can contribute up to 50 percent.

*Dual Option does not apply to Voluntary Dental plans.

¹The professional entity, Academy of General Dentistry, 2007.

DMI may not be available in all states.

DMO/PPO DENTAL PLANS			
Available with an Aetna Medical Plan to Groups with 2 – 99 Eligible Employees Available without an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees	Plan Option 1	Plan Option 2 Freedom-of-Choice Monthly selection between the DMO and the PPO Max	
Member Benefits	DMO Plan 100/80/50	DMO Plan 41	PPO Max Plan 100/70/40
Office Visit Copay	\$5	\$10	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	\$50; 3x family maximum
Annual Maximum Benefit	Unlimited	Unlimited	\$1,000
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	100%	No Charge	100%
Comprehensive oral exam	100%	No Charge	100%
Problem-focused oral exam	100%	No Charge	100%
X-rays			
Bitewing – single film	100%	No Charge	100%
Complete series	100%	No Charge	100%
PREVENTIVE SERVICES			
Adult cleaning	100%	No Charge	100%
Child cleaning	100%	No Charge	100%
Sealants – per tooth	100%	\$10	100%
Fluoride application – with cleaning	100%	No Charge	100%
Space maintainers	100%	No Charge	100%
BASIC SERVICES			
Amalgam filling	80%	\$32	70%
Resin filling – anterior	80%	\$55	70%
Oral Surgery			
Extraction – exposed root or erupted tooth	80%	\$30	70%
Extraction of impacted tooth – soft tissue	80%	\$80	70%
MAJOR SERVICES**			
Complete upper denture	50%	\$500	40%
Partial upper denture (resin base)	50%	\$513	40%
Crown – Porcelain with noble metal[†]	50%	\$488	40%
Pontic – Porcelain with noble metal[†]	50%	\$488	40%
Inlay – Metallic (3 or more surfaces)	50%	\$463	40%
Oral Surgery			
Removal of impacted tooth – partially bony	50%	\$175	40%
Endodontic Services			
Bicuspid root canal therapy	80%	\$195	40%
Molar root canal therapy	50%	\$435	40%
Periodontic Services			
Scaling & root planing – per quadrant	80%	\$65	40%
Osseous surgery – per quadrant	50%	\$445	40%
ORTHODONTIC SERVICES**			
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service, including Orthodontic Services. Does not apply to the DMO in Plan Options 1, 2, 6 & 7, and the Aetna Dental Preventive Care in Option 8.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

[†]Orthodontic coverage is only available to groups with 10 or more eligibles and for dependent children only.

[†]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Plan Options 2, 6 & 7.

Plan Options 2, 3, 4, 8 & 9: PPO Max Non-Preferred (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.

Fixed dollar amounts on the DMO in Plan Options 1, 2, 6 & 7 are the member's responsibility.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Option 5 to the prevailing fees at the 90th percentile.

Access to negotiated discounts: On the PPO plans in Plan Options 2-5, 8 & 9, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1 & 2. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Options 3 & 9.

The DMO in Plan Options 1, 6 & 7 can be offered with any one of the PPO plans in Plan Options 3-5 & 9 in a Dual Option package.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access Network. This network provides access to providers who participate in the Aetna Dental Access Network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply in situations where the Dentist participates in both the Aetna Dental Access Network and the Aetna DMO Network. DMO benefits take precedence over all other discounts, including discounts through the Aetna Dental Access Network.

The list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 48.

DMO/PPO DENTAL PLANS				
Available with an Aetna Medical Plan to Groups with 2 – 99 Eligible Employees Available without an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees	Option 3	Option 4	Option 5 (90th)	Option 6
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Plan 100/80/50	DMO Plan 41
Office Visit Copay	N/A	N/A	N/A	\$10
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum	None
Annual Maximum Benefit	\$1,500	\$1,000	\$1,500	Unlimited
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	No Charge
Comprehensive oral exam	100%	100%	100%	No Charge
Problem-focused oral exam	100%	100%	100%	No Charge
X-rays				
Bitewing – single film	100%	100%	100%	No Charge
Complete series	100%	100%	100%	No Charge
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	No Charge
Child Cleaning	100%	100%	100%	No Charge
Sealants – per tooth	100%	100%	100%	\$10
Fluoride application – with cleaning	100%	100%	100%	No Charge
Space maintainers	100%	100%	100%	No Charge
BASIC SERVICES				
Amalgam filling – 2 surfaces	80%	80%	80%	\$32
Resin filling – 2 surfaces, anterior	80%	80%	80%	\$55
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	\$30
Extraction of impacted tooth – soft tissue	80%	80%	80%	\$80
MAJOR SERVICES*				
Complete upper denture	50%	50%	50%	\$500
Partial upper denture (resin base)	50%	50%	50%	\$513
Crown – Porcelain with noble metal[†]	50%	50%	50%	\$488
Pontic – Porcelain with noble metal[†]	50%	50%	50%	\$488
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	\$463
Oral Surgery				
Removal of impacted tooth – partially bony	80%	50%	50%	\$175
Endodontic Services				
Bicuspid root canal therapy	80%	50%	50%	\$195
Molar root canal therapy	80%	50%	50%	\$435
Periodontic Services				
Scaling & root planing – per quadrant	80%	50%	50%	\$65
Osseous surgery – per quadrant	80%	50%	50%	\$445
ORTHODONTIC SERVICES*				
Orthodontic Lifetime Maximum	Does not apply	Does not apply	\$1,000	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1, 2, 6 & 7, and the Aetna Dental Preventive Care in Option 8.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

[†]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Plan Options 2, 6 & 7.

Access to negotiated discounts: On the PPO plans in Plan Options 2-5 and 8 & 9, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1 & 2. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Options 3 & 9.

Plan Options 2, 3, 4, 8 & 9: PPO Max Non-Preferred (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.

Fixed dollar amounts on the DMO in Plan Options 1, 2, 6 & 7 are the member's responsibility.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 5 to the prevailing fees at the 90th percentile.

The DMO in Plan Option 1, 6 & 7 can be offered with any one of the PPO plans in Plan Options 3-5 & 9 in a Dual Option package.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access Network. This network provides access to providers who participate in the Aetna Dental Access Network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the Dentist participates in both the Aetna Dental Access Network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 48.

DMO/PPO DENTAL PLANS			
Available with an Aetna Medical Plan to Groups with 2 – 99 Eligible Employees Available without an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees	Option 7	Option 8 (Aetna Dental Preventive CareSM)	Option 9
	DMO Plan 42 (DMO Access)	PPO Max 100/0/0	PPO Max Plan 100/80/50
Office Visit Copay	\$10	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	\$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	\$2,000
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	No Charge	100%	100%
Comprehensive oral exam	No Charge	100%	100%
Problem-focused oral exam	No Charge	100%	100%
X-rays			
Bitewing – single film	No Charge	100%	100%
Complete series	No Charge	100%	100%
PREVENTIVE SERVICES			
Adult Cleaning	No Charge	100%	100%
Child Cleaning	No Charge	100%	100%
Sealants – per tooth	\$10	100%	100%
Fluoride application – with cleaning	No Charge	100%	100%
Space maintainers	No Charge	100%	100%
BASIC SERVICES			
Amalgam filling – 2 surfaces	\$32	Discounted Fee	80%
Resin filling – 2 surfaces, anterior	\$55	Discounted Fee	80%
Oral Surgery			
Extraction – exposed root or erupted tooth	\$30	Discounted Fee	80%
Extraction of impacted tooth - soft tissue	\$80	Discounted Fee	80%
MAJOR SERVICES*			
Complete upper denture	\$500	Discounted Fee	50%
Partial upper denture (resin base)	\$513	Discounted Fee	50%
Crown – Porcelain with noble metal¹	\$488	Discounted Fee	50%
Pontic – Porcelain with noble metal¹	\$488	Discounted Fee	50%
Inlay – Metallic (3 or more surfaces)	\$463	Discounted Fee	50%
Oral Surgery			
Removal of impacted tooth – partially bony	\$175**	Discounted Fee	80%
Endodontic Services			
Bicuspid root canal therapy	\$195	Discounted Fee	80%
Molar root canal therapy	\$435**	Discounted Fee	80%
Periodontic Services			
Scaling & root planing – per quadrant	\$65	Discounted Fee	80%
Osseous surgery – per quadrant	\$445**	Discounted Fee	80%
ORTHODONTIC SERVICES*			
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1, 2, 6 & 7, and the Aetna Dental Preventive Care in Option 8.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

¹There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Plan Options 2, 6 & 7.

Access to negotiated discounts: On the PPO plans in Plan Options 2-5 and 8 & 9, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1 & 2. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Options 3 & 9.

Plan Options 2, 3, 4, 8 & 9: PPO Max Non-Preferred (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.

Fixed dollar amounts on the DMO in Plan Options 1, 2, 6 & 7 are the member's responsibility.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 5 to the prevailing fees at the 90th percentile.

The DMO in Plan Option 1, 6 & 7 can be offered with any one of the PPO plans in Plan Options 3-5 & 9 in a Dual Option package.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access Network. This network provides access to providers who participate in the Aetna Dental Access Network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the Dentist participates in both the Aetna Dental Access Network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 48.

VOLUNTARY DENTAL PLANS				
Available with an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees Available without an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees	Voluntary Option 1 DMO	Voluntary Option 2 Freedom-of-Choice Monthly selection between the DMO and the PPO Max		Voluntary Option 3 PPO Max
	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/40	PPO Max Plan 100/80/50
Office Visit Copay	\$10	\$10	N/A	\$10
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	\$50; 3X Family Maximum	\$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	\$1,000	\$1,500
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
BASIC SERVICES				
Amalgam filling – 2 surfaces	80%	90%	70%	80%
Resin filling – 2 surfaces, anterior	80%	90%	70%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	90%	70%	80%
Extraction of impacted tooth – soft tissue	80%	90%	70%	80%
MAJOR SERVICES*				
Complete upper denture	50%	60%	40%	50%
Partial upper denture (resin base)	50%	60%	40%	50%
Crown – Porcelain with noble metal¹	50%	60%	40%	50%
Pontic – Porcelain with noble metal¹	50%	60%	40%	50%
Inlay – Metallic (3 or more surfaces)	50%	60%	40%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	60%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	80%	90%	40%	50%
Molar root canal therapy	50%	60%	40%	50%
Periodontic Services				
Scaling & root planing – per quadrant	80%	90%	40%	50%
Osseous surgery – per quadrant	50%	60%	40%	50%
ORTHODONTIC SERVICES*				
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary Plan Options 1, 2, 4 & 5 and on the PPO in Voluntary Plan Option 6.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

¹There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Voluntary Plan Options 4 & 5.

Access to negotiated discounts: On the PPO plans in Voluntary Plan Options 2, 3 & 6, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 1 & 2.

Fixed dollar amounts on the DMO in Voluntary Plan Options 1, 2, 4 & 5 are the member's responsibility.

Plan Options 2, 3 & 6: PPO Max Non-Preferred (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.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

Orthodontic coverage is available on the DMO in Voluntary Options 1, 2, 4 & 5 to groups with 10 or more eligibles and for dependent children only.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access Network. This network provides access to providers who participate in the Aetna Dental Access Network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the Dentist participates in both the Aetna Dental Access Network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 48.

VOLUNTARY DENTAL PLANS			
Available with an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees Available without an Aetna Medical Plan to Groups with 3 – 99 Eligible Employees	Voluntary Option 4	Voluntary Option 5	Voluntary Option 6 (Aetna Dental Preventive Care)
	DMO Plan 41	DMO Plan 42 (DMO Access)	PPO Max 100/0/0
Office Visit Copay	\$15	\$15	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	None
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	No Charge	No Charge	100%
Comprehensive oral exam	No Charge	No Charge	100%
Problem-focused oral exam	No Charge	No Charge	100%
X-rays			
Bitewing – single film	No Charge	No Charge	100%
Complete series	No Charge	No Charge	100%
PREVENTIVE SERVICES			
Adult Cleaning	No Charge	No Charge	100%
Child Cleaning	No Charge	No Charge	100%
Sealants – per tooth	\$10	\$10	100%
Fluoride application – with cleaning	No Charge	No Charge	100%
Space maintainers	No Charge	No Charge	100%
BASIC SERVICES			
Amalgam filling – 2 surfaces	\$32	\$32	Discounted Fee
Resin filling – 2 surfaces, anterior	\$55	\$55	Discounted Fee
Oral Surgery			
Extraction – exposed root or erupted tooth	\$30	\$30	Discounted Fee
Extraction of impacted tooth – soft tissue	\$80	\$80	Discounted Fee
MAJOR SERVICES*			
Complete upper denture	\$500	\$500	Discounted Fee
Partial upper denture (resin base)	\$513	\$513	Discounted Fee
Crown – Porcelain with noble metal[†]	\$488	\$488	Discounted Fee
Pontic – Porcelain with noble metal[†]	\$488	\$488	Discounted Fee
Inlay – Metallic (3 or more surfaces)	\$463	\$463	Discounted Fee
Oral Surgery			
Removal of impacted tooth – partially bony	\$175	\$175**	Discounted Fee
Endodontic Services			
Bicuspid root canal therapy	\$195	\$195	Discounted Fee
Molar root canal therapy	\$435	\$435**	Discounted Fee
Periodontic Services			
Scaling & root planing – per quadrant	\$65	\$65	Discounted Fee
Osseous surgery – per quadrant	\$445	\$445**	Discounted Fee
ORTHODONTIC SERVICES*	\$2,400 copay	Not Covered	Discounted Fee
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary Plan Options 1, 2, 4 & 5 and on the PPO in Voluntary Plan Option 6.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

[†]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Plan Options 4 & 5.

Access to negotiated discounts: On the PPO plans in Voluntary Plan Options 2, 3 & 6, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 1, 2.

Fixed dollar amounts on the DMO in Plan Options 1, 2, 4 & 5 are the member's responsibility.

Plan Options 2, 3, 6 & Out-of-State: PPO Max Non-Preferred (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.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

Orthodontic coverage is available on the DMO in Voluntary Options 1, 2, 4 & 5 to groups with 10 or more eligibles and for dependent children only.

DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access Network. This network provides access to providers who participate in the Aetna Dental Access Network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the Dentist participates in both the Aetna Dental Access Network and the Aetna DMO network, DMO benefits take precedence over all other discounts including discounts through the Aetna Dental Access network.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 48.

OUT-OF-STATE DENTAL PLANS				
	PPO 1000	PPO 1500	PPO 2000	Voluntary OOS Option
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$75; 3X Family Maximum
Annual Maximum Benefit	\$1,000	\$1,500	\$2,000	\$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
BASIC SERVICES				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
MAJOR SERVICES*				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – Porcelain with noble metal	50%	50%	50%	50%
Pontic – Porcelain with noble metal	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing – per quadrant	50%	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%	50%
ORTHODONTIC SERVICES*				
Orthodontic Lifetime Maximum	\$1,000	\$1,000	\$1,000	\$1,000

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.

**Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

PPO Max Non-Preferred (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. Access to negotiated discounts: on the PPO plans, members are eligible to receive noncovered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Voluntary OOS Option: If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.

Out-of-State PPO Dental is for out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont and Wyoming. Out-of-state employees in these states will receive the Indemnity Dental Plan. The list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate.

For a summary list of Limitations and Exclusions, refer to page 48.

For groups with 51-99 eligible employees, consult your Aetna Representative.

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

Aetna Life Insurance Company (Aetna) Small Group packaged life and disability insurance plans include a range of flat-dollar insurance options bundled together in one monthly per-employee rate. These products are easy to understand and offer affordable benefits to help your employees protect their families in the event of illness, injury or death. You'll benefit from streamlined plan installation, administration and claims processing, and all of the benefits of our standalone life and disability products for small groups. Or, simply choose from our portfolio of group basic term life and disability insurance plans.

LIFE INSURANCE

We know that life insurance is an important part of the benefits package you offer your employees. That's why our products and programs are designed to meet your needs for:

- Flexibility
- Added value
- Cost-efficiency
- Experienced support

We help you give employees what they're looking for in lifestyle protection, through our selected group life insurance options. And we look beyond the benefit payout to include useful enhancements through the *Aetna Life EssentialsSM* program.

So what's the bottom line? A portfolio of value-packed products and programs to attract and retain workers — while making the most of the benefit dollars you spend.

Giving you (and your employees) what you want

Employees are looking for cost-efficient plan features and value-added programs that help them make better decisions for themselves and their dependents.

Our life insurance plans come with a variety of features including:

Accelerated death benefit — Also called the "living benefit," the accelerated death benefit provides payment to terminally ill employees or spouses. This payment can be up to 75 percent of the life insurance benefit.

Premium waiver provision — Employee coverage may stay in effect up to age 65 without premium payments if an employee becomes permanently and totally disabled while insured due to an illness or injury prior to age 60.

Optional dependent life — This feature allows employees to add optional additional coverage for eligible spouses and children for employers with 10 or more employees. This employee-paid benefit enables employees to cover their spouses and dependent children.

Our fresh approach to life

With *Aetna Life Essentials*, your employees have access to programs during their active lives to help promote healthy, fulfilling lifestyles. In addition, Aetna Life Essentials provides for critical caring and support resources for often-overlooked needs during the end of one's life. And we also include value for beneficiaries and their loved ones well beyond the financial support from a death benefit.

AD&D ULTRA®

AD&D Ultra is standardly included with our small group life and disability package and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. It includes extra, no-cost features, such as coverage for education or child-care expenses that make this protection even more valuable.

Benefits include:

- Death
- Dismemberment
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Third Degree Burns
- Paralysis
- Exposure and Disappearance
- Passenger Restraint and Airbag
- Education Benefit for Dependent Child and/or Spouse
- Child Care Benefit
- Coma Benefit
- Repatriation of Remains Benefit
- Total Disability Benefit

DISABILITY INSURANCE

Finding disability services for you and your employees isn't difficult. Many companies offer them. The challenge is finding the right plan ... one that will meet the distinct needs of your business. Aetna understands this.

Our comprehensive approach to disability helps give us a clear understanding of what you and your employees need ... and then helps meet those needs. You'll get the right resources, the right support and the right care for your employees at the right time:

- Our clinically based disability model ensures claims and duration guidelines are fact-based with objective benchmarks.
- We offer a holistic approach that takes the whole person into account.
- We give you 24-hour access to claim information.
- We provide return-to-work programs to help ensure employees are back to work as soon as it's medically safe to do so.
- We employ vocational rehabilitation and ergonomic specialists who can help restore employees back to health and productive employment.

INTEGRATED HEALTH AND DISABILITY

With our Integrated Health and Disability program, we can link medical and disability data to help anticipate concerns, take action and get your employees back to work sooner:

- Predictive modeling identifies medical members most likely to experience a disability, potentially preventing a disability from occurring or minimizing the impact for better outcomes.
- HIPAA-compliant so medical and disability staff can share clinical information and work jointly with the employee to help address medical and disability issues.
- Referrals between health case managers and their disability counterparts help ensure better consistency and integration.
- The Integrated Health and Disability program is available at no additional cost when a member has both medical and disability coverage from Aetna.

For a summary list of Limitations and Exclusions, refer to page 47.

TERM LIFE PLAN OPTIONS		
	2 – 9 Employees	10 – 50 Employees
Basic Life Schedule	Flat \$10,000, \$15,000, \$20,000, \$50,000	Flat \$10,000, \$15,000, \$20,000, \$50,000, \$75,000, \$100,000, \$125,000
Class Schedules	Not Available	Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class
Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60
Age Reduction Schedule	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Guaranteed Issue	\$50,000	10-25 employees \$75,000 26-50 employees \$100,000
Participation Requirements	100%	100% on non-contributory plans 75% on contributory plans
Contribution Requirements	100% Employer Contribution	Minimum 50% Employer Contribution
AD&D ULTRA®		
AD&D Schedule	Matches Life Benefit	Matches Life Benefit
Additional Features	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	\$5,000
Child Amount	Not Available	\$2,000

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees

Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees

Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees

DISABILITY PLAN OPTIONS		
SHORT TERM BENEFITS	Plan Option 1	Plan Option 2
Plan Amount	Choice of flat \$100 increments to a maximum of \$500 weekly	Choice of flat \$100 increments to a maximum of \$500 weekly
Benefits Start -- Accident	1 day	8 days
Benefits Start -- Illness	8 days	8 days
Maximum Benefit Period	26 weeks	26 weeks
Maternity Benefit	Maternity treated same as any other disability but is subject to pre-existing . If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.	Maternity treated same as any other disability but is subject to pre-existing . If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.
Pre-Existing Conditions Rule	3/12	3/12
Actively at Work Rule	Applies	Applies
Other Income Offset Integration	N/A	N/A
Definition of Disability	Earnings Loss of 20% or more	Earnings Loss of 20% or more
Class Schedules	Up to 3 classes (with a minimum requirement of 3 employees in each class) available for groups of 10 or more employees	Up to 3 classes (with a minimum requirement of 3 employees in each class) available for groups of 10 or more employees

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees

Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees

Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees
 Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees
 Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees

PACKAGED LIFE AND DISABILITY PLAN OPTIONS *					
BASIC LIFE PLAN DESIGN	Low Option	Low Option 2	Medium Option	Medium Option 2	High Option
Benefit	Flat \$10,000	Flat \$15,000	Flat \$20,000	Flat \$25,000	Flat \$50,000
Guaranteed Issue 2-9 Lives 10-50 Lives	\$10,000 \$10,000	\$15,000 \$15,000	\$20,000 \$20,000	\$20,000 \$25,000	\$20,000 \$50,000
Reduction Schedule	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75
Disability Provision	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60
Conversion	Included	Included	Included	Included	Included
Accelerated Death Benefit	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration
Dependent Life	Spouse \$5,000; Child \$2,000	Spouse \$5,000; Child \$2,000	Spouse \$5,000; Child \$2,000	Spouse \$5,000; Child \$2,000	Spouse \$5,000; Child \$2,000
AD&D ULTRA®					
AD&D Ultra®	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit
AD&D Ultra Additional Features®	Seat Belt/Airbag, Education, Child care, Repatriation, Coma, Total Disability, 365-Day Covered Loss				
Disability Plan Design					
Monthly Benefit	Flat \$500; No offsets	Flat \$1,000; Offsets are Workers' Compensation, any State Disability Plan and Primary and Family Social Security benefits			
Elimination Period	30 days	30 days	30 days	30 days	30 days
Definition of Disability	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	First 24 months of benefits: Own occupation: Earnings Loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss
Benefit Duration	24 months	24 months	24 months	24 months	60 months
Pre-Existing Condition Limitation	3/12	3/12	3/12	3/12	3/12
Types of Disability	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational
Separate Periods of Disability	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter
Mental Health / Substance Abuse	24 months	24 months	24 months	24 months	24 months
Waiver of Premium	Included	Included	Included	Included	Included
OTHER PLAN PROVISIONS					
Employer Contribution	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid
Minimum Participation	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%
Eligibility	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees
Class Schedules	2-9 Lives: Not Available; 10-50 Lives: Up to 3 classes (with a minimum requirement of 3 employees in each class) – the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class even if only two classes are offered				
Rate Guarantee	1 year	1 year	1 year	1 year	1 year
Rates PEPM	\$8.00	\$10.00	\$15.00	\$16.00	\$27.00

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.
 *Ineligible industries, please refer to page 41.

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

ARIZONA UNDERWRITING GUIDELINES

This is meant to be informative and is not intended to be all-inclusive. Other policies and guidelines may apply for groups of 51-99. This material is intended for brokers and agents and is for informational purposes only. It is not intended to be all inclusive. Other policies and guidelines may apply.

Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of the Regional Underwriting Manager. This information is the property of Aetna and its affiliates ("Aetna"), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing.

<p>Affiliated, Associated or Multiple Companies</p>	<p>Employers who have more than one business with different Tax Identification Numbers (TINs) may be eligible to enroll as one group if the following are met:</p> <ul style="list-style-type: none"> ▪ One owner has controlling interest of all business to be included; or ▪ The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and ▪ All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only 2 of the 3 businesses to be enrolled, the group will be considered a carve out, will not be Guarantee Issue, and could be declined. ▪ The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined must have the minimum number of employees required by the state. ▪ There are 50 or fewer employees in the combined employer groups. ▪ Only businesses with like or common SIC codes may be written as one group. ▪ A completed Common Ownership form is submitted. ▪ Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups. ▪ Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception. <p>Example: One owner has controlling interest of all companies to be included: Company 1 – Jim owns 75% and Jack owns 25% Company 2 – Jim owns 55% and Jack owns 45% Both companies can be written as one group since Jim has controlling interest in both.</p>
<p>Benefit Waiting Period</p>	<ul style="list-style-type: none"> ▪ Benefit waiting periods must be consistently applied to all employees, including newly hired key employees. ▪ The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days. If the employer currently has a different waiting period the employer may indicate this on the employer application. Please note that any benefit waiting period over 180 days requires underwriting manager approval. ▪ The eligibility date will be the first day of the policy month following the waiting period. <p>Example: Group A – effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period. Group B – effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period.</p> <ul style="list-style-type: none"> ▪ Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer. ▪ At initial submission of the group the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application and consistently applied to all employees. ▪ Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date. ▪ No retroactive benefit waiting period changes will be allowed.

Carve Out	<ul style="list-style-type: none"> ▪ Employers may choose to carve out employees to whom they wish to offer coverage based upon the employer's ability to state employee eligibility. ▪ Groups with over 50 eligible employees that wish to carve out a class of employees will not be considered Guarantee Issue and may be declined coverage. ▪ All class of employees must be put into writing on the Employer Application for underwriting review.
Case Submission Dates	<ul style="list-style-type: none"> ▪ Groups with 2 to 99 eligible employees must have all completed paperwork into Aetna Underwriting no later than the end of business day of the requested effective date. ▪ If not received by this date, the effective date will be moved to the next available effective date.
Census Data	<ul style="list-style-type: none"> ▪ Census data must be provided for all eligible employees, including ENROLLED, WAIVERS, and COBRA eligible employees. ▪ Include the name, date of birth, date of hire, gender, dependent status, and residence zip code (when multi-site/multi-state). ▪ Retirees – See Employee Eligibility section. ▪ COBRA eligible employees should be included on the census and noted as COBRA.
Deductible Credit	<ul style="list-style-type: none"> ▪ Employees who are eligible and want to receive credit for deductible paid to prior Company should submit a copy of the Explanation of Benefits to Aetna. They may do this at either the initial small group submission or with their first claim.
Definition of a Small Group Employer	<p>“Small employer” means either of the following:</p> <ul style="list-style-type: none"> ▪ An employer who employs at least 2 but no more than 50 eligible employees on a typical business day during any one calendar year. <p>Newly formed businesses that have been in business for at least 6 weeks may be considered if the following are provided:</p> <ul style="list-style-type: none"> ▪ Sole Proprietor: A copy of the Business License (not a professional license). ▪ Partnership or Limited Liability Partnership: A copy of the Partnership agreement. ▪ Limited Liability Company: A copy of the Articles of Organization and the Operating Agreement to include the signature page(s) of all officers. ▪ Corporation: A copy of the Articles of Incorporation to include the signature page(s) of all officers (must be followed up with a copy of the Statement of Information within 30 days of filing with the State) <p>Each Newly formed business must also provide:</p> <ul style="list-style-type: none"> ▪ Proof of Employer Identification Number/Federal Tax I.D. Number (SS# if Sole Proprietorship); and ▪ A copy of the UC018/UC020 (Quarterly Wage and Tax Statement); If not available, must provide the most recent two consecutive weeks worth of payroll records which includes, for every eligible employee enrolling, hours worked, taxes withheld, check number, and wages earned; <i>or</i> ▪ A letter from a CPA with the following information: <ul style="list-style-type: none"> – A list of all employees, to include owners, partners, officers (full time and part time) – Number of hours worked by each employee – Weekly salary for each employee – Date of hire for each employee – Have payroll records been established? – Will a Quarterly Wage and Tax Statement UC018/UC020 be filed? If so, when?

<p>Dental</p>	<p>Open enrollments are prohibited.</p> <p>Coverage Waiting Period</p> <ul style="list-style-type: none"> For Major and Orthodontic services, employees must be enrolled members of the plan for one year (not applicable to DMO). Waiting Period is waived separately for Major and Orthodontic for employees who were covered by the group's immediately preceding dental plan. <ul style="list-style-type: none"> To waive the Waiting Period for Major services, the group's immediately preceding group plan must have covered Major Services. To waive the Waiting Period for Orthodontic services, the group's immediately preceding group plan must have covered Orthodontic services. <p>Example: Prior Major coverage but no Orthodontic coverage. New plan has both Major and Orthodontic coverage. The Waiting Period is waived for Major services but not for Orthodontic services.</p> <p>Product Packaging</p> <ul style="list-style-type: none"> DMO can be either sold standalone or packaged with any PPO Option as a Dual Option. PPO can be sold standalone or packaged with the DMO as a Dual Option. Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold. Voluntary Dental plans cannot be sold or packaged with any other plan as Dual Option offering. <p>Reinstatement</p> <p>For Voluntary Dental Plan Options: Members who were once enrolled then terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules apply from the new effective date including, but not limited to, the Coverage Waiting Period.</p> <p>Ineligible Industries</p> <p>Applies when Dental is sold standalone or packaged only with Group insurance. This list does not apply if sold in combination with the Medical.</p> <table border="1" data-bbox="329 804 1175 1339"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr> <td>0761-0783</td> <td>Seasonal Employees</td> <td>7631</td> <td>Watch, Clock & Jewelry Repair</td> </tr> <tr> <td>3911-3915</td> <td>Jewelry Manufacturing</td> <td>7692-7699</td> <td>Miscellaneous Repair</td> </tr> <tr> <td>4111-4121</td> <td>Passenger Transportation</td> <td>7800-7999</td> <td>Amusement, Recreation, and Entertainment</td> </tr> <tr> <td>5271</td> <td>Mobile Home Dealers</td> <td>8000-8059</td> <td>Medical Groups</td> </tr> <tr> <td>5511-5599</td> <td>Auto Dealerships</td> <td>8071-8099</td> <td>Medical Groups</td> </tr> <tr> <td>5800-5899</td> <td>Restaurants</td> <td>8100-8199</td> <td>Legal</td> </tr> <tr> <td>6500-6799</td> <td>Real Estate</td> <td>8211-8299</td> <td>Schools, Libraries, Education</td> </tr> <tr> <td>7000-7099</td> <td>Hotels</td> <td>8300-8399</td> <td>Social Service</td> </tr> <tr> <td>7221</td> <td>Photo Studios</td> <td>8400-8499</td> <td>Museums, Art Galleries,</td> </tr> <tr> <td>7231-7241</td> <td>Beauty & Barber Shops</td> <td>8600-8699</td> <td>Botanical Gardens</td> </tr> <tr> <td>7251-7299</td> <td>Repairs, Cleaning, Personal Services</td> <td>8700-8799</td> <td>Associations & Trusts</td> </tr> <tr> <td>7319</td> <td>Advertising, Misc.</td> <td>8800-8899</td> <td>Engineering & Management Services</td> </tr> <tr> <td>7331-7338</td> <td>Direct Mailing, Secretarial Services</td> <td>8999</td> <td>Service – Private Households</td> </tr> <tr> <td>7361-7363</td> <td>Employment Agencies</td> <td>9721</td> <td>Miscellaneous Services</td> </tr> <tr> <td>7379</td> <td>Miscellaneous Computer Services</td> <td></td> <td>International Affairs</td> </tr> <tr> <td>7381-7382</td> <td>Security Systems, Armored Cars</td> <td></td> <td></td> </tr> <tr> <td>7384</td> <td>Photofinishing Labs</td> <td></td> <td></td> </tr> <tr> <td>7389</td> <td>Miscellaneous Business Services</td> <td></td> <td></td> </tr> </tbody> </table>	SIC Range	SIC Description	SIC Range	SIC Description	0761-0783	Seasonal Employees	7631	Watch, Clock & Jewelry Repair	3911-3915	Jewelry Manufacturing	7692-7699	Miscellaneous Repair	4111-4121	Passenger Transportation	7800-7999	Amusement, Recreation, and Entertainment	5271	Mobile Home Dealers	8000-8059	Medical Groups	5511-5599	Auto Dealerships	8071-8099	Medical Groups	5800-5899	Restaurants	8100-8199	Legal	6500-6799	Real Estate	8211-8299	Schools, Libraries, Education	7000-7099	Hotels	8300-8399	Social Service	7221	Photo Studios	8400-8499	Museums, Art Galleries,	7231-7241	Beauty & Barber Shops	8600-8699	Botanical Gardens	7251-7299	Repairs, Cleaning, Personal Services	8700-8799	Associations & Trusts	7319	Advertising, Misc.	8800-8899	Engineering & Management Services	7331-7338	Direct Mailing, Secretarial Services	8999	Service – Private Households	7361-7363	Employment Agencies	9721	Miscellaneous Services	7379	Miscellaneous Computer Services		International Affairs	7381-7382	Security Systems, Armored Cars			7384	Photofinishing Labs			7389	Miscellaneous Business Services		
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7221	Photo Studios	8400-8499	Museums, Art Galleries,																																																																										
7231-7241	Beauty & Barber Shops	8600-8699	Botanical Gardens																																																																										
7251-7299	Repairs, Cleaning, Personal Services	8700-8799	Associations & Trusts																																																																										
7319	Advertising, Misc.	8800-8899	Engineering & Management Services																																																																										
7331-7338	Direct Mailing, Secretarial Services	8999	Service – Private Households																																																																										
7361-7363	Employment Agencies	9721	Miscellaneous Services																																																																										
7379	Miscellaneous Computer Services		International Affairs																																																																										
7381-7382	Security Systems, Armored Cars																																																																												
7384	Photofinishing Labs																																																																												
7389	Miscellaneous Business Services																																																																												
<p>Dependent Eligibility</p>	<ul style="list-style-type: none"> Eligible dependents include an employee's spouse/domestic partner, unmarried children up to the limiting age of the plan. The limiting age for Medical and Dental is standard to age 19, to age 25 for full time students who are financially dependent upon the parent; or An unmarried child of any age who is medically certified as a dependent upon the parent, who the parent claimed as a dependent on the form for income tax returns which he/she filed with the Internal Revenue Service for the previous fiscal year. Attainment of limiting age will not terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance. Proof of incapacity and dependency shall be furnished to Aetna by the employee or the member within 31 days of the child's attainment of the limiting age and subsequently as may be required by Aetna, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Domestic Partners can be considered eligible dependents; however, the employer must choose to cover domestic partners at initial underwriting of the group. If not done at time of enrollment, approval of future request to add coverage for Domestic Partners will be postponed until the group's next anniversary date. An Affidavit of Domestic Partnership will be required. If both husband and wife work for the same company they may enroll together or separately. Children can only be covered under one parent's plan. For Medical and Dental dependents must enroll in the same benefits as the employee (participation not required). For Dependent life dependents are eligible from 14 days to age 19, or to age 23 if in school. Dependents are not eligible for AD&D. Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan. 																																																																												

Effective Date	<ul style="list-style-type: none"> ▪ The effective date must be the 1st or the 15th of the month. ▪ The effective date requested by the employer may be up to 60 days in advance. ▪ When replacing an employer-sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period. <ul style="list-style-type: none"> – For example, if the other plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.
Employee Eligibility	<p>Unless otherwise specified by the employer, Aetna will use this industry standard Employee Eligibility Criteria definition:</p> <ul style="list-style-type: none"> ▪ An employee who works for a small employer on a full time basis with a normal work week of 30 hours or more ▪ Union employees, even if currently covered under the union plan. ▪ Partners, Proprietors. <p>Eligible employees will NOT include:</p> <ul style="list-style-type: none"> ▪ Temporary or substitute employees. ▪ Part-time employees <p>Retirees</p> <ul style="list-style-type: none"> ▪ Coverage is available for Medicare-eligible retirees and/or active Medicare-eligible in accordance with the Medicare-Retiree Underwriting Guidelines. <p>COBRA Continuees</p> <ul style="list-style-type: none"> ▪ COBRA eligible employees are required to be included on the census (not eligible for Life or Disability). ▪ COBRA qualifying event, length, start and end date must be provided. ▪ Health questions must be answered for groups that use the long form medical questionnaire for 2 to 25 enrolled. <p>If the employer's Employee Eligibility Criteria definition differs from the above definition, the employer's actual definition must be provided in writing on the Employer Application at time of new business sold case underwriting.</p> <p><i>Note: Employees reported on the IRS 1099 forms and COBRA continuees are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, 1099 employees and COBRA continuees can be included for coverage subject to normal underwriting guidelines.</i></p>
Employer Contribution	<p>Single Choice Medical</p> <ul style="list-style-type: none"> ▪ The employer must contribute at least 50% of the employee rate. ▪ Coverage may be denied based upon inadequate contributions. <p>Pick-A-Plan 3 (Medical)</p> <ul style="list-style-type: none"> ▪ The employer must contribute 50% of the employee only rate of whichever plan the employee selects. ▪ The employer may choose to offer a Defined Contribution of at least \$120 or the actual cost of the plan chosen whichever is less. ▪ Coverage may be denied based upon inadequate contributions. <p>ValuePick (Medical)</p> <ul style="list-style-type: none"> ▪ The employer must contribute 25% of the employee only rate of whichever plan the employee selects. ▪ The employer may choose to offer a Defined Contribution of at least 50% or the actual cost of the plan chosen whichever is less. ▪ Coverage may be denied based upon inadequate contributions, <p>Dental</p> <ul style="list-style-type: none"> ▪ The employer must contribute at least 50% of the employee-only cost or 25% of the total plan. ▪ For Voluntary Dental plans: Employer contribution of less than 50% of the cost of the employee only coverage. ▪ For Voluntary Dental plans, employee pay all plans are permitted. ▪ Pick-A-Plan is not available. ▪ ValuePick is not available. ▪ Coverage may be denied based upon inadequate contributions. <p>Term Life – Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan. ▪ Employers with 10 – 50 eligible lives: Employer must contribute at least 50% of the cost of the plan (excluding Optional Dependent Life). ▪ Pick-A-Plan is not available. ▪ ValuePick is not available. ▪ Coverage may be denied based upon inadequate contributions. <p>Disability</p> <ul style="list-style-type: none"> ▪ Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan. ▪ Employers with 10 – 50 eligible lives: Employer must contribute at least 50% of the cost of the plan. ▪ Pick-A-Plan is not available. ▪ ValuePick is not available. ▪ Coverage may be denied based upon inadequate contributions.

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Employer Eligibility	<ul style="list-style-type: none"> ▪ All Aetna plans can be offered to sole proprietors, partnerships or corporations. ▪ Employers (Companies/Organizations) must not be formed solely for the purpose of obtaining health coverage. ▪ Non Guaranteed Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employee/employer relationship exists are not eligible for Small Group coverage. ▪ Dental and Life products have ineligible industries which are listed separately under Product Specifications. The Dental and Life ineligible industry list does not apply when dental or life is sold in combination with medical.
Employers leaving an Aetna PEO	<ul style="list-style-type: none"> ▪ Employers leaving a PEO that is currently insured with Aetna do not need to complete the Aetna PEO form. A statement signed by the employer will be sufficient.
Employer - Mid Policy Benefit Changes	<ul style="list-style-type: none"> ▪ In addition to a plan change at renewal an upgrade in benefits may be requested once in a 12-month period. ▪ A request to downgrade in benefits may be requested twice in a 12-month period. ▪ Upgrades are subject to underwriting review. ▪ Benefit changes are not allowed during the 4 months preceding the group's renewal date. ▪ High-deductible health plans (HDHP) – The 4 month limitation may be waived if the group requests to add one of the high-deductible health plans and is subject to underwriting approval. ▪ The requests for changes must be submitted to Aetna Small Group Underwriting 30 days prior to the requested effective date. ▪ Late requests will be moved to the next applicable effective date pending underwriting approval.
Employers Replacing Other Group Coverage	<ul style="list-style-type: none"> ▪ A copy of the most recent billing statement that includes the employee listing must be submitted. ▪ The employer should be told not to cancel any existing medical coverage until they have been notified of approval from the Aetna Underwriting unit.
Initial Premium Check	<ul style="list-style-type: none"> ▪ The initial premium check should be in the amount of the first month's premium and drawn on a company check. ▪ The initial premium check is not a binder check. Final premium will be determined upon underwriting review. ▪ If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contribution requirements not met, the premium will be returned to the employer.
Late Entrants	<ul style="list-style-type: none"> ▪ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. ▪ Applicants without a qualifying life event (i.e. marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below. ▪ Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added. <p>Medical</p> <ul style="list-style-type: none"> ▪ Late applicants without a qualifying event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll. <p>Dental</p> <ul style="list-style-type: none"> ▪ An employee or dependent may enroll at any time; however, coverage is limited to Preventive and Diagnostic Services for the first 12 months. ▪ No coverage for most Basic and Major Services for the first 12 months (24 months for Orthodontics). ▪ Late entrant provision does not apply to enrollees less than age 5. <p>Life</p> <ul style="list-style-type: none"> ▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. ▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI). ▪ Life late enrollee example: Group has \$75,000 life with \$50,000 guarantee issue limit. Late enrollee enrolling for \$75,000 would not automatically get the \$50,000. Since the applicant is late they must medically qualify for the entire \$75,000.

Life – Basic Term

Open Enrollments are prohibited.

Job Classifications (Position) Schedules

Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to three separate classes are allowed (with a minimum requirement of 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows:

Position/Job Class	Basic Term Life Amount	Packaged Life/Disability
Executives	\$50,000	High Option
Managers/Supervisors	\$20,000	Medium Option
All Other Employees	\$10,000	Low Option

Guaranteed Issue Coverage

Aetna provides certain amounts of life insurance without requiring an employee to answer any medical questions. These insurance amounts are called "Guarantee Issue". Employees wishing to obtain increased insurance amounts will be required to submit Evidence of Insurability, which means they must complete a medical questionnaire and may be required to submit to a medical exam. Depending on the customer's size, life insurance amounts are Guaranteed Issue up to the maximums listed below:

Basic Term Life Amount	Life Amount within Packaged Life & Disability Offering
2 – 9 eligible lives – \$50,000	Low Option – \$10,000
10 – 25 eligible lives – \$75,000	Medium Option – \$20,000
26 – 50 eligible lives – \$100,000	High Option – \$50,000

Evidence of Insurability (EOI)

EOI is required when one or more of the following conditions exist:

- 1) Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit.
- 2) New coverage is requested during the renewal period.
- 3) Coverage is requested outside of the employer's renewal period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.)

Actively at Work

Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day.

Continuity of Coverage (No Loss/No Gain)

The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers. If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.

Ineligible Industries Life/AD&D – All industries are eligible except for stand alone for groups of 26+

SIC Range	SIC Description	SIC Range	SIC Description
1000-1499	Mining	7381	Service – Detective
2892-2899	Explosives, Bombs & Pyrotechnics	7500-7599	Auto Repair & Service
3291-3292	Asbestos Products	7800-7999	Motion Picture, Amusement, Recreation
3310-3329	Primary Metal Industries	8010-8043	Medical Doctors/Clinics
3480-3489	Fire Arms/Ammunitions	8600-8699	Membership Associations
5921	Liquor Stores	8800-8899	Service – Private Household
6211	Security Brokers	9999	Non Classified Establishment
6531	Real Estate - Agents		

Groups are ineligible for coverage if 60% or more of the eligible employees are over the age of 50.

Live/Work Guidelines

- Employees enrolled in medical or dental who reside in a Non-HMO/CPOS and/or DMO network code may enroll in an HMO/DMO product offered by their Employer if they live within a 30 miles radius of their work site that is within the HMO/DMO Service Area.
- Product availability for group benefit offerings are always determined by the zip code of the Employer.
- If the employee resides at a distance further than the 30 mile radius, exception requests should be directed to Underwriting for a feasibility determination.
- Employees who are enrolling using the Live/Work Guidelines should include their **home address and zip code** as well as the work site address and zip code. All correspondence will be mailed to the employee's home address as listed on the application.

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<p>Medical</p>	<ul style="list-style-type: none"> ▪ An Arizona small employer subject to Guarantee Issue cannot be declined based on medical conditions or claims experience; however, group rates will be adjusted for medical conditions of eligible employees and/or COBRA enrollees. This rate up will range from a 1.00 RAF to a 4.00 RAF (risk adjustment factor). ▪ All eligible employees or COBRA enrollees for groups of 2-25 eligible employees applying for Medical coverage are required to complete the individual health questionnaire section of the Employee enrollment form for groups of 2-25. Failure to do so may result in a maximum 4.00 RAF (risk adjustment factor) determination. ▪ Employers of groups with 26-99 eligible employees applying for Medical coverage are required to complete the Group Medical Questionnaire. This will apply to Medical coverage only. ▪ Eligible employees must complete the waiver section of the employee application for either the employee and/or their dependents when declining coverage. The health questionnaire does not need to be completed for those individuals who are declining Medical or Life at the Guarantee Issue amount. ▪ If the employee is requesting coverage above the Guarantee Issue amount for life they will need to complete the individual health questionnaire.
<p>Option Sales Alongside other Carriers</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Standard participation of 75% must be met in order for a group to qualify for coverage for all plans. <p>Dental</p> <ul style="list-style-type: none"> ▪ Options sales alongside another Dental carrier are not allowed. ▪ All Dental plans must be sold on a full replacement basis only. <p>Life or Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ Options sales alongside another Life or Packaged Life & Disability carrier are not allowed. ▪ All Life or Packaged Life & Disability plans must be sold on a full replacement basis only. <p>Disability</p> <ul style="list-style-type: none"> ▪ Options sales alongside another Disability carrier are not allowed. ▪ All Disability plans must be sold on a full replacement basis only.
<p>Out of Area Within Arizona</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Employees residing outside of an Arizona Aetna Network Service Area must enroll in the either the Arizona PPO or the Aetna Indemnity Plan. ▪ Aetna Indemnity plan is only available if the employee resides outside of both the Arizona Aetna PPO network service area and the Arizona Aetna HMO network service area. <p>Dental</p> <ul style="list-style-type: none"> ▪ Employees residing outside of an Arizona Aetna Network Service Area. ▪ Employees who reside within Arizona but outside of a DMO service area may be offered an In-State PPO plan. <p>Life or Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ Not Applicable <p>Disability</p> <ul style="list-style-type: none"> ▪ Not Applicable
<p>Out of State Employees</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Employees residing outside of Arizona. ▪ Employers with at least 51% of their employees residing in Arizona will be allowed to offer the in state PPO plans to employees who live outside of Arizona (based upon network availability). ▪ Out-of-state employees that live/work in an out-of-state PPO network area will receive Arizona rates and products (inclusive of any required extraterritorial benefits). ▪ Out-of-state employees that do not reside in an out-of-state PPO network area will receive the Arizona Standard Indemnity products (inclusive of any required extraterritorial benefits). ▪ Out of State employees who reside in an area with a PPO only network must enroll in the Arizona PPO plan. ▪ Out of State employees who reside in an Indemnity only network must enroll in the Arizona Indemnity plan. ▪ HMO and CPOS plans are not allowed outside of Arizona. <p>Network Availability for Out-of-State</p> <ul style="list-style-type: none"> ▪ No PPO is available in the following states: AL, ID, MN, MT, ND, NM, RI, WI, and WY. ▪ No Indemnity or PPO products are available in HI or VT. <p>Dental</p> <ul style="list-style-type: none"> ▪ Out of State employees may only be offered one of the specific Out of State Dental plans comprising of 4 PPO plan designs. ▪ Maximum out of state employee percentage (and/or number of employees) will agree with the Medical guidelines for each state. ▪ Orthodontic coverage is included for groups of 10 or more eligible employees. ▪ Orthodontic coverage is only available for dependent children. <p>Life or Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ Out of State employees are eligible for the Basic Term Life or Packaged Life & Disability plans depending on the option selected by the Employer. <p>Disability</p> <ul style="list-style-type: none"> ▪ Out of State employees are eligible for the Disability plan dependent on the option selected by the Employer.

<p>Packaged Life & Disability</p>	<p>Please see benefits in the Life – Basic Term section.</p> <p>Ineligible industries for Packaged Life & Disability</p> <table border="1" data-bbox="311 193 1156 457"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr> <td>SIC RANGE 1000-1499</td> <td>SIC DESCRIPTION Mining</td> <td>SIC RANGE 7381</td> <td>SIC DESCRIPTION Service – Detective</td> </tr> <tr> <td>2892-2899</td> <td>Explosives, Bombs & Pyrotechnics</td> <td>7500-7599</td> <td>Auto Repair & Service</td> </tr> <tr> <td>3291-3292</td> <td>Asbestos Products</td> <td>7800-7999</td> <td>Motion Picture, Amusement, Recreation</td> </tr> <tr> <td>3310-3329</td> <td>Primary Metal Industries</td> <td>8010-8043</td> <td>Medical Doctors/Clinics</td> </tr> <tr> <td>3480-3489</td> <td>Fire Arms/Ammunitions</td> <td>8600-8699</td> <td>Membership Associations</td> </tr> <tr> <td>5921</td> <td>Liquor Stores</td> <td>8800-8899</td> <td>Service – Private Household</td> </tr> <tr> <td>6211</td> <td>Security Brokers</td> <td>9999</td> <td>Non Classified Establishment</td> </tr> <tr> <td>6531</td> <td>Real Estate - Agents</td> <td></td> <td></td> </tr> </tbody> </table>	SIC Range	SIC Description	SIC Range	SIC Description	SIC RANGE 1000-1499	SIC DESCRIPTION Mining	SIC RANGE 7381	SIC DESCRIPTION Service – Detective	2892-2899	Explosives, Bombs & Pyrotechnics	7500-7599	Auto Repair & Service	3291-3292	Asbestos Products	7800-7999	Motion Picture, Amusement, Recreation	3310-3329	Primary Metal Industries	8010-8043	Medical Doctors/Clinics	3480-3489	Fire Arms/Ammunitions	8600-8699	Membership Associations	5921	Liquor Stores	8800-8899	Service – Private Household	6211	Security Brokers	9999	Non Classified Establishment	6531	Real Estate - Agents		
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<p>Participation</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ For Non Contributory plans, 100% participation is required. All employees, excluding those with coverage through another employer's plan, must enroll. ▪ Employers contributing with 2-3 eligible employees: 100% of eligible, excluding those with coverage through another employer's plan, must participate. ▪ Employers contributing with 4-50 eligible employees: 75% of eligible (rounded), excluding those with coverage through another employer's plan, must participate. ▪ Pick-A-Plan 3: 75% participation with a minimum of 5 enrolled. ▪ ValuePick: 65% participation with a minimum of 5 enrolled. ▪ Employees waiving due to individual, governmental (Medicare, Champus, ACCHS, or Tricare) or spousal coverage may be required to provide proof of their other coverage by providing a copy of their insurance card if the group does not appear to be meeting the standard participation guidelines (75%). Individual coverage is not considered a valid waiver. ▪ Individual coverage is not considered a valid waiver and will count towards the participation. Copies of ID cards may be requested for confirmation. ▪ All employees waiving coverage must complete Section B and the waiver section of the application. ▪ Dependent participation is not required. ▪ Coverage may be denied based upon inadequate participation. ▪ If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement. <p>Dental</p> <ul style="list-style-type: none"> ▪ For Non Contributory plans, 100% participation is required. All employees, excluding those with other qualifying existing Dental coverage, must enroll. ▪ Employers contributing with 2-3 eligible employees: 100% participation is required, excluding those with other qualifying existing Dental coverage. ▪ Employers contributing with 4-50 eligible employees: 75% participation is required, excluding those with other qualifying existing Dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan. ▪ Coverage may be denied based upon inadequate participation. <p>Voluntary Dental</p> <ul style="list-style-type: none"> ▪ Not available for groups with less than 3 eligible employees. ▪ At least 25% of the employees must participate, excluding employees with other qualifying coverage. Enrollees excluding those with other qualifying existing Dental coverage or a minimum of 3 enrollees whichever is greater is required. Waivers are required. <p>Life or Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ For Non Contributory plans, 100% participation is required. ▪ Employers contributing with less than 10 eligible employees, 100% participation is required. ▪ Employers contributing with 10 – 50 eligible employees, 75% participation is required if the plans are at least partially contributory. ▪ Coverage may be denied based upon inadequate participation. <p>Disability</p> <ul style="list-style-type: none"> ▪ For Non Contributory plans, 100% participation is required. ▪ Employers contributing with less than 10 eligible employees, 100% participation is required. ▪ Employers contributing with 10 – 50 eligible employees, 75% participation is required if the plans are at least partially contributory. ▪ Coverage may be denied based upon inadequate participation. 																																				

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<p>Pick-A-Plan 3 ValuePick</p>	<ul style="list-style-type: none"> ▪ Pick-A-Plan 3 allows employers to offer up to three Aetna plans to their employees with standard participation and contribution guidelines. Pick-A-Plan 3 includes ValuePick plans. ▪ ValuePick is a sub-portfolio of plans that allows employers to offer up to three of the Aetna Value plans to their employees with reduced participation and contribution guidelines. ▪ Employees who choose to enroll in the richer plan are responsible for the difference. ▪ The plans, when rated, are based on the full census of the group so actual enrollment in each plan will not cause the rates to change, however, if the sold case has a different overall census than the quote they will need to be re-rated (i.e., a case quoted with 20 employees but sold with 17 employees would need to be re-rated with the new census). ▪ The group must have 5 or more enrolled employees in order to offer Pick-A-Plan 3 or ValuePick. ▪ One person must enroll in each plan and remain enrolled for the plans to remain active at renewal. ▪ Groups of 2-9 will be tabular rated (age banded). ▪ Groups of 10-99 will be composite rated. <p>1099 Employees Allowed (See 1099 Employee Section)</p>
<p>Plan Change Ancillary Additions (Life or Dental)</p>	<ul style="list-style-type: none"> ▪ Employers may request Plan Changes up to the renewal date for changes that are to be effective on the renewal date. ▪ Employers must request Plan Changes off of the renewal date at least 2 weeks prior to the desired effective date. ▪ The future renewal date of the ancillary products will be the same as the medical plan renewal date.
<p>Product Availability</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Single or Dual Choice <ul style="list-style-type: none"> – All groups with less than 5 eligible employees enrolling may choose either Single or Dual choice medical selections. – Employer may offer any of the 29 plans to their employees. ▪ Rates for 2-9 will be tabular age banded. ▪ Rates for 10-99 will be composite rated. ▪ Pick-A-Plan 3: Allowed (See Pick-A-Plan section) ▪ ValuePick : Allowed (See ValuePick section) ▪ 1099 Employees: Allowed (See 1099 Employee Section) <p>Dental</p> <ul style="list-style-type: none"> ▪ Employers with 3 or more eligible, Dental may be sold on a standalone basis or along with the Medical on a bundled or unbundled basis. ▪ Employers with less than 3 eligible employees or 2 enrolled: <ul style="list-style-type: none"> – Dental must be sold with Medical and can not be sold on a Standalone basis. – Voluntary Dental products are not available for groups with less than 3 eligible employees. ▪ If the Employer selects both Medical and Dental coverages, it must be offered to all employees. <ul style="list-style-type: none"> – Eligible employees do not have to enroll in both plans. Employees may enroll in Dental and not Medical and vice-versa. – Orthodontic coverage is included for groups with 10 or more eligible employees and is available for dependent children only. – Pick-A-Plan 3: Not Available – ValuePick: Not Available – 1099 Employees: Allowed <p>Life or Packaged Life & Disability</p> <ul style="list-style-type: none"> ▪ Employers with 2 – 9 eligible employees, Life or Packaged Life & Disability must be sold with medical and cannot be sold on a Standalone basis. ▪ Employers with 10 to 25 eligible employees, Packaged Life & Disability may be sold when packaged with medical, dental or on a Standalone basis. ▪ Employer with 26 – 50 eligible employees, Basic Term Life is available either packaged with Medical or Dental or on a Standalone basis. ▪ Employees may elect Life coverage even if they do not elect Medical coverage or vice versa. ▪ Employers with less than 10 eligible employees, certain plan differences apply. ▪ Pick-A-Plan: Not Available ▪ ValuePick: Not Available ▪ 1099 Employees: Allowed
<p>Rates – Tabular or Composite</p>	<p>Tabular Rate Structure</p> <ul style="list-style-type: none"> ▪ Employers with 2-9 enrolling employees will be tabular rated. ▪ All rates are based upon the Employer zip code. <p>Composite Rate Structure</p> <ul style="list-style-type: none"> ▪ Employers with 10-99 enrolling employees will be composite rated (minimum of 10 in state enrolling).
<p>Rate Guarantee</p>	<ul style="list-style-type: none"> ▪ Medical rates are guaranteed for one year (12 months). ▪ Life rates are guaranteed for 2 years (24 months).

<p>Renewal Benefit Changes (changes to medical and/or dental plans)</p>	<ul style="list-style-type: none"> Requests for plan changes to be effective on the renewal date, must be submitted prior to the renewal date. Requests for plan changes to be effective off of the renewal date must be submitted within 30 days of the requested effective date. The effective date for the plan change will be based upon notification receipt (this will be the date the e-mail or fax was sent to Aetna). 						
<p>Signature Dates</p>	<ul style="list-style-type: none"> The Aetna Employer Application and all employee applications must be signed and dated prior to and within sixty (60) days of the requested effective date. All employee applications must be completed by the employee himself/herself. 						
<p>Spin Off Groups (current Aetna customers leaving an Aetna group only)</p>	<p>Aetna will consider the group guarantee issue with the following:</p> <ul style="list-style-type: none"> A letter from the group or broker indicating the group is enrolling as a spin off. Letter needs to include the name of the group they are spinning off from. Ownership documents showing that the spin off company is a newly formed separate entity. A minimum of 2 weeks payroll. If the group that is spinning off has been in business longer than 2 weeks, payroll will be required for amount of time in business up to a maximum of 6 consecutive weeks. Medical claims will be requested and used along with the health information included on the employee application in order to provide an accurate RAF (risk adjustment factor). 						
<p>Tax Documentation</p>	<ul style="list-style-type: none"> When a company is Doing Business as (DBA), a copy of the Filed Assumed Name Certificate or Business Name Registration (Fictitious Name or DBA) should be provided. Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status. The employer must submit a copy of the most recently filed UC-018/UC-020 (Quarterly Wage Tax Statement) which must contain the names, salaries, and withholdings for all employees of the employer group along with a signature of the company representative. In the event that a UC-018/UC-020 is not available because the employer was not in business during the preceding calendar quarter or the employer has outsourced payroll functions, a copy of the payroll documentation from the company or the company's payroll administrator or employee leasing company; organization documents, or other reasonable proof must be provided. When a UC-018/UC-020 or payroll records are submitted: <ul style="list-style-type: none"> Employees who have terminated, work part-time or are newly-hired should be noted accordingly on the document. Any handwritten comments added to the document must be signed and dated by the employer. For newly-hired employees not listed on the document the employer must provide at least 2 weeks of payroll (which includes hours worked, wages earned, and taxes withheld) or a letter from the employer verifying the names of all employees and numbers of hours worked. Churches must provide Form 941 including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941. Other documentation may be requested by Underwriting upon receipt and review of sold case documents for final underwriting approval and installation. Altered legal documentation will not be accepted. Proprietors, Partners or Officers of the business who do not appear on the UC018/UC020 or payroll must submit one of the following identified documents along with a completed and signed Proof of Eligibility Form <table border="1" data-bbox="311 1159 1117 1482"> <tr> <td data-bbox="311 1159 652 1264"> <p>Sole Proprietor Franchise Limited Liability Company (operating as a Sole Proprietor)</p> </td> <td data-bbox="652 1159 1117 1264"> <p>IRS Schedule SE and Schedule C filed with Form 1040C; or IRS Form 1040; Schedule F or K-1</p> </td> </tr> <tr> <td data-bbox="311 1264 652 1339"> <p>Partner Partnership Limited Liability Partnership</p> </td> <td data-bbox="652 1264 1117 1339"> <p>IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</p> </td> </tr> <tr> <td data-bbox="311 1339 652 1482"> <p>Corporate Officer Limited Liability Company (operating as C Corp) C-Corporation Personal Service Corporation S-Corporation</p> </td> <td data-bbox="652 1339 1117 1482"> <p>Statement by Domestic Stock or Statement of Information IRS Forms 1120; IRS Form 1120 or IRS Form 1120 W (C-Corp & Personal Service Corp) IRS Form 1120 S, Schedule K1 or 1040 ES (estimated tax) (S-Corp) IRS Form 8832 (Entity classification as a corporation)</p> </td> </tr> </table>	<p>Sole Proprietor Franchise Limited Liability Company (operating as a Sole Proprietor)</p>	<p>IRS Schedule SE and Schedule C filed with Form 1040C; or IRS Form 1040; Schedule F or K-1</p>	<p>Partner Partnership Limited Liability Partnership</p>	<p>IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</p>	<p>Corporate Officer Limited Liability Company (operating as C Corp) C-Corporation Personal Service Corporation S-Corporation</p>	<p>Statement by Domestic Stock or Statement of Information IRS Forms 1120; IRS Form 1120 or IRS Form 1120 W (C-Corp & Personal Service Corp) IRS Form 1120 S, Schedule K1 or 1040 ES (estimated tax) (S-Corp) IRS Form 8832 (Entity classification as a corporation)</p>
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<p>1099 Employees</p>	<p>Employees reported on the IRS 1099 forms who meet Aetna's standard criteria for determining 1099 status may be considered only if all 1099 employees are offered coverage. They must meet the following requirements:</p> <ul style="list-style-type: none"> No more than 50% of the group's employees can be 1099 employees. 1099 employees must be employed by the company full time and year round. All present and future 1099 employees are subject to the same eligibility requirements as taxed employees. The employer must contribute the same amount for 1099 employees as for all other employees qualifying for coverage. The employer must have at least two taxed employees, with tax documents that verify the company is a valid business. The new group must include a list of all 1099 employees and a completed and signed 1099 contractor form. 						

LIMITATIONS AND EXCLUSIONS

These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

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, the plan documents may contain exceptions to this list based on state mandates or the plan design purchased.

Aetna HMO, HMO+ (QPOS) & CPOS

All medical and hospital services not specifically covered or which are limited or excluded by the plan documents, including costs of services before coverage begins and after coverage terminates.

- Blood and blood by-products, except as administered on an inpatient or emergency care basis
- 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
- 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 the plan documents
- Long-term rehabilitation
- Nonmedically necessary services or supplies
- Orthotics, except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling or prescription drugs
- Special duty nursing
- Therapy or rehabilitation, other than those listed as covered
- Treatment of behavioral disorders
- Weight-control services including surgical procedures, medical treatments, weight control/ loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Aetna 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
- 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 the 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

- Weight-control services including surgical procedures, medical treatments, weight control/ loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Aetna CPOS, PPO & Indemnity: 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 conditions 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 12 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 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.

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 may 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 conditions exclusion does not apply to pregnancy, nor to a child under age 18 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.

LIMITATIONS AND EXCLUSIONS

DENTAL

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to the plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance.
- Experimental services, supplies or procedures.
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder.
- Replacement of lost, missing or stolen appliances and certain damaged appliances.
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved.

Specific service limitations:

DMO plans: Oral exams (4 per year)*

- PPO plans: Oral exams (2 routine and 2 problem-focused per year)
- All plans:
 - Bitewing X-rays (1 set per year)*
 - Complete series X-rays (1 set every 3 years)*
 - Cleanings (2 per year)*
 - Fluoride (1 per year; children under 16)
 - Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)*
 - Scaling & root planing (4 quadrants every 2 years)
 - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in the plan documents

*The frequency limits for these services will not apply to the DMO plans if they are needed more frequently due to medical necessity.

AD&D ULTRA

This coverage is only for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- A bodily or mental infirmity
- A disease, ptomaine or bacterial infection**
- Medical or surgical treatment**
- Suicide or attempted suicide (while sane or insane)
- An intentionally self-inflicted injury
- A war or any act of war (declared or not declared)
- 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, an accident in which the blood level as operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

DISABILITY

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from you committing, or attempting to commit a felony
- Is due to war or any act of war (declared or not declared)
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Occurs during the first 12 months of your coverage and is due to a pre-existing condition for which you were diagnosed, treated or received services, treatment, drugs or medicines three months prior to your coverage effective date
- Results from an automobile accident caused by you while you are intoxicated, ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred)

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense, the person will not be deemed to be disabled and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three (3) months prior to coverage effective date.

**These do not apply if the loss is caused by an infection that results directly from the injury or surgery needed because of the injury. The injury must not be one that is excluded by the terms of the contract.

SUBMISSION DETAILS AND GUIDELINES

EMPLOYER INFORMATION

Employer Application

Complete all pages of the application

- Employer Signature must be of an office or corporate officer.
- Number of eligible and enrolled employees.
- Premium percentage paid by Employer.
- Indicate selected products in Section II — Medical Coverage Selection.
- Applications will not be accepted more than 60 days from the date signed.
- No altered applications (a new application will be required).

Employer Medicare Application

- Complete and sign if any employees are electing an Aetna Medicare plan.
- Only 1st of the month effective dates are available for the entire group's submission.

UC018/UC020 or other applicable tax documents

- Part-time, terminated, seasonal or temporary must be indicated on this wage and tax report.
- For seasonal industries such as farming laborers or season processing fruit plants, four (4) consecutive quarters of wage and tax reports may be requested by underwriting.
- All enrolling employees must be represented on the wage and tax form or included on a payroll report.
- Out-of-state employees require proof of employment if not identified on the UC018/UC020. This would be the quarterly wage and tax statement filed in that particular state where the employee is living and/or working.
- If owner, partner, or corporate officer is not listed on the UC018/UC020, submit the Small Group Proof of Eligibility form signed by the employee along with the requested documents.
- If newly hired employees are not identified on the UC018/UC020, submit a minimum of two weeks payroll indicating compensation and taxes withheld.

Premium Check made payable to Aetna Health

- A premium check on company stock for 100% of the first month's Medical, Dental, and Life premiums payable to "Aetna Health."

Copy of current/prior medical/dental carrier's latest bill

- Include employee roster and premium summary page.

EMPLOYEE INFORMATION

Employee applications completed and signed by each employee

- Any alterations must be initialed and dated by the employee.
- Individual waiver forms completely filled out for each employee and/or family member waiving coverage (to be signed by the employee).
- Employees need to sign and date the signature page prior to the requested effective date.

Dental Submissions (in addition to items under Employee Information section)

- Employee Enrollment Forms
- Waiver completed for employees not electing Dental

Group Insurance Submissions (in addition to items under Employer Information section)

- Employee Enrollment Form
- Individual Health Statement required if selecting Life amount in excess of Guaranteed Issue Amount
- Waiver completed for employees not electing Life

Medicare information (in addition to items under Employer Information section)

- Effective date of all plans must be first of the month
- Group Medicare Enrollment Forms
- Employee Medicare Enrollment Forms
- Illustrative rates circled for plan selection

Complete/Review Broker information

- Complete, sign, and date the Agent/Broker Certification section of the Employer Application
- Review all items on this page for completion prior to submissions
- Verify underwriting guidelines were reviewed and understood
- Submit a copy of the Aetna quote package
- Complete and provide the Aetna Agent Agreement, if applicable

Avoid potential delays in getting your client approved and enrolled. Make sure your new case submissions are complete.

For more information about Aetna's Small Business Solutions, please contact your local Aetna Account Executive or the Small Group Service Center from 8 a.m. to 5 p.m. PT

Toll Free #:

1-877-249-2472

Fax #:

1-888-258-4530

E-mail Address:

ASGBLAZ_NV_WA@Aetna.com

Overnight Mailing Address:

Aetna Small Group
Underwriting
1385 E. Shaw Avenue
Fresno, CA 93710

Mailing Address:

Aetna Small Group
Underwriting
P.O. Box 24004
Fresno, CA 93779-4004

Effective dates may be the first or fifteenth of the month only. If purchasing a group Medicare plan, only the first of the month effective date is available for the entire group's submission.

All required paperwork must be received by Aetna by the 1st business day after the requested effective date.

AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions®

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/Dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. 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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

