AETNA HSA

Through First National Administrators (2-50)

1. **BROKERS MUST BE APPOINTED PRIOR TO SUBMITTING FIRST CASE** (takes up to 2 weeks to process)
2. Employer Application Form
3. Employee applications signed by both the employer and employee
4. Waiver form completely filled out for each employee waiving coverage (Not needed for HMO or NYC Community Plan)
5. Copy of signed quote – MUST be signed by employer or case WILL NOT be approved
6. Proof of Eligibility Form
7. Employee Count Attestation Form
8. Copy of itemized prior carrier list bill – MUST include complete employee list
9. First month's premium check made payable to: Aetna (MUST BE COMPANY CHECK)
10. Proof of Full Time Student Status
11. Case submission Checklist
12. Late Submission Form (due 5 days prior)
13. Employer Funding Certification and Statement of Understanding

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Participation Requirements

Participation Requirement is 60% excluding waivers. Waivers are defined as spousal, Medicare or VA.

Tax Documents - subject to change according to Aetna underwriters:

- Existing Corp – Most recent NYS-45
- Newly Formed Business – Articles of Incorporation, payroll showing tax withholdings & CPA letter listing names of all employees, # of hours worked on a regular basis, indication of salary draw and Tax ID
- New Hire – New Hired employees should be written in on the quarterly wage report and signed by the employer. Aetna underwriters may request payroll
- K1 or Schedule C plus Proof of Eligibility Form. K1's MUST equal 100%
- All Required paperwork must be received by Aetna on the 25th of the previous month for 1st of the month effective dates and the 10th of the month for a 15th of the month effective date

**Effective dates: 1st & 15th only*

ATTENTION ALL BROKERS!!

You **MUST** be appointed with Aetna PRIOR to the sale of ANY Aetna case. Failure to do so will result in not being paid Aetna commissions now or in the future. Having a vendor number does not necessarily mean you are appointed. If you are submitting a case and have not been appointed yet, please call Noreen at FNA/Greater Metro Commission Dept.

WELCOME TO THE AETNA HEALTHFUND® HEALTH SAVINGS ACCOUNT (HSA)

Welcome to the Aetna HealthFund® Health Savings Account (HSA). We know how important your employees are to you, and we want to work with you to ensure a smooth implementation process, setting a strong foundation for ongoing support and account maintenance.

Your privacy is important
HealthEquity, a personal health care financial services company that specializes in HSAs, is the administrator of your Aetna HealthFund HSA. Together, Aetna and HealthEquity are pleased to offer the latest technology to protect your personal, financial and medical information and keep it secure

This HSA administrative guide will take you through the implementation process, explain the roles and responsibilities of HSA participation and serve as an ongoing reference.

Customer Service

- Member Services – 1-866-382-3512
  - Member Services hours of operation – 24 hours a day, 7 days a week
- Broker Services - 1-800-819-5852
- Employer Services – 1-866-382-3510
  - Broker/Employer hours of operation – Monday – Friday, 7am – 6pm MST.

The Sale

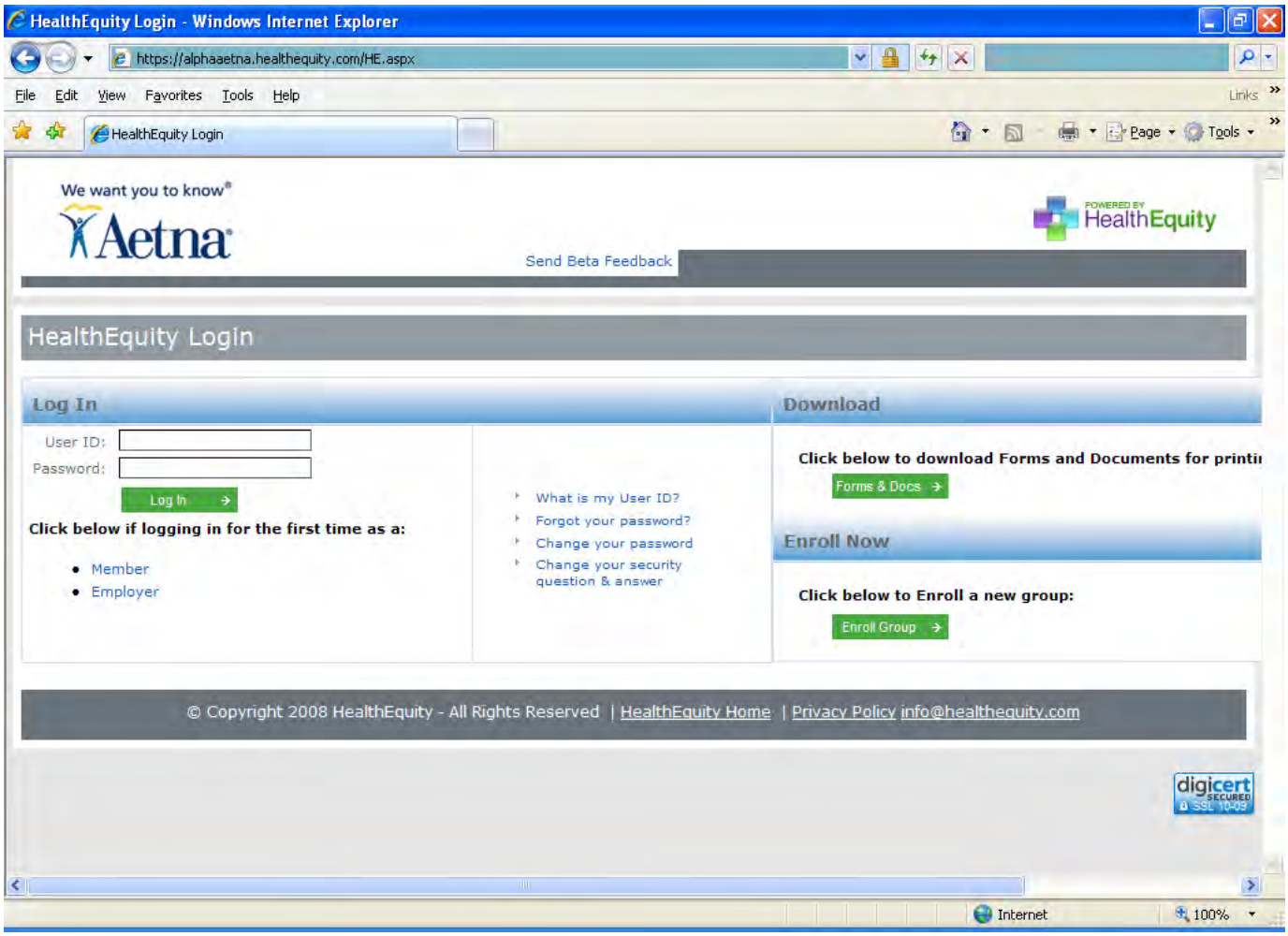
- Case is sold – medical plan paperwork is mailed/e-mailed to regional underwriting office
- Underwriting logs case into Sold Case Log (Rabbit)
  - Important note: The employer name in the Sold Case Log and Master Application must be identical.
- Follow normal underwriting workflow from here.
- Sold Case Log as well as the HEQ will be reviewed on a quarterly basis for accuracy and to view for terminated cases.
- Once a case terminates, we will move the case to the HEQ Unaffiliated Group - $3.95 per member per month administration fee is accessed.

Employer Setup Process

Please note – Employers must set themselves up at the Employer level prior to enrolling employees in the HSA. On the below screen, you would click "Enroll Group".

Broker/Employer Setup Process (on line instructions)

- Broker logs into Producer World
- Under Market Segment, choose Small Group **or**
- Broker/Employer logs onto http://aetna.healthequity.com to set up the employer.



- Important note: The Sold Case Log, Master Application and company name must all be the same.
    - After you click on "Enroll Group", you will create a unique user name and password.
    - Information needed is company name, tax id, contact phone number and zip code
- Within one business day after set up, the Employer will be sent an e-mail confirming their setup and directs them to their personal Employer portal.
- Individual employee enrollment can begin within 24 hours of receipt of the e-mail.
- **EMPLOYERS MAY DELEGATE A BROKER AT THIS TIME TO PERFORM ALL OR SOME POST SETUP FUNCTIONS.**

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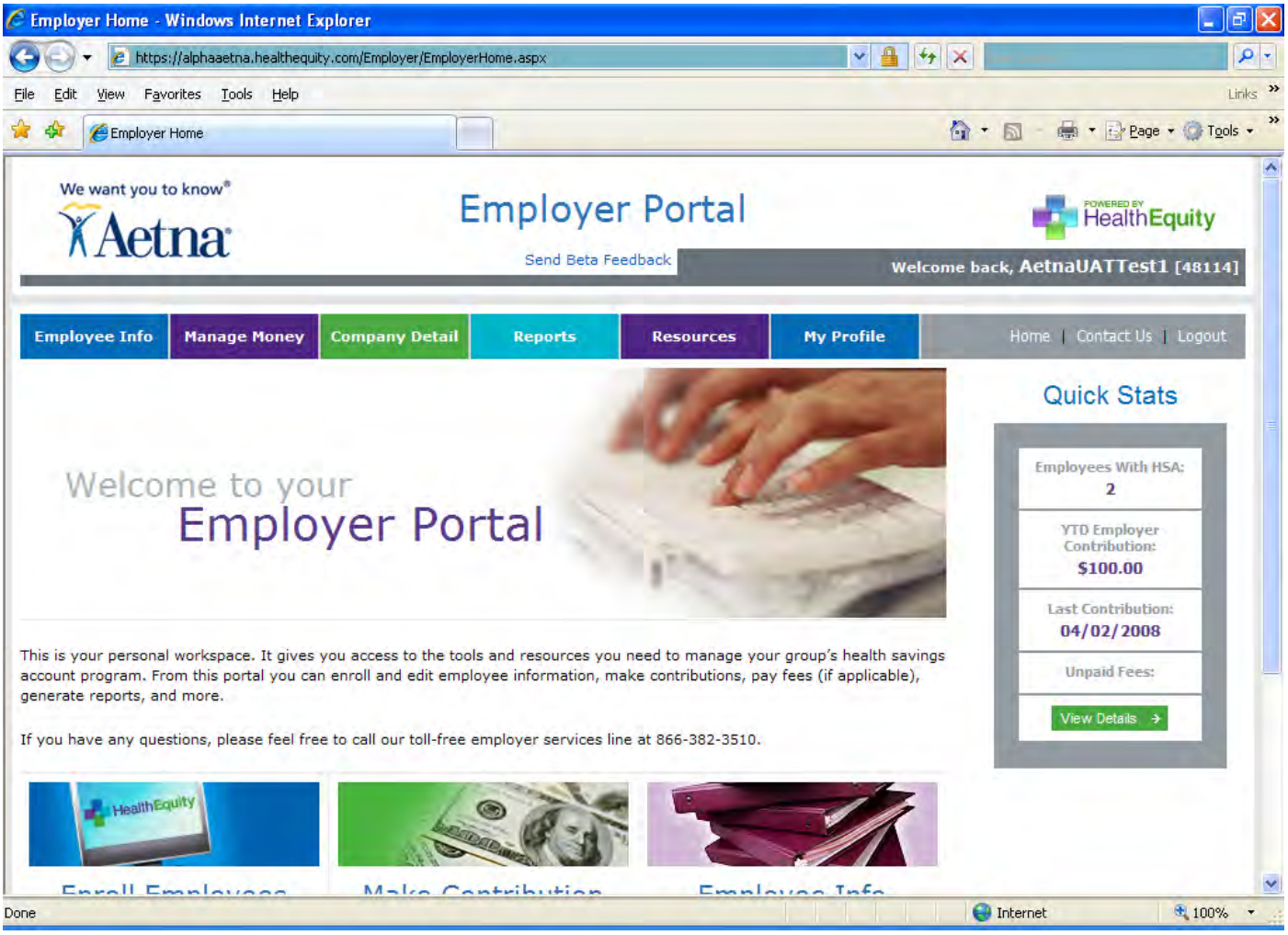

- Once the Employer is set up, the Employer/Broker can then log on to the Employer portal to create individual accounts and electronic processing of funding. Due to privacy restrictions, the Employer maintains control over who can view their specific employer portal.

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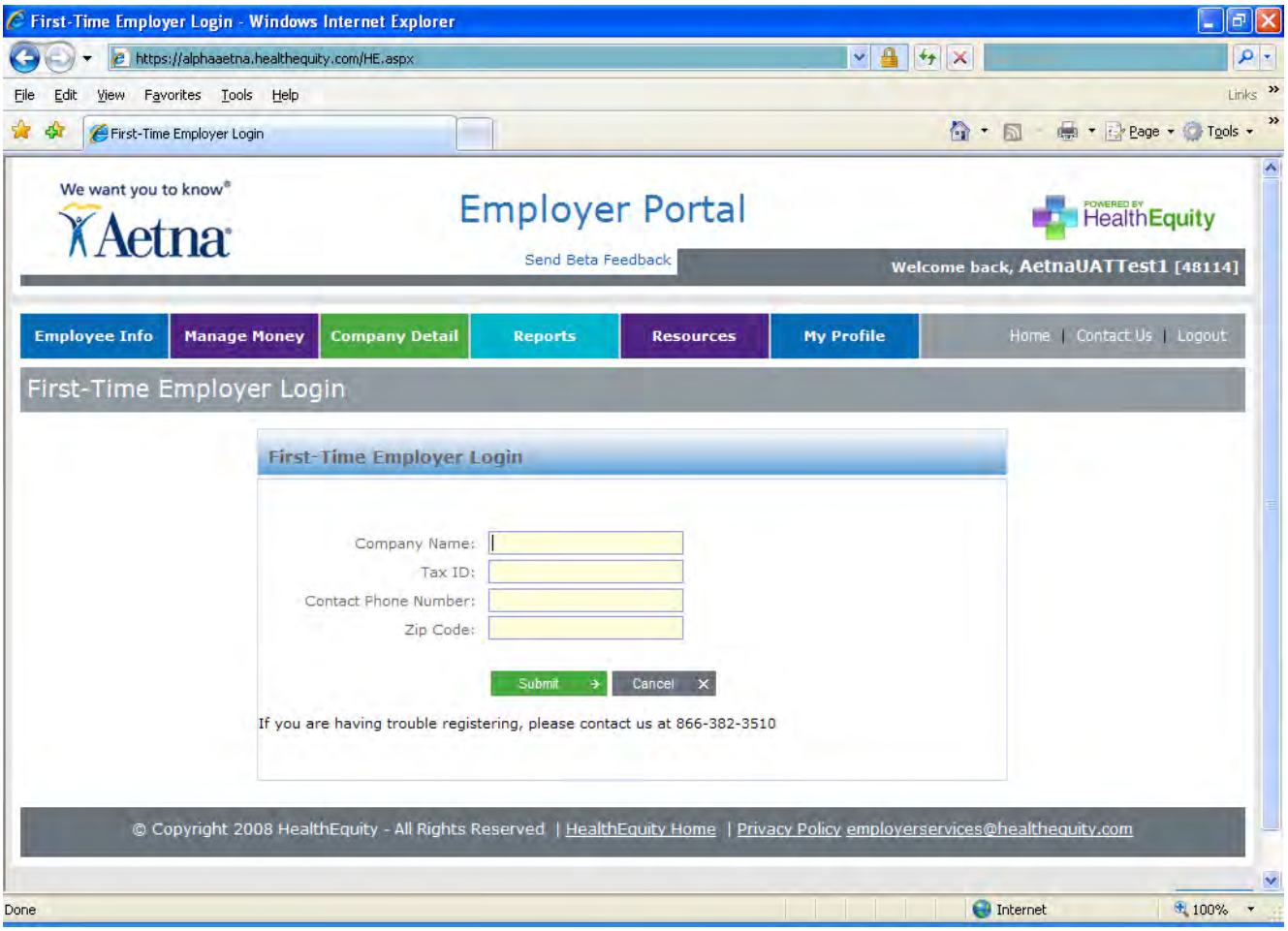
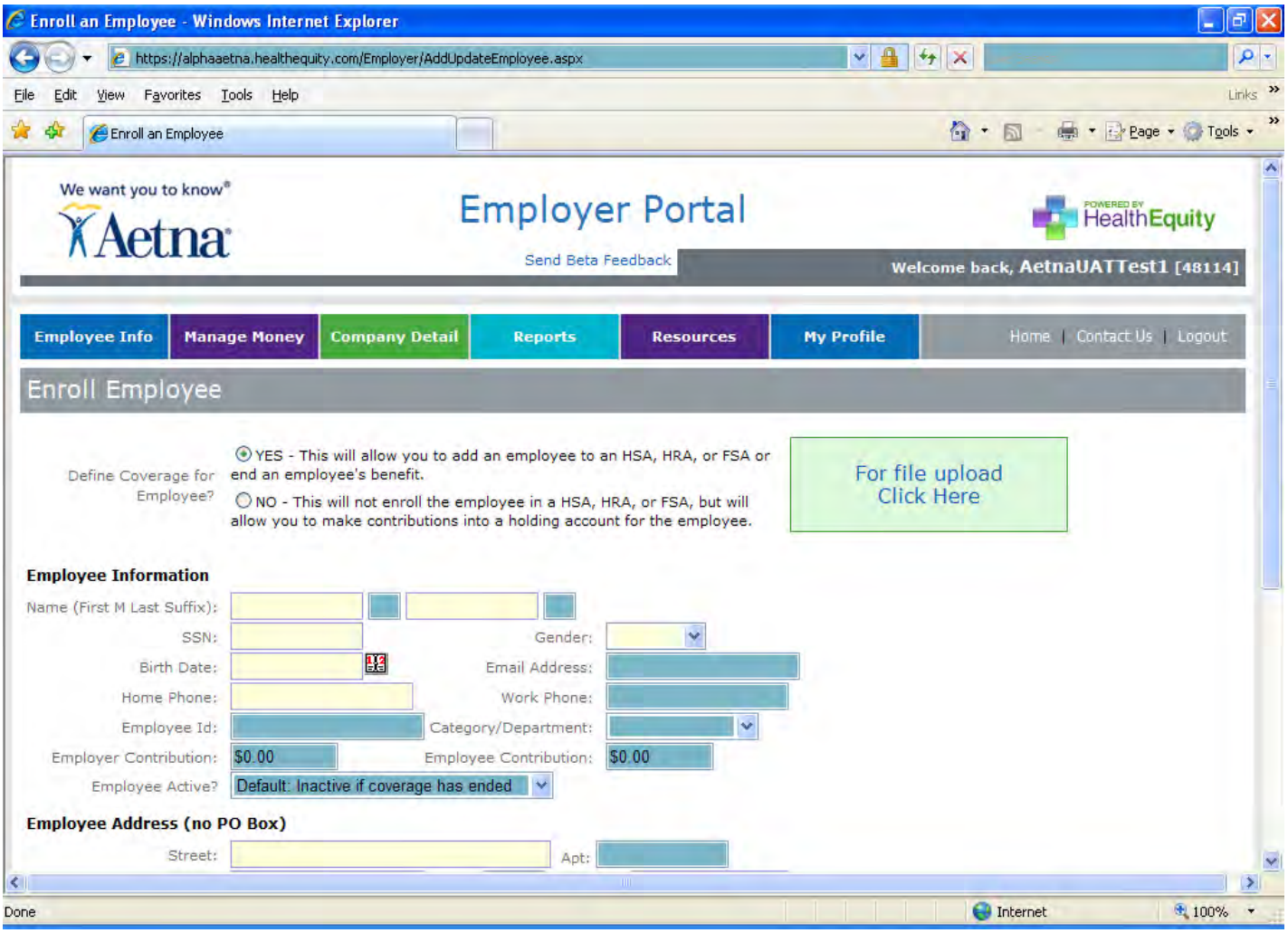


- HEQ calls the Employer within 5 days of date the Employer set up the site to give instructions on using the employer portal.
- The instruction call can last from ½ to 1 hour – Employers/Brokers can schedule a call with HEQ or can call the toll free Plan Sponsor Services number between 7am and 6pm Monday through Friday.

<u>Enrolling Employees</u>

- Employer goes into their personal employer portal to set up an individual HSA. Employers fill out the required information regarding the employee. Link: http://aetna.healthequity.com



- Section 326 of the U.S.A. PATRIOT Act mandates that all banks verify certain information about a consumer before any account can be opened. An HSA will be established only after the employee has successfully completed the Customer Identification Process ("CIP"). The CIP is generally completed within 24-48 of employee set up.
- See CIP Instructions below for more detailed information, including what happens if an employee fails CIP.
- Once the HSA is established, the account holder will be mailed a debit card, pin number (if requested) and client guide. These materials normally arrive within 10-16 business days after the HSA is established.

<u>Broker/Employer Setup Process (Paper instructions)</u>

- All forms can be downloaded from http://aetna.healthequity.com
- Broker logs into Producer World
- Under Market Segment, they choose Small Group
- Under Small Group, they choose Forms & Marketing
- Under Forms & Marketing, they choose the specific state

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- All enrollment material will be housed under this site. (Web site information will also be given to encourage web-enrollment)
- Enrollment Material includes:
    - Enrollment Form (Employer and Employee) – If using paper enrollment, the Employer needs to fill out an **enrollment form to enroll the Employer** in the system.
- The following forms are required for the employee enrollment:
    - Employee enrollment form
    - Custodial Agreement
    - Fee Schedule
- Enrollment forms are mailed or faxed to HEQ. Once forms are received, they are entered into the system within 24 hours. Forms are retained at HEQ.
- Enrollments can be faxed to 1-520-844-7090 or mailed to:

Aetna HealthFund HSA
c/o HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020

- The account will open once the individual's information has been reviewed through a government required identify screening process (part of the US Patriot Act – usually completed within 24-48 hours). This process is referred to as the Customer Identification Process (CIP).
- See CIP Instructions below for more detailed information.

<u>Employer (Paper Instructions)</u>

- Employer can log into http://aetna.healthequity.com and print out forms.
- Employer Enrollment Material includes:
    - Employer Enrollment Form

- Employee Enrollment Material includes:
    - Custodial Agreement*
    - Fee Schedule*
    - Enrollment forms are mailed or faxed to HEQ
- Enrollments can be faxed to 1-520-844-7090 or mailed to:

Aetna HealthFund HSA
c/o HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020

- Section 326 of the U.S.A. PATRIOT Act mandates that all banks verify certain information about a consumer before any account can be opened. An HSA will be established only after the employee has successfully completed the Customer Identification Process ("CIP"). The CIP is generally completed within 24-48 of employee set up.
- See CIP Instructions below for more detailed information, including what happens if an employee fails CIP.

- Once the HSA is established, the account holder will be mailed a debit card, pin number (if requested) and client guide. These materials normally arrive within 10-16 business days after the HSA is established.

CUSTOMER IDENTIFICATION PROCESS (CIP)

Section 326 of the U.S.A. PATRIOT Act mandates that all banks verify certain information about a consumer before an account can be opened. Thus, each individual who enrolls in an HSA must be vetted through the customer identification process (CIP) before an HSA can be established. CIP is initiated within one business day of receiving an individual's enrollment information. An unsuccessful CIP will be identified within three business days. For more information about what happens when CIP is unsuccessful, please see "Unsuccessful CIP", below.

Status of Accounts during CIP

- Until the employee passes CIP, the account is established placed in a "Verification in Progress" status.
- While In Verification in Progress" status:
    - Contributions are posted to the account; however funds may not be available.
    - Contributions Earn Interest
    - If the account holder passes CIP, the account status will change to "open".

Ensuring a successful CIP:
The following information is required for a successful CIP: Name, Address, Date of Birth and Social Security Number. Inaccurate or missing information will delay the CIP and require additional documentation.

Name

- Must be an individual's legal name
- Do not use nicknames
- Indicate any name changes within the past year (marriage or divorce)
- Documents to establish proof of identity: drivers license, birth certificate, passport, marriage license, divorce decree.

Social Security Number

- Beware of typographical errors, transposing number and additional or missing digits
- Documents to establish proof of social security number: copy of social security card

Address

- Use legal address only.
- Documents to establish proof of address: drivers license, copy of a utility bill

Date of Birth

- Beware of typographical errors, transposing numbers, extra or missing digits.
- Documents to establish date of birth: birth certificate or drivers license

Successful CIP

Upon successful completion of CIP, the HSA accountholder will receive a Welcome Kit and an HSA Debit Card. Refer to the HSA Accountholder Experience section of this manual for more information.

Unsuccessful CIP

An accountholder who has not initially passed CIP will receive a letter identifying the reason for the CIP fail and the information needed to pass CIP

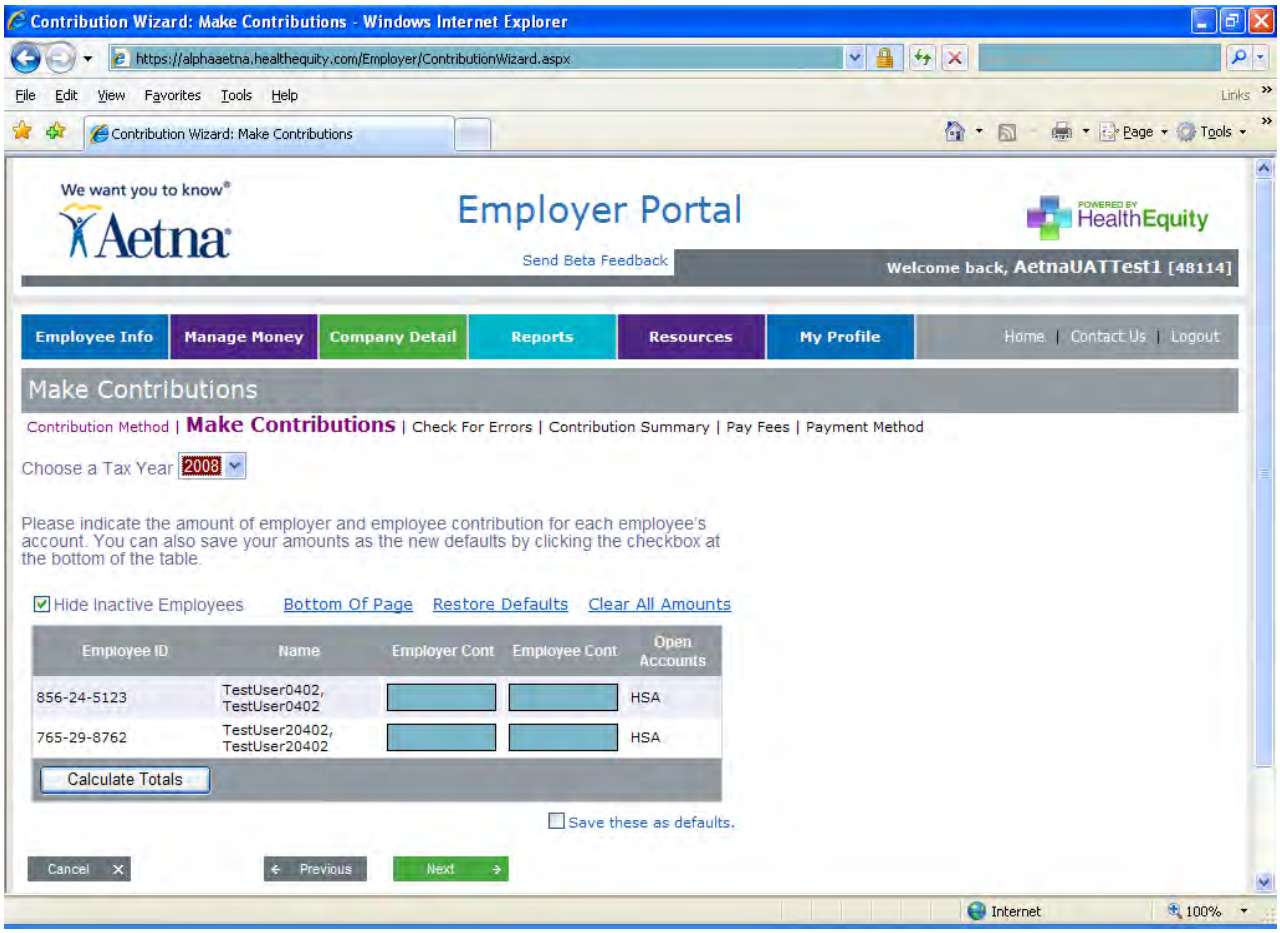
- If no response is received within 15 business days, a second letter will be mailed to the accountholder. An e-mail is also sent to the Employer asking for assistance with clearing the account
  If an accountholder does not respond, funds will be returned to the account holder.

Making Employer Contributions

Employer Contribution Reporting:

- Employer/broker logs into http://aetna.healthequity.com and goes to their personal portal to allocate member payroll and Employer contributions.
- Once in the Employer portal, click on "Make Contributions"
- Enter employee information, including contribution amount

Another option is to store the information in a file and upload the file.



- If the employer elects EFT for contributions (debit is only option offered) or sends check for contributions allocated on the portal.
    - If EFT is elected, funds are automatically withdrawn from the account the Employer has designated – funds are withdrawn on the same day the debit is done and funds are allocated into the member account within 2-3 business days.
- If a check is to be mailed, a confirmation code is automatically assigned when sending a check is elected on the portal**. THIS CONFIRMATION CODE MUST ACCOMPANY THE CHECK.**
    - Checks are mailed to the following address:

      Aetna HealthFund HSA
      c/o HealthEquity Inc.
      15 West Scenic Pointe Drive, Suite 400
      Draper, UT 84020
- HEQ receives contributions and allocation instructions
- Deposits funds to member accounts
- Funds are available to the member within 2 business days after processing for checks and 1 day for EFT.
- If funds received are over the allocated amount, the monies allocated will be applied and the overage will be returned to the originator within 60 days if no further instructions are received.
- If funds received are under the allocated amount, no deposits will be applied. An outreach call will be made to the originator and if no further instructions are received, the whole amount will be returned within 14 days.

<u>Making Employee Contributions:</u>

- If an employee wants to make contributions other than through payroll deductions, they can set up their own EFT or send a check in to the address above. Forms can be found on the website.

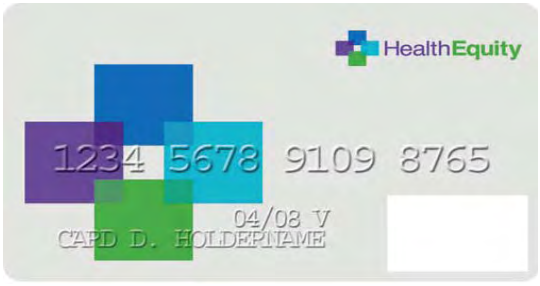
<u>Disbursements</u>

Members can withdraw funds from their HSA in 3 ways: Cash withdrawals, debit card withdrawals or by using PayChoice Bill Pay.

- Cash withdrawals can be requested to reimburse the account holder for expenses which were paid out of pocket at the time of purchase. Reimbursement may be made by paper check or via EFT to another bank account owned by the accountholder. Note: if check reimbursement is requested, $2.00 is charged per check – no charge if EFT is used for reimbursement.
- PayChoice Bill Pay – Account holders can organize and pay their medical claims using this on-line payment tool.
    - Members can pay a provider on-line via a check (no fee) or EFT
    - Payments can be made on a pre-determined schedule.
    - HEQ customer service representatives can assist in working with providers to set up a payment schedule.
    - Members can reimburse themselves for out of pocket medical expenses.
    - Records and stores medical claim records

- Members can create and print monthly and yearly statements.

- HSA Visa Card – Once an HSA is established for an employee, s/he is issued an HSA Visa Card.
- The HSA Visa Card can only be used at certain merchants (e.g. at the pharmacy for prescription purchases
- **The HSA Visa Card cannot be used at an ATM**.
- The HSA account holder can receive additional HSA Visa cards for a $5.00 fee – members need to call to order additional cards.



HSA Visa Card Activation

- Register at http://aetna.healthequity.com.

Interest

HSA balances are FDIC insured and interest bearing. Interest is compounded and calculated daily for each tier of account balances and outlines in the table below and is credited to the HSA monthly as of the last business day of the statement cycle. If the HSA is closed before the accrued interest is credited no interest will be paid for that month. The interest rate is calculated quarterly and set using a formula based on the Feds Funds Target rate and is subject to change at any time.

Members should refer to their monthly statements or call HealthEquity for current rates and conditions.

	Daily Account Balance	HealthEquity Rate	APY*
Tier 1	$0 - $1,000	0.25%	0.25%
Tier 2	$1,001 - $2,000	0.25%	0.25%
Tier 3	$2,001 - $5,000	1.50%	1.26%
Tier 4	$5,001 - $10,000	1.75%	1.77%
Tier 5	Over $10,000	2.25%	2.28%

*APY means Annual Percentage Yield.

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Investment Options:

- HSA members are required to accumulate $2,000 in their FDIC insured interest-bearing portion of their HSA before investing in alternative options. HSA balances above $2,000 may remain in the FDIC insured portion of the HSA or they may be invested in various non-FDIC insured mutual funds in a Schwab Investment Account that is administered by HEQ. HSA disbursements are paid from the FDIC insured portion of the HSA. If the FDIC insured portion of the HSA does not have the $2,000 required balance, future contributions will be directed into the FDIC insured portion of the HSA until the minimum balance requirement is satisfied.
- Members must have an active e-mail account in the HEQ system and a balance of more than $2,000 in the HSA in order to invest. Any money in excess of the $2,000 may be invested. Example, if a member has a balance of $3,000; they can invest any amount over $2,000 (from $1 to $1,000) but must keep the $2,000 in their cash account.
- Members can choose from 12 mutual funds.
- Investments are not FDIC insured.
- There are no fees associated with having an investment account.
- May take up to 1 week for investments to be traded

Reports

If 5 or more members have elected to open an HSA, you can produce reports via the employer portal. These are aggregate level reports which can give you insight into employee account balances and account usage.

Tax Reporting Requirements

HSA Trustee/Custodian

The HSA trustee/custodian is responsible for the following reporting obligations:

- Form 1099S-A
  - Mailed in January for the previous tax year
  - Reports all account distributions (i.e., HSA withdrawals), including ATM withdrawals, debit card purchases and check payments.

- Form 5498S-A
  - Mailed in May for the previously tax year
  - Reports all contributions to the HSA, through April 15th
  - Includes interest earned through December 31st of the tax year. (Earned interest is not a contribution to the HSA.)
  - States the year-end account value
  - Incoming rollovers, trustee-to-trustee transfers and qualified HSA distributions are not reported as contributions; these are reported separately on this form.

Employer Responsibility

Employers are responsible for reporting any contributions made by the employer, including contributions made via Section 125 salary reduction elections by employee. These amounts should be included on the employee's W-2.

- Form W-2

- Box 12 (code W) is used to report all Employer contributions, including employees' pre-tax payroll deductions.

Accountholder Responsibility

Every HSA accountholder must file Form 8889 as part of his or her annual Form 1040 tax filing

- Form 8889
  - Report all contributions, withdrawals, earned interest, excess contributions and any withdrawals for non-qualified expenses.

All forms references in this section can be found at the IRS website, http://www/irs.gov/.

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Customer Service

- Member Services – 1-866-382-3512
  - Member Services hours of operation – 24 hours a day, 7 days a week
- Broker Services - 1-800-819-5852
- Employer Services – 1-866-382-3510
  - Broker/Employer hours of operation – Monday – Friday, 7am – 6pm MST.

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HealthEquity™

How to get the most out of your Aetna HealthFund HSA.

Aetna®

15 West Scenic Pointe Drive
Suite 400
Draper, Utah 84020
866-382-3512
http://aetna.healthequity.com

GCON07-01

Welcome to HealthEquity®

HealthEquity is your health savings account (HSA) administrator, which means it's our job to help you better understand and manage the financial side of your health care.

You've made a great decision by choosing an Aetna HealthFund HSA.

You now have a health savings account that can be funded with tax-advantaged contributions that earn interest or investment returns. Best of all, the services that come with your Aetna HealthFund HSA help you make informed health care decisions. We hope to help you find ways to save money on your health care services and medical products. And with our online payment tools, we also hope to make it easy and convenient for you to see, understand and pay for your health care expenses.

Learn more.

The pages that follow will guide you through the basics of your health savings account, how an HSA works with your Aetna health plan, and what kind of additional HSA services are at your fingertips.

If you have any questions not answered in this guide, please call our 24/7, toll free Member Services anytime at 1-866-382-3512.

Table of Contents

Getting started.

1. You either have or soon will receive your HSA VISA® card. This card has a sticker attached with a toll free phone number. Call that number to activate your card.

Use your card to access your HSA funds (see page 8 for information on some great ways to use your card). Although you swipe the card and sign just like a credit card, it will debit funds directly from your HSA.

2. Log on to http://aetna.healthequity.com to access your Member Account. The first time you go to the site you'll be asked to log in and create a password. It'll just take a few minutes and, once you've signed up, you can return anytime to manage your account and use your HealthEquity Account Services.

Your privacy is important to us.

We use the latest technology to protect your personal, financial and medical information and keep it secure. Our processes and policies have all been designed to provide state-of-the-art information security and privacy. For more information, please refer to the enclosed privacy policy statement.

What you can do with your HSA.

1. Pay qualified health care expenses – Use the HealthEquity online PayChoice™ payment platform at http://aetna.healthequity.com to pay for qualified health care expenses. You can use your HSA VISA® card, request a check by phone or online, or transfer funds online.

2. Save money for future medical expenses – You may not have significant health care expenses every year, but saving the maximum amount every year (see page 6) helps you build a sizeable nest egg for times when you may be faced with more significant health care expenses. By the way, that money is not taxed at the federal level when you use it to pay for qualified medical expenses (see page 16). (If you use your HSA funds for non-qualified medical expenses then you are subject to taxes and if you use your HSA funds for any non-qualified expenses before age 65 they will be subject to tax *and* penalties.)

3. Save for post-retirement expenses – Once you reach age 65, you can use your HSA funds to pay for any health care expenses you wish and they will still be tax-free. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties, similar to a 401(k) plan.

Remember – Your Aetna HealthFund HSA is your money. Whatever you don't spend in a given year rolls over into the next. And if you change jobs or retire, the money goes with you.

Go to http://aetna.healthequity.com for more information and online tools

Watch how your HSA savings can grow.

How your HSA grows depends on how much is contributed and the returns you earn. But here's a general idea of what your HSA can do for you when you save.

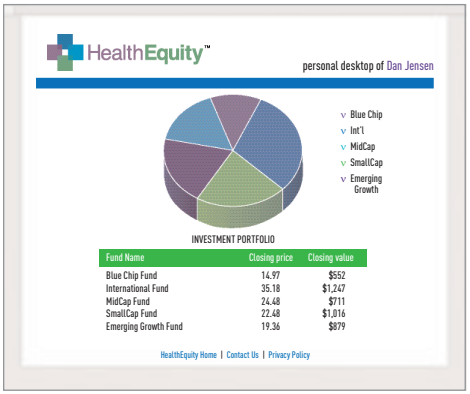
If you were to contribute the maximum annual amount for family coverage ($5,950) over twenty years and never spend it, you would save $245,429. Contribute the maximum yearly amount for individual coverage ($3,000) and never spend the funds and your total savings would be $123,745.*

If you were to contribute the maximum annual amount for family coverage ($5,950) over twenty years and spend the minimum annual deductible from your HSA ($2,300), you would save $150,557. Contribute the maximum yearly amount for individual coverage ($3,000) and spend the minimum annual deductible from your HSA ($1,150) and your savings would be $76,310.*

* Savings totals are presented for illustrative purposes only. The examples above assume the account holder elects available investment options and earns a 7% APR over a twenty-year period. Actual performance will vary based on individual investment choices and market fluctuations. Contribution maximums are subject to change by Congress.

Invest your HSA savings.

HealthEquity has partnered with leading mutual funds to provide a selection of high-quality investments for our HSA members. Here's how you can take advantage of these investment opportunities:



- Maintain $2,000 minimum HSA cash balance
- Invest any funds above that minimum
- Buy and sell shares as often as you wish
- NO trading fees
- NO set up charges

You can review your investments anytime at http://aetna.healthequity.com. Any gains or losses will not be treated as contributions or distributions from your HSA. Just remember, your investments are not FDIC insured. If you have questions, call 1-866-382-3512.

How to make contributions to your HSA.

Your employer can choose to contribute to your HSA and so can you, up to the legal maximum. In 2009, the maximum annual contribution for individual coverage as set by the IRS is $3,000 and the maximum family coverage contribution is $5,950. Be sure you don't exceed the annual maximum contribution amount or you could be assessed penalties. If you are 55 or older, you can make additional contributions that are also tax deductible. The allowable "catch-up" contributions to HSAs for 2009 is $1,000.

Call our 24-hour, toll free HealthEquity Member Services anytime at 1-866-382-3512

How to deposit money in your HSA.

Your employer can allow you to automatically deposit money by payroll deduction to contribute to your HSA. These contributions are made with pre-tax dollars so they cannot be deducted on your tax return.

If you're not already contributing by payroll deduction, ask your employer if they can set it up for you.

You can also contribute directly to your HSA. In most cases, direct contributions are made with after tax dollars and you can deduct them on your tax return. If you'd like to make direct contributions from your personal checking or savings account, go to http://aetna.healthequity.com. Follow the instructions, provide your personal account information, and set up your electronic funds transfer. That's all there is to it. If you want to make automatic recurring contributions, you can set that up as well. Or you can call us at 1-866-382-3512 and we can help you.

A smart way to pay for medical expenses.

Here are several payment scenarios to use your HSA to pay health care expenses.

When you have enough money in your HSA.

- Make sure you wait until the bill has been processed by your health plan so their negotiated discount has been applied.

- You can then call the provider with your HSA VISA® card number or simply write the number on your bill to have payment taken directly from your HSA.

- You can also go online to your Member Account at http://aetna.healthequity.com and schedule to pay in full on a specific date.

- Or you can pay from another account or with a credit card. If you pay this way, you can reimburse yourself from your HSA, or enter the payment details online to create a record for future reimbursement (see "Lifetime Claims and Spending Record" on page 15). You can do both at http://aetna.healthequity.com.

When you don't have enough in your HSA.

- Make sure you wait until the bill has been processed by your health plan so their negotiated discount has been applied.

- Go online to your Member Account or call a HealthEquity Member Services Representative to set up a payment based on future contributions to your HSA.

- You can schedule a number of future payments to automatically be sent to your provider.

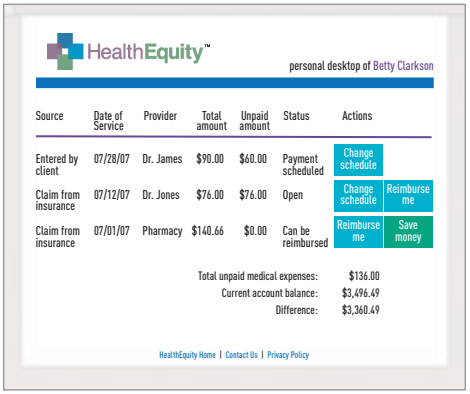
Go to http://aetna.healthequity.com for more information and online tools

Paying at the pharmacy.

- Call the number on your health plan ID card to find a participating pharmacy.
- Call to renew a current prescription or take your new prescription to the pharmacy.
- Present your pharmacy card or health plan ID to the pharmacist. The pharmacy will submit an online claim to your plan.
- Your health plan will automatically apply the network discount and record the discounted amount against your deductible. (This doesn't take long. It happens while you wait.)
- The pharmacist will request payment from you for the discounted amount before giving you your prescription. Give the pharmacist your HSA VISA® card for payment if you have enough money in your HSA. (Choose the "credit" option to have money withdrawn without having to use a PIN.)
- You may also pay by check, cash, or credit card at the time of the purchase. You can later submit an online reimbursement request. Or, you can choose to enter the payment details into your HealthEquity online Member Account to create a record for future reimbursements. From your online Member Account, click on 'My Money' and select 'Reimbursement/Payment'. You will be able to enter the claim information and direct HealthEquity to make an immediate or future reimbursement. (see "Lifetime Claims and Spending Record" on page 15).

How reimbursement works.

If you paid for a qualified medical expense from an account other than your HSA – and did not use your HSA VISA® card – you are eligible for reimbursement from your HSA. You can choose to save the money and let it grow or simply go online to request that we transfer funds from your HSA into another account or send you a check.



Here's how to submit a request:

1. Once you have received qualified medical care or purchase qualified medical supplies be certain to keep your receipt.

2. Check your HealthEquity account statement or your HealthEquity online account to ensure you have HSA funds available.

3. Complete the online reimbursement request or call our Member Services at 1-866-382-3512 to submit a request.

4. We will deposit the funds directly into your personal checking or savings account or send you a reimbursement check, provided you have funds available in your HSA.

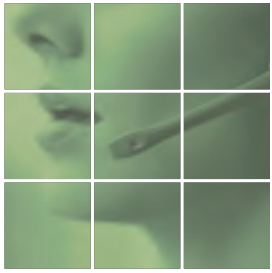
5. You can check your HSA online to review the status of the reimbursement request.

Important: If you don't have enough money in your HSA when you need to pay a medical expense, you can pay it from another account and, when you have enough money in your HSA, then request your reimbursement. Remember, you can only be reimbursed for expenses that were incurred after your HSA was established.

Call our 24-hour, toll free HealthEquity Member Services anytime at 1-866-382-3512

Get the best prices by getting information from your Member Services Representative.

Your HealthEquity Member Services Team works 24/7 to help you find the best prices on qualified health care expenses as well as identifying the best ways to spend your health care dollars.

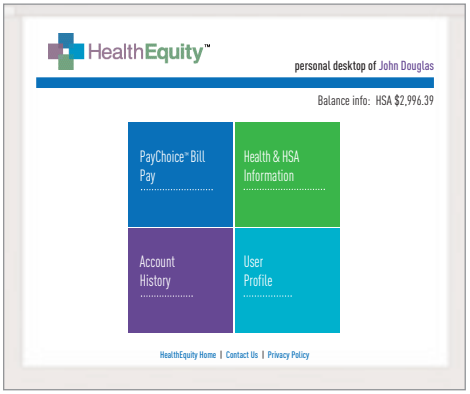


- Use in-network health care providers – These are physicians, other medical professionals, hospitals, labs and care facilities that have agreed to negotiated rates with Aetna. Find your in-network providers by calling the 800 number on your Aetna ID card or visit online at http://www.aetna.com.

- Generic Alternatives – We can help you find out if there are generic equivalents for your prescription drugs and how much you can save if one is available.

- Other ways to save on pharmacy costs – Using mail order pharmacies can often save you money by allowing you to purchase your prescription in larger quantities.

Your HealthEquity® Account Services.



Web-based HSA Tools.

Along with your Aetna HealthFund HSA comes a set of HSA web tools to help you understand and manage the financial side of your health care. They can be accessed through your online Member Account at http://aetna.healthequity.com or you can call our Member Services at 1-866-382-3512 and they can help you use the tools.

Member Services.

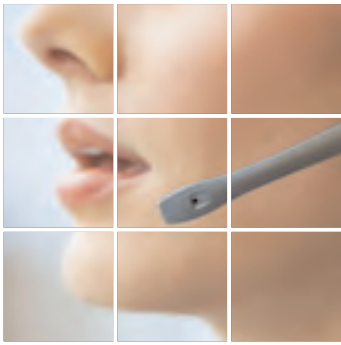
As we've mentioned before, one of the most helpful features of having an Aetna HealthFund HSA is your 24/7 access to HealthEquity Member Services. These aren't simply hired hands who answer phones. They're trained HSA experts who are ready to help you understand and manage your HSA and the financial side of your health care. They can work with your health plan and health care providers.

Anytime you have questions – 24 hours a day, 7 days a week, 365 days a year – you can call Member Services for answers at 1-866-382-3512.

Go to http://aetna.healthequity.com for more information and online tools

Our Member Services Team is here to help you resolve issues and get the most from your HSA, including:

- HSA Administrative Help
  - How your HSA works
  - Account balance inquiries
  - Activating HSA VISA® cards
  - Ordering a HSA VISA® card
  - Requesting reimbursements
  - Paying providers
  - Understanding medical claims



Your HSA VISA® card.

Every account includes one free HSA VISA® card. To activate it, call the number on the sticker on your card. For additional and replacement cards, please call our Member Services line at 1-866-382-3512.

Account Administration.

Our easy-to-use PayChoice™ payment platform at http://aetna.healthequity.com gives you the flexibility to:

- Manage your account information
- See real-time balances
- Reimburse yourself
- Make payments from your account directly to the provider
- Schedule one or more payments in advance
- Set up electronic funds transfers

Investment Options.

To be eligible to invest some or all of your HSA funds, you must maintain a minimum HSA balance. Please contact Member Services to find what the minimum balance requirement is for your HSA or visit http://aetna.healthequity.com. HealthEquity does not charge commissions or investment fees to use the investment option. You are free to buy and sell shares as many times as you want at no cost. Remember, investments in mutual funds are not FDIC insured against loss of value.

Lifetime Claims and Spending Record.

Your online Member Account gives you permanent health care financial records. For example, if you choose to pay your medical expenses out of pocket, rather than from your health savings account, you can record these claims and payments in your Claims and Spending Record and then, after age 65, you can pay yourself back with tax-free dollars from your HSA.

Qualified Medical Expenses.

Your health savings account may be used to pay for qualified medical expenses as determined by law. (But remember, just because an expense is a qualified medical expense doesn't mean it applies towards your deductible – laser eye surgery, for example.) Review your Certificate of Coverage or call your health plan for complete details about what applies to your deductible.

Here's a partial list of qualified medical expenses:

- Acupuncture
- Alcoholism or drug addiction treatment
- Ambulance services
- Artificial limbs
- Artificial teeth
- Bandages
- Birth control pills and other prescription contraceptives
- Braille books and magazines (excess cost)
- Breast reconstruction surgery
- Car Modifications for Disabilities
- Certain non prescription/over-the-counter drugs
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches, purchase or rental
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Eye surgery
- Eyeglasses
- Fertility enhancement
- Guide dog or other animal
- Hearing Aids
- Home care
- Lead-based paint removal
- Legal fees to authorize treatment of mental illness
- Legal termination of pregnancy
- Long-term care
- Medical conferences concerning chronic illnesses
- Nonprescription medicines
- Nursing home
- Nursing services
- Optometrist
- Oxygen
- Prescription medications
- Psychoanalysis (other than related to training)
- Smoking cessation programs
- Special education (if prescribed by doctor)
- Special home for mentally challenged person
- Sterilization (reproductive)
- Telephone or television for hearing impaired
- Therapy prescribed as treatment
- Transplants (costs of donor)
- Transportation and other travel costs for medical care
- Weight loss program (if prescribed by doctor)
- Wheelchair
- Wig (for hair loss if prescribed by doctor)

For more information about qualified medical expenses, contact your tax advisor, visit www.IRS.gov, or contact the IRS directly and ask for section 213 (d).

Partial list of expenses your HSA dollars MAY NOT be used to pay:

Baby-sitting, childcare, and nursing services for a normal, healthy baby

Controlled substances in violation of federal law

Elective cosmetic surgery

Dancing lessons

Diaper services, unless needed to relieve the effects of a particular disease

Electrolysis or hair removal

Expenses used in figuring health coverage tax credit

Funeral expenses

Future medical care

Hair transplant

Health club dues

Household help other than that qualifying as long term care

Illegal operations and treatments

Insurance premiums other than those explicitly included (medical premiums after age 65)

Liposuction

Maternity clothes

Medicines imported from another country

Nutritional supplements unless prescribed for a medically diagnosed condition

Personal use items unless specifically included

Swimming lessons

Teeth whitening

Veterinary fees, except for guide or assistance animals

Weight-loss program

Aetna Avenue®— Your Destination for Small Business Solutions®

NEW YORK PLAN GUIDE

PLANS EFFECTIVE OCTOBER 1, 2011

For businesses with 2-50 eligible employees

64.10.300.1-NY A (7/11)

Aetna®

Health care is a journey …

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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 health 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.

64.43.300.1-NY (6/10)

CHOICE

For business owners and employees

At Aetna, we provide employers a choice of health insurance benefits plans. Within these benefits programs, employers can choose specific plan designs that fit business and employee needs. And, 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

- NYC Community Plan℠
- Exclusive Provider Organization (EPO) plans
- HSA-Compatible plans
- Traditional plans

Dental, life and disability plans — providing valuable protection

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice plan design option
- Preventive
- 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 health 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. Secure and online, Aetna eEnrollment makes managing health benefits easy and eliminates time-consuming, expensive paper-based processes.

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

- Look up rates for providers, facilities and hospitals for common services and treatments
- Track medical claims online
- Discount programs for vision, dental and other health care
- Personal Health Record providing a complete picture of health
- Temporary ID cards available for members to print as needed
- Simple Steps To A Healthier Life®, an online health and wellness program

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.

64.44.300.1-NY (6/10)

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that for small business owners, health insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2-50 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.

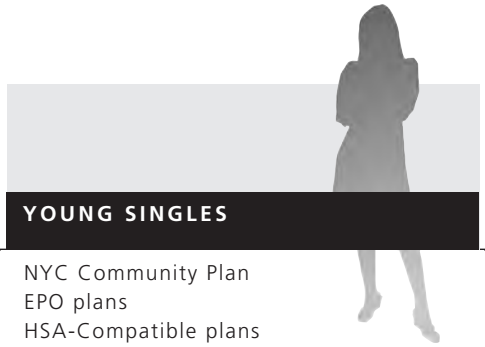
AETNA'S MARKET MAP

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 ...

Basic benefits for your employees Limiting the expense to your business Allowing employees to buy-up and share more of the cost	*You might be a ...* **Basic buyer**	**These plans fit ...** • NYC Community Plan℠ • OA EPO 5-11 • OA EPO 6-11
Employee responsibility Consumerism's ability to make a difference Tools and resources to support consumerism Innovative plan design	*You might be a ...* **Value seeker**	**These plans fit ...** • OA EPO 2-10/10 HSA Compatible • OA EPO 4-10/10 HSA Compatible • OA EPO 5-11 HSA Compatible
Traditional benefits plans Limiting the financial impact on employees	*You might be a ...* **Traditionalist**	**These plans fit ...** • OA EPO 1-11 • OA EPO 2-11 • OA MC 3-11



YOUNG SINGLES

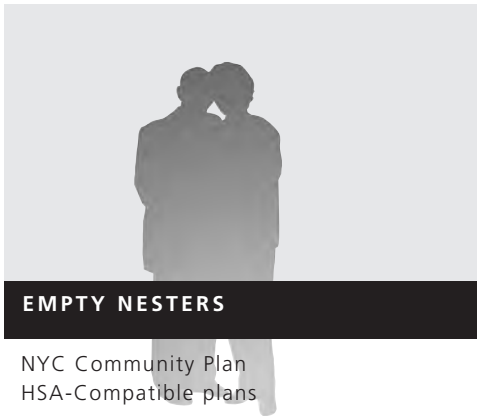
NYC Community Plan
EPO plans
HSA-Compatible plans

YOUNG FAMILIES

NYC Community Plan
EPO plans
HSA-Compatible plans
Traditional plans

ESTABLISHED FAMILIES

NYC Community Plan
EPO plans
HSA-Compatible plans
Traditional plans



EMPTY NESTERS

NYC Community Plan
HSA-Compatible 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.

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.

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.

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.

Aetna Avenue

MEDICAL OVERVIEW

PROVIDER NETWORK*

County	OA EPO	OA MC	NYC Community Plan
Albany	•	•	
Allegany	•	•	
Ashland	•	•	
Bronx	•	•	•
Brooklyn	•	•	•
Broome	•	•	
Cattaraugus	•	•	
Cayuga	•	•	
Chautauqua	•	•	
Chemung	•	•	
Chenango	•	•	
Clinton	•	•	
Columbia	•	•	
Cortland	•	•	
Delaware	•	•	
Dutchess	•	•	
Erie	•	•	
Essex	•	•	
Fulton	•	•	
Greene	•	•	
Hamilton	•	•	
Herkimer	•	•	
Kings	•	•	•
Livingston	•	•	
Madison	•	•	
Montgomery	•	•	
Nassau	•	•	

County	OA EPO	OA MC	NYC Community Plan
New York	•	•	
Niagara	•	•	
Oneida	•	•	
Onondaga	•	•	
Orange	•	•	
Oswego	•	•	
Putnam	•	•	
Queens	•	•	•
Rensselaer	•	•	
Richmond	•	•	•
Rockland	•	•	
Saratoga	•	•	
Schenectady	•	•	
Schuyler	•	•	
Staten Island	•	•	•
Steuben	•	•	
Suffolk	•	•	
Sullivan	•	•	
Tioga	•	•	
Tompkins	•	•	
Ulster	•	•	
Warren	•	•	
Washington	•	•	
Westchester	•	•	
Wyoming	•	•	
Yates	•	•	

*Network subject to change.

Product Name	Product Description	PCP Required	Referrals Required	Network
NYC Community Plan	*NYC Community Plan* The plan is specifically designed and available for residents who live or work and access health care in the five boroughs of New York City — Manhattan, Bronx, Staten Island, Queens and Brooklyn. The NYC Community Plan is an in-network only plan that has two in-network levels of benefits — Referred Benefits and Self-Referred Benefits. *Members access care through NYC Community Plan Primary Care Physicians* With this health benefits plan, members begin by selecting a NYC Community Plan Primary Care Physician (PCP) from the NYC Community Plan's Referred participating providers. Members select a PCP who will coordinate their health care needs for covered benefits or services. Each covered dependent of the member's family may choose his or her own NYC Community Plan PCP. *The NYC Community Plan Referred Benefits:* ▪ Member's PCP coordinates his or her covered health care services. ▪ Referrals are required for services not rendered by the member's PCP; no benefits are payable without a referral. ▪ Benefits include low out-of-pocket costs with no lifetime dollar maximum limitations. ▪ No copay for routine and preventive care services to encourage early detection and prevention of many ailments. *The NYC Community Plan Self-Referred Benefits:* ▪ Members may use the plan's Self-Referred participating providers without referrals from their PCPs. ▪ Member out-of-pocket costs are significantly higher when using Self-Referred participating providers. ▪ Members share the cost of care through deductible and coinsurance amounts including lifetime dollar maximum limitations.	Yes	Yes	NYC Community Plan
Aetna Open Access® Elect Choice® (OA EPO)	The Aetna Open Access Elect Choice plan provides a network-only based managed care product with comprehensive health care benefits. Members are not required to select a PCP to coordinate their care or to obtain referrals for specialty care. Only services rendered by a network provider are covered, except for emergency or urgently needed care.	Optional	No	Elect Choice EPO (Open Access)
Aetna Open Access Managed Choice® (OA MC)	Aetna Open Access Managed Choice® members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs.	Optional	No	Managed Choice POS (Open Access)
Indemnity	This indemnity plan option is available for employees who live outside the plan's network service area. Members coordinate their own health care and may access any recognized provider for covered services without a referral.	No	No	N/A

AETNA OPEN ACCESS MANAGED CHOICE AND OPEN ACCESS ELECT CHOICE HSA COMPATIBLE PLANS

The Aetna Open Access Managed Choice and Open Access Elect Choice insurance plans are compatible with a Health Savings Account (HSA).

It is completely at the discretion of the employer or employee whether or not to establish an HSA. Should an employer or their qualified employee(s) decide to establish an HSA, they may be eligible for an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses. See page 8 for more details on the Aetna HealthFund® Health Savings Account.

Administrative fees

FEE DESCRIPTION	FEE
HSA	
Initial Set-Up	$0
Monthly Fees	$0
POP*	
Initial Set-Up**	$175
Renewal	$100
HRA and FSA***	
Initial Set-Up**	
2-25 Employees	$350
26-50 Employees	$450
Renewal Fee	
2-25 Employees	$225
26-50 Employees	$275
Monthly Fees†	$5.25 per participant
Additional Set-Up Fee for "stacked" plans (those electing an Aetna HRA and FSA simultaneously)	$150
Participation Fee for "stacked" participants	$10.25 per participant
Minimum Fees	
0-25 Employees	$25 per month minimum
26-50 Employees	$50 per month minimum
TRA	
Annual Fee	$350
Transit Monthly Fees	$4.25 per participant
Parking Monthly Fees	$3.15 per participant
COBRA	
Annual Fee 20-50 Employees	$100
Monthly Fee	$0.88 per employee

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.

*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.

†For 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, and are unfunded liabilities of your employer. Fund balances are not vested benefits. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information subject to change.

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

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.

AETNA NYC COMMUNITY PLAN℠ OPTIONS*

PLAN OPTIONS	NYC Community Plan 1-11		NYC Community Plan 6-11	
MEMBER BENEFITS	Referred	Self-Referred	Referred	Self-Referred
Plan Coinsurance	Not Applicable	30% after deductible	Not Applicable	30% after deductible
Calendar Year Deductible**	Not Applicable	$5,000 Individual $15,000 Family	Not Applicable	$5,000 Individual $15,000 Family
Calendar Year Out-of-Pocket Maximum**	Not Applicable	$20,000 Individual $60,000 Family	Not Applicable	$20,000 Individual $60,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Office Visit	$20 copay	30% after deductible	$30 copay	30% after deductible
Specialist Office Visit	$40 copay	30% after deductible	$50 copay	30% after deductible
Preventive Care				
Well-Child Exams & Immunizations (Age and frequency schedules apply)	$0 copay	0%; deductible waived	$0 copay	0%; deductible waived
Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay	30% after deductible	$0 copay	30% after deductible
Outpatient Services				
Lab	$0 copay	30% after deductible	$0 copay	30% after deductible
X-ray and Complex Imaging Services (MRA/MRS, MRI, PET and CAT Scans)	$40 copay	30% after deductible	$50 copay	30% after deductible
Inpatient Hospital	$750 copay per admission	30% after deductible	$300 copay per day up to 3 days per admission	30% after deductible
Outpatient Surgery	$150 copay	30% after deductible	$150 copay	30% after deductible
Emergency Room (Copay waived if admitted)	$150 copay	Paid as Referred	$150 copay	Paid as Referred
Urgent Care	$35 copay	30% after deductible	$35 copay	30% after deductible
Chiropractic Services	$40 copay	30% after deductible	$50 copay	30% after deductible
Outpatient Physical, Occupational and Speech Therapy (Limited to 20 combined visits per calendar year; Referred and Self-Referred combined)	$40 copay	30% after deductible	$50 copay	30% after deductible
Durable Medical Equipment ($2,500 calendar year maximum; Referred and Self-Referred combined)	50%	50% after deductible	50%	50% after deductible
Glasses and Contact Lens Reimbursement	Not Covered		Not Covered	
Aetna Vision℠ Discount Program	Included		Included	
PRESCRIPTION DRUGS††				
Retail (30-day supply)	$15 / $45 / $70	Not Covered	Generics Only – $15 / 50%	Not Covered
Mail Order (31-90 day supply)	$30 / $90 / $140	Not Covered	Generics Only – $30 / 50%	Not Covered
Prescription Drug Calendar Year Maximum	Unlimited	Not Covered	Generics Only – Unlimited	Not Covered

For footnotes, see **page 17**.

AETNA OPEN ACCESS ELECT CHOICE® (OA EPO) PLAN OPTIONS*

PLAN OPTIONS	OA EPO 1-11	OA EPO 2-11	OA EPO 3-11	OA EPO 4-11
MEMBER BENEFITS	Network	Network	Network	Network
Plan Coinsurance	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Calendar Year Deductible**	$1,000 Individual $3,000 Family	$2,000 Individual $6,000 Family	$1,500 Individual $4,500 Family	$2,500 Individual $7,500 Family
Calendar Year Maximum Out-of-Pocket Limit**	$3,000 Individual $9,000 Family	$4,000 Individual $12,000 Family	$4,500 Individual $13,500 Family	$5,000 Individual $15,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Office Visit	$30 copay; deductible waived	$30 copay; deductible waived	$30 copay; deductible waived	$40 copay; deductible waived
Specialist Office Visit	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	$60 copay; deductible waived
Preventive Care				
Well-Child Exams, Immunizations, Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived	$0 copay; deductible waived	$0 copay; deductible waived	$0 copay; deductible waived
Glasses and Contact Lens Reimbursement	$100 every 24 months	$100 every 24 months	$100 every 24 months	$100 every 24 months
Aetna Vision℠ Discount Program	Included	Included	Included	Included
Outpatient Services				
Lab	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	$60 copay; deductible waived
X-ray and Complex Imaging Services (MRA/MRS, MRI, PET and CAT Scans)	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Inpatient Hospital	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	10% after deductible	20% after deductible	20% after deductible
Emergency Room (Copay waived if admitted)	$150 copay; deductible waived	$150 copay; deductible waived	$150 copay; deductible waived	$150 copay; deductible waived
Urgent Care	$75 copay; deductible waived	$75 copay; deductible waived	$75 copay; deductible waived	$75 copay; deductible waived
Chiropractic Services	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	$60 copay; deductible waived
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per calendar year)	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	$60 copay; deductible waived
Durable Medical Equipment ($1,500 calendar year maximum)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC				
Retail (30-day supply)	$15 / $35 / $70	$15 / $35 / $70	$15 / $35 / $70	$15 / $35 / $70
Mail Order (31-90 day supply)	$30 / $70 / $140	$30 / $70 / $140	$30 / $70 / $140	$30 / $70 / $140

For footnotes, see **page 17**.

AETNA OPEN ACCESS ELECT CHOICE® (OA EPO) PLAN OPTIONS*

PLAN OPTIONS	OA EPO 5-11	OA EPO 6-11
MEMBER BENEFITS	Network	Network
Plan Coinsurance	30% after deductible	30% after deductible
Calendar Year Deductible**	$2,500 Individual $7,500 Family	$3,000 Individual $9,000 Family
Calendar Year Maximum Out-of-Pocket Limit**	$6,000 Individual $18,000 Family	$8,000 Individual $24,000 Family
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician Office Visit	$50 copay; deductible waived	$50 copay; deductible waived
Specialist Office Visit	$75 copay; deductible waived	$75 copay; deductible waived
Preventive Care		
Well-Child Exams, Immunizations, Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived	$0 copay; deductible waived
Glasses and Contact Lens Reimbursement	$100 every 24 months	$100 every 24 months
Aetna Vision℠ Discount Program	Included	Included
Outpatient Services		
Lab	$75 copay; deductible waived	$75 copay; deductible waived
X-ray and Complex Imaging Services (MRA/MRS, MRI, PET and CAT Scans)	30% after deductible	30% after deductible
Inpatient Hospital	30% after deductible	30% after deductible
Outpatient Surgery	30% after deductible	30% after deductible
Emergency Room (Copay waived if admitted)	$150 copay; deductible waived	$150 copay; deductible waived
Urgent Care	$75 copay; deductible waived	$75 copay; deductible waived
Chiropractic Services	$75 copay; deductible waived	$75 copay; deductible waived
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per calendar year)	$75 copay; deductible waived	$75 copay; deductible waived
Durable Medical Equipment ($1,500 calendar year maximum)	50% after deductible	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC		
Retail (30-day supply)	$15 / $35 / $70	$15 / $35 / $70
Mail Order (31-90 day supply)	$30 / $70 / $140	$30 / $70 / $140

For footnotes, see page 17.

AETNA OPEN ACCESS ELECT CHOICE® (OA EPO) HSA COMPATIBLE† PLAN OPTIONS*

PLAN OPTIONS	OA EPO 2-10/10 HSA Compatible	OA EPO 4-10/10 HSA Compatible	OA EPO 5-11 HSA Compatible
MEMBER BENEFITS	Network	Network	Network
Plan Coinsurance	10% after deductible	20% after deductible	10% after deductible
Plan Year Deductible**	$2,500 Individual $5,000 Family	$3,500 Individual $7,000 Family	$5,000 Individual $10,000 Family
Plan Year Maximum Out-of-Pocket Limit**	$5,000 Individual $10,000 Family	$5,950 Individual $11,900 Family	$5,950 Individual $11,900 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Office Visit	10% after deductible	20% after deductible	10% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	10% after deductible
Preventive Care			
Well-Child Exams, Immunizations, Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived	$0 copay; deductible waived	$0 copay; deductible waived
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Included	Included
Outpatient Services (Lab, X-ray and Complex Imaging Services — MRA/MRS, MRI, PET and CAT Scans)	10% after deductible	20% after deductible	10% after deductible
Inpatient Hospital	10% after deductible	20% after deductible	10% after deductible
Outpatient Surgery	10% after deductible	20% after deductible	10% after deductible
Emergency Room and Urgent Care	10% after deductible	20% after deductible	10% after deductible
Chiropractic Services	10% after deductible	20% after deductible	10% after deductible
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per plan year)	10% after deductible	20% after deductible	10% after deductible
Durable Medical Equipment ($1,500 plan year maximum)	50% after deductible	50% after deductible	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC			
Retail (30-day supply)	After plan deductible is met, $15 / $35 / $70	After plan deductible is met, $15 / $35 / $70	After plan deductible is met, $15 / $35 / $70
Mail Order (31-90 day supply)	After plan deductible is met, $30 / $70 / $140	After plan deductible is met, $30 / $70 / $140	After plan deductible is met, $30 / $70 / $140

For footnotes, see **page 17**.

AETNA OPEN ACCESS MANAGED CHOICE® (OA MC) PLAN OPTIONS*

PLAN OPTIONS	OA MC 3-11		OA MC 4-11	
MEMBER BENEFITS	Network	Out-of-Network	Network	Out-of-Network
Plan Coinsurance	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Calendar Year Deductible**	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family	$3,000 Individual $9,000 Family	$5,000 Individual $15,000 Family
Calendar Year Maximum Out-of-Pocket Limit**	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family	$5,500 Individual $16,500 Family	$10,000 Individual $30,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Payment for Out-of-Network Care◊	N/A	Professional: 110% of Medicare Facility: 140% of Medicare	N/A	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Office Visit	$25 copay; deductible waived	30% after deductible	$30 copay; deductible waived	40% after deductible
Specialist Office Visit	$50 copay; deductible waived	30% after deductible	$30 copay; deductible waived	40% after deductible
Preventive Care				
Well-Child Exams & Immunizations (Age and frequency schedules apply)	$0 copay; deductible waived	0%; deductible waived	$0 copay; deductible waived	0%; deductible waived
Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived	30% after deductible	$0 copay; deductible waived	40% after deductible
Glasses and Contact Lens Reimbursement (Network and Out-of-Network combined)	$100 every 24 months		$100 every 24 months	
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Outpatient Services				
Lab	$50 copay; deductible waived	30% after deductible	$30 copay; deductible waived	40% after deductible
X-ray and Complex Imaging Services (MRA/MRS, MRI, PET and CAT Scans)	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Inpatient Hospital	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Room (Copay waived if admitted)	$150 copay; deductible waived	Paid as Network	$150 copay; deductible waived	Paid as Network
Urgent Care	$75 copay; deductible waived	30% after deductible	$75 copay; deductible waived	40% after deductible
Chiropractic Services	$50 copay; deductible waived	30% after deductible	$30 copay; deductible waived	40% after deductible
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per calendar year; Network and Out-of-Network combined)	$50 copay; deductible waived	30% after deductible	$30 copay; deductible waived	40% after deductible
Durable Medical Equipment ($1,500 calendar year maximum; Network and Out-of-Network combined)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC				
Retail (30-day supply)	$15 / $35 / $70	$15 / $35 / $70 plus 30%	$15 / $35 / $70	$15 / $35 / $70 plus 30%
Mail Order (31-90 day supply)	$30 / $70 / $140	Not Covered	$30 / $70 / $140	Not Covered

◊We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits and you should contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

AETNA OPEN ACCESS MANAGED CHOICE® (OA MC) HSA COMPATIBLE† PLAN OPTION*

PLAN OPTIONS	OA MC 3-11 HSA Compatible	
MEMBER BENEFITS	Network	Out-of-Network
Plan Coinsurance	20% after deductible	40% after deductible
Plan Year Deductible**	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Plan Year Maximum Out-of-Pocket Limit**	$5,500 Individual $11,000 Family	$9,000 Individual $18,000 Family
Lifetime Maximum	Unlimited	Unlimited
Payment for Out-of-Network Care◊	N/A	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Preventive Care		
Well-Child Exams & Immunizations (Age and frequency schedules apply)	$0 copay; deductible waived	0%; deductible waived
Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived	40% after deductible
Glasses and Contact Lens Reimbursement (Network and Out-of-Network combined)	Not Covered	
Aetna Vision℠ Discount Program	Included	Not Covered
Outpatient Services (Lab, X-ray and Complex Imaging Services — MRA/MRS, MRI, PET and CAT Scans)	20% after deductible	40% after deductible
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room	20% after deductible	Paid as Network
Urgent Care	20% after deductible	40% after deductible
Chiropractic Services	20% after deductible	40% after deductible
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per plan year; Network and Out-of-Network combined)	20% after deductible	40% after deductible
Durable Medical Equipment ($1,500 plan year maximum; Network and Out-of-Network combined)	50% after deductible	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC		
Retail (30-day supply)	After plan deductible is met, $15 / $35 / $70	After plan deductible is met, $15 / $35 / $70 plus 30%
Mail Order (31-90 day supply)	After plan deductible is met, $30 / $70 / $140	Not Covered

◊We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you choose out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits and you should contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

AETNA INDEMNITY PLAN OPTION*

PLAN OPTIONS	Indemnity 1-10/10
MEMBER BENEFITS	
Plan Coinsurance	20% after deductible
Calendar Year Deductible**	$2,500 Individual $7,500 Family
Calendar Year Maximum Out-of-Pocket Limit**	$5,000 Individual $15,000 Family
Lifetime Maximum	Unlimited
Primary Care Physician Office Visit	20% after deductible
Specialist Office Visit	20% after deductible
Preventive Care	
Well-Child Exams, Immunizations, Adult Physicals, Routine GYN, Routine Mammograms, Routine DRE, Routine PSA, Routine Colorectal Cancer Screening & Routine Vision Exams (Age and frequency schedules apply)	$0 copay; deductible waived
Glasses and Contact Lens Reimbursement	$100 every 24 months
Aetna Vision℠ Discount Program	Included
Outpatient Services (Lab, X-ray and Complex Imaging Services — MRA/MRS, MRI, PET and CAT Scans)	20% after deductible
Inpatient Hospital	20% after deductible
Outpatient Surgery	20% after deductible
Emergency Room and Urgent Care	20% after deductible
Chiropractic Services	20% after deductible
Outpatient Physical, Occupational and Speech Therapy (Limited to 30 combined visits per calendar year)	20% after deductible
Durable Medical Equipment ($1,500 calendar year maximum)	50% after deductible
PRESCRIPTION DRUGS†† — MANDATORY GENERIC	
Retail (30-day supply)	$15 / $35 / $70
Mail Order (31-90 day supply)	$30 / $70 / $140

For footnotes, see **page 17**.

FOOTNOTES

*This is a partial description of plans and benefits available; for more information, refer to the specific plan design summary. The dollar amount and percentage copayments indicate what the member is required to pay.

For OA EPO Plans 1-11 through 6-11 and Indemnity 1-10/10: All covered expenses accumulate towards the Deductible and Maximum Out-of-Pocket Limit; only those out-of-pocket expenses resulting from the application of deductible and coinsurance percentage may be used to satisfy the Maximum Out-of-Pocket Limit; and certain services may not apply toward the Deductible or Maximum Out-of-Pocket Limit. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Maximum Out-of-Pocket Limit.

For OA MC Plans 3-11 and 4-11: All covered expenses accumulate separately toward the network and out-of-network Deductible and Maximum Out-of-Pocket Limit; only those out-of-pocket expenses resulting from the application of deductible and coinsurance percentage may be used to satisfy the Maximum Out-of-Pocket Limit; and certain services may not apply toward the Deductible or Maximum Out-of-Pocket Limit. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket Limit amount to the Family Maximum Out-of-Pocket Limit.

For OA EPO HSA Compatible Plans: All covered expenses, including prescription drugs, accumulate towards the Deductible and Maximum Out-of-Pocket Limit; only those out-of-pocket expenses resulting from the application of deductible, coinsurance percentage and copays, including prescription drug copays, may be used to satisfy the Maximum Out-of-Pocket Limit. The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Maximum Out-of-Pocket Limit can be met by a combination of family members or by any single individual within the family. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the plan year.

For OA MC HSA Compatible Plan: All covered expenses, including prescription drugs, accumulate separately toward the network and out-of-network Deductible and Maximum Out-of-Pocket Limit; only those out-of-pocket expenses resulting from the application of deductible, coinsurance percentage and copays, including prescription drug copays, may be used to satisfy the Maximum Out-of-Pocket Limit. The Individual Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Maximum Out-of-Pocket Limit can be met by a combination of family members or by any single individual within the family. Once the Family Maximum Out-of-Pocket Limit is met, all family members will be considered as having met their Maximum Out-of-Pocket Limit for the remainder of the plan year.

For NYC Community Plans: All covered expenses accumulate separately toward the Referred and Self-Referred Deductible and Out-of-Pocket Maximum; only those out-of-pocket expenses resulting from the application of coinsurance percentage may be used to satisfy the Out-of-Pocket Maximum; and certain services may not apply toward the Deductible and Out-of-Pocket Maximum.

◊We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you *choose* out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. When you *choose* out-of-network care, Aetna "recognizes" an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your doctor sets his or her own rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit Aetna.com. Type "how Aetna pays"" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you *choose* to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits and you should contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

†Based upon Treasury guidance available as of the print date.

††Pharmacy plans include Prior Authorization and Step-Therapy. 90-Day Transition of Coverage (TOC) for Prior Authorization and Step-Therapy included on pharmacy plans. Transition of Coverage for Prior Authorization and Step-Therapy helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time Prior Authorization and Step-Therapy requirements will not apply to certain drugs. Once the 90 calendar days has expired, Prior Authorization and Step-Therapy edits will apply to all drugs requiring Prior Authorization and Step-Therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring Prior Authorization and Step-Therapy during the Transition of Coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a Prior Authorization or approval for a medical exception for this drug. NOTE: Step-Therapy and TOC for Step-Therapy are not included on HSA Compatible plans.

Pharmacy Plans also include Mandatory Generic — If the member or the physician requests brand when generic is available, the member pays the applicable copay or coinsurance plus the difference between the generic price and the brand price.

NOTE: For a summary list of Limitations and Exclusions, refer to page 44.

Aetna Avenue

DENTAL OVERVIEW

AETNA DENTAL® PLANS

Small business decision makers can choose from a variety of plan design options that help you offer a dental benefits and dental insurance plan that's just right for your employees.

The Mouth Matters℠

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!

The Aetna Dental/Medical Integration℠ 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.[2] 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.

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

[2]"Dental/medical integration, Improved oral health can lead to a better overall health" *Smart Business Chicago* (1/07).

*DMI may not be available in all states.

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 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 usual 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 option. The Freedom-of-Choice plan design option provides the administrative ease of one plan, yet members get to choose between the DMO and PPO 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.

The Aetna DentalFund® plan

The Aetna DentalFund plan is one of the first dental plans to combine a dental fund benefit with a base dental plan. The paid premium covers both the fund benefit and the traditional benefits of the dental plan. The plan combines the Fund with a PPO Max plan where preventive care is paid through the dental plan. Members can use their funds to pay for basic and major services received from any licensed dentist. If any dental fund dollars are not used during the year, they can be rolled over and added to the following year's dental fund balance.

*Dual Option plan***

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.

*Discounts for non-covered services may not be available.

**Dual Option does not apply to Voluntary Dental plans.

SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	Option 2	Option 3 Freedom-of-Choice Monthly selection between the DMO and PPO		Option 4
	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/50	PPO Max Plan 100/80/50
Office Visit Copay	$5	$5	None	None
Dental Fund	N/A	N/A	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	None	None	$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%	50%	50%
Partial upper denture (resin base)	50%	60%	50%	50%
Crown — Porcelain with noble metal[1]	50%	60%	50%	50%
Pontic — Porcelain with noble metal[1]	50%	60%	50%	50%
Inlay — Metallic (3 or more surfaces)	50%	60%	50%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	50%	60%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	80%	90%	50%	50%
Molar root canal therapy	50%	60%	50%	50%
Periodontic Services				
Scaling & root planing — per quadrant	80%	90%	50%	50%
Osseous surgery — per quadrant	50%	60%	50%	50%
***ORTHODONTIC SERVICES**	$2,300 copay	$2,300 copay	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan option 10. The DentalFund in Plan Option 7 can be used to pay for any non-covered service, excluding Orthodontic services. Any unused portion of the Fund will roll over to the next calendar year.

*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 DMO in Plan Options 2, 3, 8 & 10 or the DentalFund in Plan Option 7.

Fixed dollar amounts on the DMO in Plan Options 2, 3, 8 & 10, including office visit and ortho copays, are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be 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. Discounts are not insurance.

The DMO in Plan Options 2 & 10 can be offered with any of the PPO plans in Plan Options 4-6 & 9 in a Dual Option package.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Option 9.

Plan Options 3, 4 & 7; 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.

Out-of-Network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

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 42.

SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	Option 5 Active PPO Plan		Option 6	Option 7 Consumer-Directed
	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/50	PPO 1500 Plan 100/80/50	DentalFund/PPO Max 100/0/0
Office Visit Copay	None	None	None	None
Dental Fund	N/A	N/A	N/A	$50 Single; $100 Family
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	None
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	80%	100%	100%
Comprehensive oral exam	100%	80%	100%	100%
Problem-focused oral exam	100%	80%	100%	100%
X-rays				
Bitewing — single film	100%	80%	100%	100%
Complete series	100%	80%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	80%	100%	100%
Child Cleaning	100%	80%	100%	100%
Sealants — per tooth	100%	80%	100%	100%
Fluoride application — with cleaning	100%	80%	100%	100%
Space maintainers	100%	80%	100%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces	80%	60%	80%	Not Covered
Resin filling — 2 surfaces, anterior	80%	60%	80%	Not Covered
Oral Surgery				
Extraction — exposed root or erupted tooth	80%	60%	80%	Not Covered
Extraction of impacted tooth — soft tissue	80%	60%	80%	Not Covered
***MAJOR SERVICES**				
Complete upper denture	50%	50%	50%	Not Covered
Partial upper denture (resin base)	50%	50%	50%	Not Covered
Crown — Porcelain with noble metal[1]	50%	50%	50%	Not Covered
Pontic — Porcelain with noble metal[1]	50%	50%	50%	Not Covered
Inlay — Metallic (3 or more surfaces)	50%	50%	50%	Not Covered
Oral Surgery				
Removal of impacted tooth — partially bony	50%	50%	50%	Not Covered
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	Not Covered
Molar root canal therapy	50%	50%	50%	Not Covered
Periodontic Services				
Scaling & root planing — per quadrant	50%	50%	50%	Not Covered
Osseous surgery — per quadrant	50%	50%	50%	Not Covered
***ORTHODONTIC SERVICES**	50%	50%	50%	Not Covered
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	Does not apply

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan option 10. The DentalFund in Plan Option 7 can be used to pay for any non-covered service, excluding Orthodontic services. Any unused portion of the Fund will roll over to the next calendar year.

*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 DMO in Plan Options 2, 3, 8 & 10 or the DentalFund in Plan Option 7.

Fixed dollar amounts on the DMO in Plan Options 2, 3, 8 & 10, including office visit and ortho copays, are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be 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. Discounts are not insurance.

The DMO in Plan Options 2 & 10 can be offered with any of the PPO plans in Plan Options 4 -6 & 9 in a Dual Option package.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Option 9.

Plan Options 3, 4 & 7; 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.

Out-of-Network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

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 42.

SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	**Option 8 Freedom-of-Choice Monthly selection between the DMO and PPO**		**Option 9**	**Option 10**
	DMO Plan 100/90/60	PPO 1500 Plan 100/80/50	PPO 2000 Plan 100/80/50	DMO plan 41
Office Visit Copay	$5	None	None	$5
Dental Fund	N/A	N/A	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	$50; 3X Family Maximum	$50; 3X Family Maximum	None
Annual Maximum Benefit	None	$1,500	$2,000	None
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%	$100
BASIC SERVICES				
Amalgam filling — 2 surfaces	90%	80%	80%	$32
Resin filling — 2 surfaces, anterior	90%	80%	80%	$55
Oral Surgery				
Extraction — exposed root or erupted tooth	90%	80%	80%	$30
Extraction of impacted tooth — soft tissue	90%	80%	80%	$80
***MAJOR SERVICES**				
Complete upper denture	60%	50%	50%	$500
Partial upper denture (resin base)	60%	50%	50%	$513
Crown — Porcelain with noble metal[1]	60%	50%	50%	$488
Pontic — Porcelain with noble metal[1]	60%	50%	50%	$488
Inlay — Metallic (3 or more surfaces)	60%	50%	50%	$463
Oral Surgery				
Removal of impacted tooth — partially bony	60%	50%	80%	$175
Endodontic Services				
Bicuspid root canal therapy	90%	50%	80%	$195
Molar root canal therapy	60%	50%	80%	$435
Periodontic Services				
Scaling & root planing — per quadrant	90%	50%	80%	$65
Osseous surgery — per quadrant	60%	50%	80%	$445
***ORTHODONTIC SERVICES**	$2,300 copay	Not covered	50%	$2,300 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply	$1,000	Does not apply

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan option 10. The DentalFund in Plan Option 7 can be used to pay for any non-covered service, excluding Orthodontic services. Any unused portion of the Fund will roll over to the next calendar year.

*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 DMO in Plan Options 2, 3, 8 & 10 or the DentalFund in Plan Option 7.

Fixed dollar amounts on the DMO in Plan Options 2, 3, 8 & 10, including office visit and ortho copays, are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be 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. Discounts are not insurance.

The DMO in Plan Options 2 & 10 can be offered with any of the PPO plans in Plan Options 4 - 6 & 9 in a Dual Option package.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Option 9.

Plan Options 3, 4 & 7; 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.

Out-of-Network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

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 42.

AETNA OUT-OF-STATE SMALL GROUP DENTAL PLANS

	Low Option No Ortho	Low Option Ortho	Medium Option No Ortho	Medium Option Ortho
	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	$50; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000	$1,500	$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%	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**	Not covered	50%	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000	Does not apply	$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.
Access to negotiated discounts: On all PPO Max plans, members may be 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. Discounts are not insurance.
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.
Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.
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 42.
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, Wyoming.

AETNA OUT-OF-STATE SMALL GROUP DENTAL PLANS

	High Option No Ortho	High Option Ortho	Voluntary Out-of-State Option 1** No Ortho	Voluntary Out-of-State Option 1** Ortho
	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	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	$2,000	$2,000	$1,000	$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**	Not covered	50%	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000	Does not apply	$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.

**For the voluntary Out-of-State 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.

Access to negotiated discounts: On all PPO Max plans, members may be 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. Discounts are not insurance.

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.

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

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 42.

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, Wyoming.

SMALL GROUP DENTAL PLANS

Voluntary Options — Available With and Without an Aetna Medical Plan to Groups with 3-50 Eligible Employees	**Voluntary Option 2**	**Voluntary Option 3 Freedom-of-Choice Monthly selection between the DMO and PPO**		**Voluntary Option 4**	**Voluntary Option 5**
	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/50	PPO Max Plan 100/80/50	DMO plan 41
Office Visit Copay	$10	$10	N/A	N/A	$10
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$75; 3X Family Maximum	$75; 3X Family Maximum	None
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	$1,500	None
DIAGNOSTIC SERVICES					
Oral Exams					
Periodic oral exam	100%	100%	100%	100%	No Charge
Comprehensive oral exam	100%	100%	100%	100%	No Charge
Problem-focused oral exam	100%	100%	100%	100%	No Charge
X-rays					
Bitewing — single film	100%	100%	100%	100%	No Charge
Complete series	100%	100%	100%	100%	No Charge
PREVENTIVE SERVICES					
Adult Cleaning	100%	100%	100%	100%	No Charge
Child Cleaning	100%	100%	100%	100%	No Charge
Sealants — per tooth	100%	100%	100%	100%	$10
Fluoride application — with cleaning	100%	100%	100%	100%	No Charge
Space maintainers	100%	100%	100%	100%	$100
BASIC SERVICES					
Amalgam filling — 2 surfaces	80%	90%	70%	80%	$32
Resin filling — 2 surfaces, anterior	80%	90%	70%	80%	$55
Oral Surgery					
Extraction — exposed root or erupted tooth	80%	90%	70%	80%	$30
Extraction of impacted tooth — soft tissue	80%	90%	70%	80%	$80
***MAJOR SERVICES**					
Complete upper denture	50%	60%	50%	50%	$500
Partial upper denture (resin base)	50%	60%	50%	50%	$513
Crown — Porcelain with noble metal[1]	50%	60%	50%	50%	$488
Pontic — Porcelain with noble metal[1]	50%	60%	50%	50%	$488
Inlay — Metallic (3 or more surfaces)	50%	60%	50%	50%	$463
Oral Surgery					
Removal of impacted tooth — partially bony	50%	60%	50%	50%	$175
Endodontic Services					
Bicuspid root canal therapy	80%	90%	50%	50%	$195
Molar root canal therapy	50%	60%	50%	50%	$435
Periodontic Services					
Scaling & root planing — per quadrant	80%	90%	50%	50%	$65
Osseous surgery — per quadrant	50%	60%	50%	50%	$445
***ORTHODONTIC SERVICES**	$2,400 copay	$2,400 copay	Not covered	Not covered	$2,400 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Voluntary Option 5.

*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 2, 3 & 5.

Fixed dollar copay amounts on the DMO in DMO Voluntary Options 2, 3 & 5 are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Voluntary Plan Options 3 & 4, members may be 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. Discounts are not insurance.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 2, 3 & 5.

Voluntary Plan Options 3 & 4: 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.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only. Minimum of 5 must enroll for Orthodontic coverage.

If there is a lapse in coverage, members may not re-enroll in the plan for a period of 24 months 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.

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 42.

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

Aetna Life Insurance Company (Aetna) Small Group packaged life and disability insurance or benefits 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 benefits payout to include useful enhancements through the *Aetna Life Essentials*℠ 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 benefits 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 insurance or benefits plans provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. This includes extra features at no additional cost to you, 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 insurance or benefits 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 in-depth 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.
- Health Insurance Portability and Accountability Act (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 43.

Life insurance policies and Disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

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
Guaranteed Issue	$20,000	10-25 employees $75,000 26-50 employees $100,000
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
Disability 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
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

PACKAGED LIFE AND DISABILITY PLAN OPTIONS

Basic Life Plan Design	Low Option	Medium Option	High Option
Benefit	Flat $10,000	Flat $20,000	Flat $50,000
Guaranteed Issue **2-9 Lives** **10-50 Lives**	 $10,000 $10,000	 $20,000 $20,000	 $20,000 $50,000
Reduction Schedule	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75
Disability Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60
Conversion	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
Dependent Life	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
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 $1000; Only offset Workers' Compensation, any State Disability Plan, and Primary and Family Social Security benefits	Flat $1000; Only offset Workers' Compensation, any State Disability Plan, and Primary and Family Social Security benefits
Elimination Period	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.	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	60 months
Pre-Existing Condition Limitation	3/12	3/12	3/12
Types of Disability	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
Mental Health/ Substance Abuse	24 months of benefits	24 months of benefits	24 months of benefits
Waiver of Premium	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
Minimum Participation	2-9 Lives — 100% 10+ Lives — 75%	2-9 Lives — 100% 10+ Lives (with Medical) — 70% 26+ Lives (Standalone) — 75%	2-9 Lives — 100% 10+ Lives — 75%
Eligibility	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
Rates PEPM	$8.00	$15.00	$27.00

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

Life insurance policies and Disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

For Businesses with 50 or Fewer Eligible Employees

This material is for informational purposes only and 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 except where Head Underwriter approval is indicated. 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.

Census Data	▪ Census data must be provided on all eligible, including COBRA eligible and/or State Continuation employees. Include name, date of birth, date of hire, gender, dependent status, and residence zip code. ▪ Retirees are not eligible. ▪ COBRA/Continuation eligible's should be included on the census and noted as COBRA/Continuation. ▪ Rates are quoted on a 4-tier structure: single, couple, employee plus child(ren), family.
Case Submission Dates	▪ All required paperwork must be received by Aetna on the 25th of the previous month for 1st of the month effective dates and the 10th of the month for 15th of the month effective date.
COBRA and/or State Continuees	▪ COBRA coverage will be extended in accordance with the federal law. ▪ COBRA and State Continuees are not eligible for Life or Disability coverage. State Continuees are not eligible for Stand Alone Dental, Life or Disability coverage. ▪ Health information must be provided on COBRA and State Continuees along with the rest of the group. ▪ COBRA/State continuees qualifying event, length, start and end date must be provided. ▪ Employers with 20 or more employees (full and part-time) are eligible to offer COBRA coverage. ▪ Employers with less than 20 employees (full and part-time) are eligible to offer State Continuation. ▪ Note: COBRA/State 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, COBRA/State Continuees can be included for coverage subject to normal underwriting guidelines.
Deductible Credit	▪ 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 no later than 90 days after the effective date. ▪ This may be submitted at the initial small group submission or with their first claim.

Dependent Eligibility	▪ Eligible dependents include an employee's spouse or domestic partner. If both husband and wife work for the same company they may enroll together or separately, except one and two life groups, the spouse must enroll separately. ▪ Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26. ▪ Children can only be covered under one parent's plan. ▪ Children's coverage can be extended to age 30 for medical. – Option 1 — Young Adult Option to age 30 upon written request. Premium is based on single employee rate. – Option 2 — Make Available Option to age 30. Premium adjusted to incorporate the expanded depended age. ▪ Stepchildren are eligible if they reside with the employee. ▪ Grandchildren are eligible if court ordered. ▪ Life — children are eligible to age 19 or 23 if attending school on a regular basis and dependent solely on the employee for support. ▪ Dependents are not eligible for AD&D or Disability coverage. ▪ For Medical and Dental, dependents must enroll in the same benefits as the employee (participation is not required). ▪ Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan. See product-specific Life/AD&D and Disability guidelines under Product Specifications. ▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan.
Dual Option	▪ Groups with a minimum of 5 enrolled in any Aetna product with 50% participation after valid waivers are eligible for any combinations of our Aetna Open Access Managed Choice plans, Aetna Open Access EPO plans or NYC Community Plans. ▪ A minimum of one person must enroll in each plan when a dual option is offered. ▪ Not allowed the same medical plan to be offered with different Pharmacy options. The medical plans must be different.
Triple Option	▪ Groups with a minimum of 10 employees enrolling in any Aetna product with 50% participation after valid waivers are eligible for any combination of our Aetna Open Access Managed Choice Plans, Aetna Open Access EPO plans or NYC Community Plans. ▪ A minimum of one person must be enrolled in each plan when a triple option is offered. ▪ Not allowed the same medical plan to be offered with different Pharmacy options. The medical plans must be different.
Effective Date	▪ 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.
Electronic Funds Transfer	▪ Payment for the first month's premium at new business can be processed via an Electronic Funds Transfer. ▪ Once the group is approved and the contract is issued, future monthly premiums can by paid online or by calling an automated phone number, **1-866-350-7644**, with no extra charge. This eliminates the need for checks, envelopes and postage while also supplying peace of mind that payments have been received.

Employee Eligibility	▪ Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 20 hours, and who have met any authorized waiting period. ▪ If an employee and dependent work for the same company and elect to enroll as employee and dependent, applicable documentation to determine dependent's actual employment status must be provided as any other employee of the group (i.e., NYS-54, Partnership documentation, etc.) ▪ Part-time, temporary, or substitute employees are not eligible. ▪ Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. ▪ If the employer's Employee Eligibility Criteria definition differs from the above definition (more than 20 hours), the employer's actual definition must be provided on the Employer Application at the time of new business submission. Note: the normal workweek cannot be less than 20 hours. ▪ Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa. ▪ Employees/Individuals not eligible for coverage include 1099 contractors, temporary, seasonal, substitute, uncompensated employee(s), volunteer, early retiree (<65 years of age), inactive owner, shareholder only, board member(s), outside consultant(s), officer(s) who are not active, managing member who is not active, investor only, or a silent partner. ▪ NY Small Group reform excludes union employees who are covered by a collective bargaining agreement. ▪ For life and disability, 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 for one full day. ▪ An employee can waive medical coverage and still enroll for dental and life/AD&D and disability. ▪ An employee is eligible to enroll in a NYC Community Plan only if he or she resides or works and accesses health care in the five boroughs of New York City — Manhattan, Bronx, Queens, Staten Island and Brooklyn. Retirees ▪ Retiree coverage is not available. ▪ Medicare eligible retirees who are enrolled in an Aetna Medicare Plan are eligible to enroll in Standard Dental Plans in accordance with these Dental Underwriting Guidelines. ▪ Retirees are not eligible for Life or Disability insurance coverage.
Employer Definition	▪ An employer with 2 – 50 eligible employees.
Employer Eligibility	▪ Group applicants that do not meet the above definition of a small employer are not eligible for coverage. ▪ Medical plans can be offered to sole proprietorships, partnerships or corporations. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage. ▪ Associations, Taft-Hartley groups, Professional Employers Organizations (PEO) employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage. ▪ Dental and Packaged Life and Disability have ineligible industries which are listed separately under Product Specifications. ▪ The Dental ineligible industry list does not apply when Dental is sold in combination with Medical.
Initial Premium Check	▪ 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 and does not bind Aetna to provide coverage. ▪ Electronic Funds Transfer option is available for the initial premium payment. ▪ If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer. ▪ If the initial premium check is returned for non-sufficient funds, coverage will be terminated retroactive to the effective date.

Licensed, Appointed Producers	▪ Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna Products. ▪ License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted.
Live/Work	▪ Live or work allowed as long as either the work zip or the residence zip is within the situs area (CT, DE, MD, NJ, NY, PA, VA, DC.)
Municipalities and Townships	▪ A township is generally a small unit that has the status and powers of local government. ▪ A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town, or village. A municipality is typically governed by a mayor and city council, or municipal council. In most countries a municipality is the smallest administrative subdivision to have its own democratically elected officials. ▪ Underwriting Requirements – Quarterly Wage and Tax Statement (QWTS). – W2 — Elected or Appointed officials and Trustees "may" be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS rather they may be paid via W2 and must provide a copy of their W2. – If elected officials are to be covered, provide a copy of the charter or contract indicating which classes or employees are to be covered, the minimum hours required to work per week to be eligible for coverage, and confirmation that coverage will be offered to all employees meeting the minimum number and participation will be maintained.
Newly Formed Business (in operation less than 3 months)	Newly formed businesses that have been in business for <u>at least 6 weeks</u> may be considered if the following are provided: ▪ 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) Each Newly formed business must also provide: ▪ Proof of Employer Identification Number/Federal Tax ID Number; and ▪ Quarterly Wage and Tax statement. If not available, when will one be filed; and ▪ The most recent two consecutive weeks worth of payroll records which includes hours worked, taxes withheld, check number and wages earned; or ▪ A letter from a CPA with the following information: – 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 be filed? If so, when? ▪ Groups that are not subject to Guarantee Issue may be declined.

PEO **(Professional Employer Organization)**	▪ As long as we can determine the group is a small employer via a QWTS or payroll records, the group may be accepted. ▪ There may be situations where the small employer contracts for services with a PEO. As long as the PEO provides payroll specific for the small group and we can determine it is a small group through the small employers TAX ID number on the payroll.
Prior Aetna Coverage	▪ Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until: (1) 12 months after the termination date and (2) payment of two months of premium in advance of issuance of the health benefit plan. Additionally, all premiums still owed on the prior Aetna plan must be paid in full. ▪ Current carrier bill with billing summary and employee roster is required; group must be no more than one month in arrears on payments (i.e., current month only may not yet be paid).
Rate Guarantee	▪ Medical rates are guaranteed for one year (12 months). ▪ Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date this does not apply. ▪ Life rates are guaranteed for 2 years (24 months).
Rating	▪ Community rated
Replacing Other Group Coverage	▪ Provide a copy of the current billing statement that includes the account summary. ▪ The employer should be told not to cancel any existing medical coverage until they have been notified of approval from the Aetna Underwriting unit.
Signature Dates	▪ The Aetna Employer Application and all employee applications must be signed and dated prior to and within ninety (90) days of the requested effective date. ▪ All employee applications must be completed by the employee himself/herself.
Spin Off Groups (current Aetna customers leaving an Aetna group only)	Aetna will consider the group with the following: ▪ 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 the amount of time in business up to a maximum of 6 consecutive weeks. ▪ Current Aetna customers leaving an Aetna group will have medical claims reviewed along with the health information provided on the employee application and included in the overall medical assessment of the group.

Tax Information/ Documents for groups with 2 to 20 eligibles AND groups with 21+ eligibles WITHOUT prior GROUP coverage

Groups 2 to 20 eligible employees and groups 21+ eligible employees without prior coverage must provide the following:

- A copy of the most recent Quarterly Wage and Tax Statement (QWTS) must be provided for all groups.
- The QWTS must contain the names and wages of all employees of the employer group.
- Employees who have terminated, work part-time or are newly hired should be noted accordingly on the QWTS.
- Any hand written comments added to the QWTS must be signed and dated by the employer. The underwriter may request payroll in questionable situations.
- Newly hired employees should be written in on the Quarterly Wage & Tax Statement and signed by the employer. The underwriter may request payroll in questionable situations.
- 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.
- Proprietors, Partners or Officers of the business who do not appear on the QWTS should submit one of the following identified documents. This list is not all inclusive. The employer may provide any other documentation to establish eligibility.

Sole Proprietor ▪ Franchise ▪ Limited Liability Company (operating as a Sole Proprietor)	▪ IRS Form 1040 along with Schedule C (Form 1040) ▪ IRS Form 1040 along with Schedule SE (Form1040) ▪ IRS Form 1040 along with Schedule F (Form 1040) ▪ IRS 1040 along with Schedule K1 (Form 1065) ▪ Any other documentation the owner would like to provide to determine eligibility
Partner ▪ Partnership ▪ Limited Liability Partnership	▪ IRS Form 1065 Schedule K-1 ▪ IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) ▪ Partnership agreement if established within 2 years — eligible partners must be listed on agreement ▪ Any other documentation the owner would like to provide to determine eligibility
Corporate Officer ▪ Limited Liability Company (operating as C Corp) ▪ C-Corporation ▪ Personal Service Corporation ▪ S-Corporation	▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040) ▪ IRS Form 1120 W (C-Corp & Personal Service Corp) ▪ 1040 ES (Estimated Tax) (S-Corp) ▪ IRS Form 8832 (Entity classification as a corporation) ▪ W2 ▪ Articles of Incorporation if established within 2 years — corporate officers must be listed ▪ Any other documentation the owner would like to provide to determine eligibility

Tax Information/ Documents for groups with 21+ eligibles WITH prior GROUP coverage	▪ A QWTS is not needed if a bill roster is provided and at least 75% of the employees are on the prior carrier billing statement. ▪ A copy of the current billing statement that includes the account summary and employee roster is needed. ▪ The underwriter may request additional information if warranted.
Two or more companies — Affiliated, Associated or Multiple Companies, Common Ownership	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: ▪ 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. ▪ 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. ▪ The two or more groups may have multiple Standard Industrial Classification (SIC); however, rates will be based on the SIC code for the group with the majority of employees (not applicable to medical). ▪ Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception. *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.
Waiting Period	▪ 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. ▪ The benefit waiting period for future employees may be 1, 2, 3, 4, 5 or 6 months. ▪ A change to the benefit waiting period may only be made on the plan anniversary date. ▪ No retro active changes will be allowed. ▪ Only 1 waiting period is allowed. ▪ Benefit waiting periods must be consistently applied to all employees, including newly hired key employees ▪ For new hires, the eligibility date will be the first day of the policy month following the waiting period. *Examples:* 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.

PRODUCT SPECIFICATIONS

	Medical	Dental	Basic Life/AD&D, Packaged Life and Disability
Product Availability	▪ 2 to 50 eligible employees. ▪ May be written standalone or with ancillary coverage as noted in the following columns. ▪ Only non-occupational injuries and disease will be covered. ▪ NYC Community Plan is only available to employers who are located in the five boroughs of New York City — Manhattan, Bronx, Queens, Staten Island and Brooklyn.	1 life ▪ Not available 2 eligible employees ▪ Standard Dental available with Medical. ▪ Voluntary Dental not available. 3 to 50 eligible employees ▪ Standard Dental available with or without Medical. ▪ Voluntary Dental available with or without Medical. ▪ Standalone available. Standalone Dental has ineligible Industries which are listed separately under the SIC code section of the guidelines. Orthodontia coverage ▪ Available with 10 or more eligible employees with a minimum of 5 enrolled employees for dependent children only.	Life ▪ 1 life not available. ▪ 2 to 9 eligible employees available if packaged with Medical. ▪ 10 to 50 eligible employees available if packaged with Medical or Dental. ▪ 26 to 50 eligible available on a standalone basis. Packaged Life and Disability ▪ 2 to 50 eligible employees if packaged with medical. ▪ 10 to 50 eligible employees on a standalone basis. ▪ A plan sponsor cannot purchase both Life and Packaged Life and Disability plans. ▪ Product packaging rule is a group level requirement. Employees will be able to individually elect Life, Disability or Packaged Life & Disability insurance even if they do not elect Medical coverage.
Excluded Class/ Carve Outs	NYC Community Plans: ▪ Union employees, as a class, may be excluded by an employer as not being eligible for coverage. ▪ Coverage of management employees only is permitted when selling an HMO. Aetna Open Access Managed Choice/EPO ▪ Union employees, as a class, may be excluded by an employer as not being eligible for coverage. ▪ Coverage of management employees only is not permitted when selling Managed Choice or EPO.	Not allowed	Not allowed

PRODUCT SPECIFICATIONS

	Medical	Dental	Basic Life/AD&D, Packaged Life and Disability
Employer Contribution	Contracts issued for NYC Community Plans: ▪ We strongly recommend groups with less than 10 eligible lives, the employer contribute 100% of the employee only cost or 50% of the total cost of the plan. ▪ We strongly recommend groups with 10 to 50 eligible lives, the employer contributes at least 50% of the total cost of the plan. Contracts Issued for Aetna Open Access Managed Choice/EPO products: ▪ Groups with less than 10 eligible lives, the employer must contribute 100% of the employee-only cost or 50% of the total cost of plan. ▪ Groups with 10 to 50 eligible lives, the employer must contribute at least 50% of the employee-only cost or 50% of the total cost of the plan.	Standard Dental ▪ 2 to 50 eligible's ▪ 25% of the total cost of the plan or 50% of the cost of employee only coverage. Voluntary Dental ▪ Employer contribution of less than 50% of the cost of the employee-only coverage. ▪ Employee-Pay-All plans are permitted. Standard and Voluntary ▪ Coverage can be denied based on inadequate contributions.	▪ 2 to 9 eligible employees — 100% of the total cost of the basic Life plan. ▪ 10 to 50 eligible employees — At least 50% of the total cost of the plans excluding Optional Dependent Term Life. All ▪ Coverage can be denied based on inadequate contributions.
Late Applicants	▪ An employee or dependent that 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.		
	▪ 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.	▪ An employee or dependent may enroll at any time; however, coverage is limited to Preventive & Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics). ▪ Late Entrant provision does not apply to enrollees less than age 5.	▪ 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 EOI. ▪ Life late enrollee example: Group has $50,000 life with $20,000 guarantee issue limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late they must medically qualify for the entire $50,000.

PRODUCT SPECIFICATIONS

	Medical	Dental	Basic Life/AD&D, Packaged Life and Disability
Medical Underwriting	Not applicable	Not applicable	▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested. ▪ Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts listed below will be required to submit Evidence of Insurability (EOI) which means they must complete an individual health statement and may have to submit to medical evidence via medical records at their expense.
Out-of-state employees	▪ Any active employee who resides outside of CT, DE, MD, NJ, NY, PA, VA and DC (Situs Area) is considered an Out-of-State employee. ▪ In order for Aetna to accommodate an out-of-state/Situs employee, we must cover the active employees in the domiciled state. More than 50% of domiciled employees must work in New York. ▪ Any employee residing in a state with an Aetna Managed Choice or Elect Choice (EPO) Network will be eligible to enroll in the New York Managed Choice or EPO Benefit Plan. ▪ Any employee not residing in a state with an Aetna Managed Choice or EPO Network will be enrolled in the New York Indemnity Benefit Plan. ▪ Indemnity is not available in HI or VT. ▪ Any employee located in CT, DE, MD, NJ, NY, PA, VA or DC, but not residing within an Aetna Managed Choice or EPO Network will be enrolled in the New York Indemnity Benefit Plan. ▪ Out-of-state employees residing in Louisiana are required to have a separate plan quoted and sold based on Louisiana rates and benefits. These employees are still underwritten as part of the group, however, the plans and rates for the LA members will not be based on where the Employer is located.	▪ Out-of-state employees can only be offered one of the specific out-of-state Dental plans; 3 PPO and 3 Indemnity plan designs. ▪ Only one out-of-state Indemnity plan may be selected for the group. ▪ Maximum out-of-state employee percentage (and/or number of employees) will agree with the Medical guideline for each state. ▪ Out-of-state employees must be enrolled in a PPO Dental plan if available, otherwise an indemnity Dental plan. ▪ OOS PPO dental is not available in the following states: AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, VT, and WY.	▪ Not applicable. ▪ Employees are eligible for Basic Term Life and Packaged Life/Disability.

PRODUCT SPECIFICATIONS

	Medical	Dental	Basic Life/AD&D, Packaged Life and Disability
Participation	NYC Community Plans ▪ Contracts issued for the NYC Community Plan do not require a minimal participation. ▪ All groups must meet minimum eligibility requirements. Non-contributory plans ▪ 100% participation is required, excluding valid waivers. Open Access Managed Choice/ EPO, Contributory Plans ▪ 2 to 50 employees. ▪ 50% excluding valid waivers. ▪ Waivers are defined as spousal, Medicare or VA. ALL ▪ Every eligible employee listed on the quarterly wage and tax statement must complete an enrollment form or waiver form. ▪ Other coverage sponsored by the same employer does not count as a valid waiver.	Non-contributory plans ▪ 100% participation is required, excluding those with other qualifying dental coverage. Contributory ▪ 50% 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. ▪ Employees may select coverage for eligible dependents under the dental plan even if they elected single coverage on the medical plan or vice versa. ▪ Coverage can be denied based on inadequate participation.	All ▪ COBRA and State Continuees are not eligible. ▪ Retirees are not eligible. Life ▪ 2 to 50 employees — 50% or 5, whichever is fewer, must participate in the plan. ▪ Employees may elect Life insurance even if they do not elect medical coverage and the group must meet the required participation percentage. If not, then Life will be declined for the group. ▪ Coverage can be denied based on inadequate participation.
Plan Change Group Level	▪ Plan anniversary date only.	▪ Dental plans must be requested 30 days prior to the desired effective date. ▪ The future renewal date of the change will be the same as the medical plan anniversary date.	▪ Packaged Life/Disability must be requested 30 days prior to the desired effective date. ▪ Non-packaged plans are only available on the plan anniversary date.
Plan Change Employee Level	▪ Employees are not eligible to change plans until the group's open enrollment period which is upon their annual renewal (except for qualified Special Enrollment events).	▪ Freedom-of-Choice — May change from voluntary to standard and vice versa at anytime.	▪ Employees are not eligible to change plans until the group's open enrollment period which is upon their annual renewal (except for qualified Special Enrollment events).
Rate Guarantee	▪ Medical rates are guaranteed for one year (12 months).	▪ Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date this does not apply.	▪ Life rates are guaranteed for 2 years (24 months).

PRODUCT SPECIFICATIONS

<table>
<tr><th></th><th>Medical</th><th>Dental</th><th>Basic Life/AD&D,
Packaged Life and Disability</th></tr>
<tr><td>Standard Industrial Classification Code (SIC)</td><td>▪ All industries are eligible.
▪ The employer should provide the SIC code (four digit number) or NAIC state code 6 digit code) filed with the state on the business tax return and/or the Workers' Compensation form.</td><td>▪ All industries are eligible if sold with medical.
▪ The following industries are not eligible when Dental is sold standalone or packaged only with Life.
<table><tr><th>SIC Code</th><th>SIC Description</th></tr><tr><td>7933</td><td>Bowling Centers</td></tr><tr><td>8611</td><td>Business Associations</td></tr><tr><td>7911</td><td>Dance Studios, Schools</td></tr><tr><td>7361-7363</td><td>Employment Agencies</td></tr><tr><td>7999</td><td>Misc Amusement and Recreation</td></tr><tr><td>8699</td><td>Misc Membership Organizations</td></tr><tr><td>8999</td><td>Misc Services</td></tr><tr><td>7991</td><td>Physical Fitness Facilities</td></tr><tr><td>8811</td><td>Private Households</td></tr><tr><td>7941-7948</td><td>Professional Sports Clubs & Producers, Race Tracks</td></tr><tr><td>8621-8651</td><td>Professional Membership Organizations, Labor Unions, Civic Social & Fraternal Organizations, Political Organizations</td></tr><tr><td>7992-7997</td><td>Public Golf Courses, Amusements, Membership Sports & Recreation Clubs</td></tr><tr><td>8661</td><td>Religious Organizations</td></tr><tr><td>7922-7929</td><td>Theatrical Producers, Bands, Orchestras, Actors</td></tr></table></td><td>Basic Term Life
▪ All industries are eligible.
Packaged Life/Disability
▪ The following industries are not eligible.
<table><tr><th>SIC Code</th><th>SIC Description</th></tr><tr><td>3291-3292</td><td>Asbestos Products</td></tr><tr><td>7500-7599</td><td>Automotive Repairs/ Services</td></tr><tr><td>8010-8043</td><td>Doctors Offices Clinics</td></tr><tr><td>2892-2899</td><td>Explosives, Bombs & Pyrotechnics</td></tr><tr><td>3480-3489</td><td>Fire Arms & Ammunition</td></tr><tr><td>5921</td><td>Liquor Stores</td></tr><tr><td>8600-8699</td><td>Membership Associations</td></tr><tr><td>1000-1499</td><td>Mining</td></tr><tr><td>7800–7999</td><td>Motion Picture/ Amusement & Recreation</td></tr><tr><td>9999</td><td>Non-classified Establishments</td></tr><tr><td>3310-3329</td><td>Primary Metal Industries</td></tr><tr><td>6531</td><td>Real Estate — Agents</td></tr><tr><td>6211</td><td>Security Brokers</td></tr><tr><td>7381</td><td>Service — Detective Services</td></tr><tr><td>8800-8899</td><td>Service — Private Household</td></tr></table></td></tr>
</table>

DENTAL ONLY

Coverage Waiting Period	▪ PPO and Indemnity Plans — For Major and Orthodontic Services employees must be an enrolled member of the employer's plan for 1 year before becoming eligible. ▪ DMO — there is no waiting period. ▪ Discount plans do not qualify as previous coverage. ▪ Virgin group (no prior coverage) — the waiting periods apply to employees at case inception as well as any future hires. ▪ Takeover/Replacement cases (prior coverage) — you must provide a copy of the last billing statement and schedule of benefits in order to provide credit. If a group's prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a dental plan in place that covered Major (and Ortho, if applicable) immediately preceding our takeover of the business. *Example:* Prior Major coverage but no Ortho coverage. Aetna plan has coverage for both Major and Ortho. The Waiting Period is waived for Major services but not for Ortho services.
Product Packaging	Voluntary ▪ Dental Dual Option sales are not permitted. All Voluntary plans must be a single plan sold. ▪ All Voluntary plans require a minimum of 3 to enroll. ▪ Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll. Standard ▪ DMO can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled. ▪ PPO can be sold standalone or packaged with the DMO as a Dual Option with a minimum of 2 enrolled. ▪ Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold. ▪ Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll. Dual Option ▪ Dual option is DMO and another non-FOC product with a minimum of 2 enrolled. ▪ Triple option not available. ▪ Dual option not available for voluntary, preventive or consumer-directed plans.
Open Enrollment	▪ An employee or dependent can enroll within 31 days of first becoming eligible, for example, when the plan is first offered by the group or a new hire/dependent. ▪ An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible unless a qualifying life event has occurred or the enrollee is less than age 5.
Option Sales	▪ Option sales alongside another dental carrier are not allowed. ▪ All dental plans must be sold on a full replacement basis.
Reinstatement (applies to Voluntary Plans only)	▪ Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.

LIFE AND DISABILITY ONLY

Job Classification (Position) Schedules

- Varying levels of coverage based on job classifications are available for groups with 10 or more lives.
- Up to 3 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 (5) times the benefit of the class with the lowest benefit even if only 2 classes are offered. For example, a schedule may be structured as follows:

Position/Job Class	Basic Term Life Amount	Disability	Packaged Life & Disability
Executives	$50,000	Flat $500	High Option
Managers, Supervisors	$20,000	Flat $300	Medium Option
All Other Employees	$10,000	Flat $200	Low Option

Guaranteed Issue Coverage

- Aetna provides certain amounts of Life insurance to all timely entrants without requiring an employee to answer any Medical questions. These insurance amounts are called "Guaranteed 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 provide medical records.
- On-time enrollees who do not meet the requirements of Evidence of Insurability will receive the Guaranteed Issue Life amount.
- Late enrollees must qualify for the entire amount and are not guaranteed any coverage.

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.

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) Coverage is not requested within 31 days of eligibility for contributory coverage.

3) New coverage is requested during the anniversary period.

4) Coverage is requested outside of the employer's anniversary period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).

5) Reinstatement or restoration of coverage is requested.

6) Requesting Life or Disability at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the Guarantee Issue Limit. Example: Group has $50,000 life with $20,000 Guarantee Issue Limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late, they must medically qualify for the entire $50,000.

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

All products

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, other than reconstructive surgery following a mastectomy
- Custodial care
- Dental care and X-rays, other than treatment of sound natural teeth due to an accidental injury within 12 months following the injury or care needed to repair congenital defects or anomalies
- Donor egg retrieval
- Experimental and investigational procedures, except in connection with certain types of clinical trials
- Hearing aids
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs, unless medically necessary
- Treatment of those services for or related to treatment of obesity or for diet or weight control, unless medically necessary

Pre-existing conditions exclusion provision

This plan imposes 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 6 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-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 prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63-day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at 1-888-80-AETNA (for OA EPO and OA MC plan options) or **1-888-702-3862** (for NYC Community Plan options) if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carriers 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 the age of 19. 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 (CONTINUED)

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.
- Services subject to Late Entrant penalties: Members who do not enroll within the first 31 days of becoming eligible may be subject to a late entrant penalty.
- Services subject to waiting periods. (The waiting period may be waived in certain situations.)

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 and root planing (4 quadrants every 2 years)
  - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in the plan documents.

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 felony provided that the covered person is convicted of the felony
- A covered person's intoxication or being under the influence of any narcotics unless administered or consumed on the advice of a physician
- 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 person committing or attempting to commit, a felony
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Is due to war or any act of war (declared or not declared)
- Results from an automobile accident caused by a person while that person is 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.

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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 benefits/ health insurance plans, dental benefits and insurance plans and life and disability insurance plans/policies contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Legal Reference Program services are independently offered and administered by ARAG North America (ARAG). Aetna does not participate in attorney selection or review and does not monitor ARAG services, content or network. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount 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. NYC Community Plans are underwritten by Aetna Health Inc. and/or Aetna Health Insurance Company of New York. 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. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. 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**.

Aetna®

www.aetna.com

64.10.300.1-NY A (7/11)

Aetna HealthFund® HSA

Employer Enrollment Form

Employer Information

Company Name: _____ Tax ID Number: _____

Contact Name: _____ Title: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

Street Address: _____

City: _____ State: _____Zip: _____

Billing Address (if different): _____

City: _____ State: _____Zip: _____

Industry Code (SIC):_____ Total Medical Benefit Eligible Employees:_____ Total Employees:_____

Insurance Information

Insurance Company Name: _____ Group Effective Date: _____

Group Number: _____ Plan Renewal Date: _____

Single Annual Deductible $_____ **Family** Annual Deductible: $_____

Health Savings Account Information

An employer may make contributions to its employees' Aetna HealthFund HSAs. The employer may also collect employee contributions to their HSAs via Payroll Deduction and remit those contributions to HealthEquity once the HSAs have been established.

The employer contribution must be comparable for each employee within the same coverage type (individual or family).

In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, your employees may be asked to provide additional information and/or documentation before their accounts can be established.

Signature

_____ _____ _____

Print Name Signature Date

Please Mail or Fax Completed Forms to:
HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020
Fax 5208447090

Aetna HealthFund® HSA

Employee Enrollment Form

Employer Name _____

Qualified for a Health Savings Account

This enrollment form is to open an Aetna HealthFund HSA that is used to accumulate assets for the payment of qualified healthcare expenses. Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account you must meet three criteria: 1) You must be covered by a qualified high deductible health plan, 2) You cannot be covered by another health plan, including Medicare and 3) You cannot be claimed as a dependent on another individual's tax return.

Personal Information

Name: First: _____ Last: _____ Middle Initial: _____

Street Address: Street: _____

City: _____ State: _____ Zip: _____

Mailing Address: Street: _____

(if different) City: _____ State: _____ Zip: _____

Date of Birth: _____ Email: _____ *(for statements and notices)*

Contact Phone: (_____) _____ Social Security Number: _____ Gender: ☐ M ☐ F

Insurance Coverage: Coverage Effective Date _____ Coverage Type: ☐ Single ☐ Family

Authorization and Certification

- I accept the terms of the Aetna HealthFund HSA enrollment form and the HSA Custodial Agreement. The HSA Custodial Agreement is available by clicking going to http://aetna.healthequity.com and clicking on "Forms and Docs."
- In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.

_____	_____	_____
Print Name	Signature	Date

Please Mail or Fax Completed Forms to:
HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020
Fax 5208447090

Aetna

HealthEquity

Aetna HealthFund® HSA
Beneficiary Designation Form

Personal Information

Name: First: ________________________ Last: ____ Middle: _________

Social Security Number or Aetna HealthFund HSA Account Number: ____

Beneficiary(s)

Please designate the beneficiary(s) for your Aetna HealthFund HSA who will receive the balance in your account upon your death. Complete all fields below for the beneficiaries you designate to ensure timely completion of this request.

First Name: ___________________ Last Name: ______________________ Relationship: _____________________ Percentage _____%
Social Security Number: ______________________ Date of Birth: _______________
Address: __________________________________ City:__________________ State:________ Zip Code _______

First Name: ___________________ Last Name: ______________________ Relationship: _____________________ Percentage _____%
Social Security Number: ______________________ Date of Birth: _______________
Address: __________________________________ City:__________________ State:________ Zip Code _______

First Name: ___________________ Last Name: ______________________ Relationship: _____________________ Percentage _____%
Social Security Number: ______________________ Date of Birth: _______________
Address: __________________________________ City:__________________ State:________ Zip Code _______

First Name: ___________________ Last Name: ______________________ Relationship: _____________________ Percentage _____%
Social Security Number: ______________________ Date of Birth: _______________
Address: __________________________________ City:__________________ State:________ Zip Code _______

Estate or Trust Name: _________________________________ Tax ID: _______________________________ Percentage _____%
Address: __________________________________ City:__________________ State:________ Zip Code _______

Total 100%

Required: Authorization of Spouse

Spousal Consent
This section must be reviewed if the member is married and a resident of a community or marital property state. Due to important tax and legal consequences of giving up a community property interest, individuals signing this section should consult with an independent legal or tax advisor.

Current Marital Status
□ I am not married—I understand that if I become married in the future, I must complete a new Beneficiary Designation form.
□ I am married—I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above-named member. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this account, I have been advised to see a tax professional. I hereby give the accountholder any interest I have in the funds or property deposited in this account and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by HealthEquity.

____ ____
Signature of Spouse Date Signature of Witness (Required—Cannot be Spouse) Date

HSA Client Signature

___________________________________ ____ _____________
Print Name Signature Date

Please Mail or Fax Completed Forms to:
HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020
Fax: 801-727-1005

Health Savings Account Custodial Agreement

The account owner (or Member) named is establishing this health savings account (hereafter HSA or Account) exclusively for the purpose of paying or reimbursing qualified medical expenses of the Account owner, his or her spouse, and dependents. The Account owner represents that, unless the Account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high-deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

The Account owner and HealthEquity, Inc. (Custodian) make the following Agreement:

Article I. Contributions

1. Custodian will accept additional cash contributions for the tax year made by the Account owner or on behalf of the Account owner (by an employer, family member, or any other person). No contributions will be accepted by Custodian for any Account owner if the amount would result in total contributions that exceed the maximum amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the Account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer medical savings account (Archer MSA) (unless prohibited under this Agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.
4. Qualified HSA distributions from a health care flexible spending account (FSA) or health reimbursement arrangement (HRA) must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account (IRA) must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II. Contribution Limits

1. For calendar year 2011, the maximum annual contribution limit is $3,050 for an Account owner with single coverage and $6,150 for an Account owner with family coverage. For calendar year 2012, maximum annual contribution limits increase to $3,100 for an Account owner with single coverage and $6,250 for an Account owner with family coverage. These limits are subject to cost-of-living adjustments each year.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For the calendar year 2009 and in later years, an additional $1,000 catch-up contribution may be made for an Account owner who is at least age 55 or older and not enrolled in Medicare.
4. Contribution limits for the current tax year may be found at www.treasury.gov or in IRS Publication 969— Health Savings Accounts and Other Tax-Favored Health Plans.
5. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III. Account Owner Responsibilities

It is the responsibility of the Account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the Account owner shall notify the Custodian that there exist excess contributions to the HSA. It is the responsibility of the Account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV. Nonforfeitable

The Account owner's interest in the balance in this custodial Account is nonforfeitable.

Article V. Investment Limitations

1. No part of the custodial funds in the Account may be invested in life insurance contracts or in collectibles as defined in IRC section 408(m).
2. The assets of the Account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the Account owner nor Custodian will engage in any prohibited transaction with respect to the Account (such as borrowing or pledging the Account or engaging in any other prohibited transaction as defined in IRC section 4975).

Article VI. Distributions

1. Distributions of funds from this HSA may be made at any time upon the direction of the Account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the Account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the Account owner's gross income and are subject to an additional 20 percent tax (starting Jan. 1, 2011; 10% previously) on that amount. The additional 20 percent tax (starting Jan. 1, 2011; 10% previously) does not apply if the distribution is made after the Account owner's death, disability, or reaching age 65.
3. Custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the Account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show if required, that the distribution is tax-free.

Article VII. Payable Upon Death

If the Account owner dies before the entire interest in the Account is distributed, the entire Account will be disposed of as follows:

1. If the beneficiary is the Account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the Account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the Account owner's estate, the fair market value of the Account as of the date of death is taxable on the Account owner's final return. For other beneficiaries, the fair market value of the Account is taxable to that person in the tax year that includes such date.

Article VIII. Reporting Requirements

1. The Account owner agrees to provide Custodian with information necessary for Custodian to prepare any report or return required by the IRS.
2. Custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX. Controlling Provisions

Notwithstanding any other article that may be added or incorporated in this Agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this Agreement that is inconsistent with IRC section 223 or IRS published guidance will be void.

Article X. Amendments

This Agreement will be amended from time to time to comply with the provisions of the Internal Revenue Code (IRC) or IRS published guidance. Other amendments may be made with the consent of the persons whose accounts are represented in this Agreement.

Article XI. Additional Provisions

11.01 **Definitions.**

Family Coverage. Coverage that includes Member and other family members.

High-Deductible Health Plan (HDHP). In 2011 and 2012, minimum annual deductibles are $1,200 for individuals and to $2,400 for families. In 2011, annual out-of-pocket maximums are $5,950 for self-only coverage and $11,900 for family coverage. In 2012, annual out-of-pocket maximums increase to $6,050 for self-only coverage and $12,100 for family coverage. These limits are subject to cost-of-living increases each year; specific guidance for a given tax year can be found at www.treasury.gov.

Member. Person who establishes the HSA or Account as Account owner.

Custodian. HealthEquity, Inc.

Qualified Medical Expenses. Amounts paid for medical care as defined in IRC section 213(d) for Member, his or her spouse, or dependents (as defined in IRC section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses.

11.02 **Notices, Change of Address, Materials, and Communication.**

Any notice regarding this HSA will be considered effective when Custodian mails it to the last address of Member or intended recipient which Custodian has in its records or sends it by e-mail if Member has consented to electronic delivery. Any notice given to Custodian will be considered effective when Custodian actually receives it in writing at its place of business. Member must notify Custodian in writing of any changes of address at: HealthEquity, Inc., Attn: Account Inquiry, 15 W Scenic Point Dr, Ste 400, Draper, UT 84020.

Member agrees that Custodian may, but shall not be required (unless required under applicable law) to, inform Member by forwarding materials or otherwise communicating with Member as to any questions, decisions, or other matters for which a vote may be requested, necessary or helpful, and Custodian shall thereafter have no responsibility whatsoever with respect thereto.

11.03 **Representations and Responsibilities.**

Member represents and warrants that any information given or to be given with respect to this HSA is complete and accurate and Custodian is entitled to rely upon any such information or directions given it by Member or Member's authorized agent. Custodian shall not be required to determine the validity or sufficiency of any receipt, affidavit, notice, or other paper or agreement required to be delivered to Custodian under this Agreement.

In the event that Member has provided an electronic signature to Custodian in connection with an account application or other click sign agreement, Member agrees Custodian may rely on such electronic signature for purposes of Member's authorization of withdrawals or third-party transfers, notices to change of name or address, or other instructions to Custodian. Custodian shall not be required to obtain Member's physical signature for such purposes or any other purpose, except as may be required by law.

Anything in this Agreement to the contrary notwithstanding, Custodian may choose to request direction from Member as to any specific action or situation that arises with the HSA, and if a request for direction is made, Custodian shall incur no liability for following Member's direction or for taking no action if no such direction is furnished to Custodian.

11.04 **Cash Account, Investment Account, Funds Availability and Funds Movement. (See also Article XIII).**

All contributions to the Account shall be made into a FDIC-insured cash account (Cash Account); all distributions shall be made from the same Cash Account. Member is responsible for reviewing all provided materials and understanding generally how medical expenses may be paid from the Cash Account, and how funds are made available for investment. Member and Member's Account will be liable for any overdraft charges imposed by Custodian.

Funds on deposit in Member's Account will generally be available for withdrawal from the Account within two (2) to five (5) business days of Member's deposit. Unless otherwise instructed by Member, deposits received during non-business hours will be considered to be made on the next full banking day.

If the funds in Member's HSA exceed a certain threshold as specified by Custodian, Member may be given the option of investing any balance above that threshold in certain available mutual funds (Investment Account). If sufficient funds are not available, no purchases will be allowed. Member has the sole authority and responsibility to select and to direct the investment in the Investment Account. Any income or dividends generated by the Investment Account shall be reinvested in the same fund that initially paid the dividends. Custodian will not act as an investment advisor to Member and Custodian will not review nor recommend any investment in the Investment Account. Custodian shall have no duty to disclose any risks associated with any investment and shall not have any liability for any loss of principal or income, nor for any expense which Member may incur relating to any investment.

11.05 **Interest on HSA.**

Interest is credited to Member's Account monthly as of the last day of the statement cycle. If the Account is closed before accrued interest is credited, no interest will be paid or accrued for that month. Interest accrues no later than one business day after the day Custodian receives the funds provided the Account has been opened. The current interest rate payable is listed in Member's monthly statement and is subject to change.

11.06 **Service Fees and Compensation.**

Custodian may charge maintenance, service, and other designated fees (for example, a transfer, withdrawal, or termination fee), or expenses for maintaining Member's HSA as set forth in Custodian's written schedule of fees then in effect, which is provided in Member's Welcome Kit, which fees may be changed upon 30-days written notice to Member. Monthly maintenance fees will be charged for any month that the Account is opened. Custodian may deduct such fees or expenses from the funds in Member's HSA or, at its discretion, charge Member separately for any fees or expenses. Custodian may also allow fees to be paid from other sources, such as Member's employer or health plan. Custodian also receives as additional compensation including (i) the difference between the interest received by Custodian on Cash Accounts and the amount paid to Member, (ii) interchange fees arising from HealthEquity Visa® health account card (HealthEquity Visa Debit Card) transactions, and (iii) management and administration fees paid to Custodian on the Investment Accounts.

11.07 **Amendments.**

Except for those amendments allowed under Article X, amendments will take effect upon 30-days written notice, and Member will be deemed to have consented to any other amendments to this Agreement, unless within 30 days from the date Custodian provides a copy of such amendment (by mail or electronic delivery), Member notifies Custodian that he/she does not consent to the amendment. In that event, the Account will be closed.

11.08 **Distributions.**

Only Member is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution qualifies to be tax-free. Member represents and warrants that each self-initiated distribution will be for qualified medical expenses for purposes of tax reporting to the IRS unless Member provides written notification to Custodian to the contrary before the end of the tax year.

Custodian may make any distributions required or authorized hereunder by mailing Custodian's check, or other property, or by ACH, or by Fed wire, or other electronic transfer to the payee at the address last furnished to Custodian.

11.09 **HealthEquity Visa® Debit Cards.**

The HealthEquity Visa Debit Card is issued by The Bancorp Bank pursuant to a license from Visa USA Inc. The Bancorp Bank; Member FDIC. Member agrees that he/she may make HealthEquity Visa Debit Card transactions only to the extent there are sufficient available funds in the HSA. Custodian has no obligation to permit any withdrawal at a time when there are insufficient funds in Member's HSA. In the event there is an overdraft in a Member's Account, Member shall be liable for any overdraft or collection fees. The use of any HealthEquity Visa Debit Card in connection with the HSA may be limited to eligible merchants that provide, among other things, health care related goods and services and supply applicable MCC codes for verification purposes. Member is responsible for notifying Custodian as soon as possible if the HealthEquity Visa Debit Card is lost or stolen, to avoid potential losses. Notification must be made by calling HealthEquity at the number printed on the back of Member's HealthEquity Visa Debit Card, on Member's statement, or on the HealthEquity web site provided to log in to Member's Account.

11.10 **Transfer/Rollover.**

Custodian can receive amounts transferred to this HSA from the custodian or trustee of another HSA or certain other types of accounts. However, Custodian also reserves the right not to accept any transfer.

11.11 **Verification of Accounts.**

To help the government fight the funding of terrorism and money-laundering activities, Federal law requires Custodian to verify certain information provided by Member for identification purposes including Member's name, address, taxpayer identification number (TIN), and date of birth. Until this information has been verified pursuant to applicable federal laws, the Account may not be used. During such time, Custodian will charge its customary fees for maintaining the Account; upon request from Member, Custodian will close the Account and return funds to the original contributor.

11.12 **Governing Law; Invalidity; Waiver.**

The terms of this Agreement shall be governed by and construed in accordance with the laws of the State of Utah without giving effect to principles of law regarding conflicts of laws. If any part of this Agreement is held to be illegal or invalid, the remaining parts shall not be affected. Neither Member nor Custodian's failure to enforce at any time or for any period of time any of the provisions of the Agreement shall be construed as a waiver of such provisions.

11.13 **Employer Contributions.**

Custodian shall not be liable for any losses, damages, costs, penalties, or expenses Member incurs as a result of any employer's failure to make any contributions to Member's HSA. Custodian is not responsible for monitoring employer's HSA contributions or notifying any Member of employer contributions. Member is responsible for contacting his/her own employer regarding its contributions and monitoring those contributions. In considering whether contributions have exceeded the allowable annual contribution limit, Member must take into account any employer contributions as well as any transfers or contributions previously made by Member that also count towards the annual contribution limit.

11.14 **Additional Parties on the Account and Beneficiaries.**

If Member has added a spouse and/or another third party to write checks and/or use the HealthEquity Visa Debit Card, including a second HealthEquity Visa Debit Card if one has been requested on Account, then Member acknowledges and agrees (a) it is Member's sole responsibility to inform the authorized individual(s) about the purpose of the HSA and the tax consequences of using checks and HealthEquity Visa Debit Card for items that are not qualified expenses, (b) to be bound by, and to have the HSA bound by, any action taken by such authorized individual(s), and (c) to indemnify and hold harmless Custodian from any damages or expenses resulting from any actions taken by such authorized individual(s).

At any time, and from time to time, Member shall have the right to designate one or more beneficiaries to whom distribution of the balance of the HSA shall be made in the event of death prior to the complete distribution of the Account. Any such beneficiary designation shall not be deemed valid until Custodian receives a signed designation in form satisfactory to Custodian. If Member designates his or her spouse, then, upon Member's death, the HSA will become the spouse's HSA as of the date of death. If no beneficiary has been designated, the HSA will pass to Member's estate and be distributed as directed by the personal representative of the estate.

11.15 **Additional Distributions.**

Custodian may make a distribution absent instruction from Member, if directed to do so pursuant to a court order, garnishment, IRS levy, or other levy. In such event, Custodian shall not incur any liability for acting in accordance with such court order or levy.

Article XII. General Powers and Duties of Custodian and Limits Thereon

12.01 **Custodian's Authorization and Empowerment:**

Member hereby authorizes and empowers Custodian:

- To hold funds received from time to time from Member or another source, such as rollovers and HSA transfers on behalf of Member's HSA. The Cash Account shall hold all the assets of the HSA other than the available mutual funds maintained in the Investment Account pursuant to the terms of this Agreement and Member's directions.
- To invest and reinvest the Investment Account only at Member's direction from the list of available mutual funds, or to sell investments to cover fees or overdrafts without any investment responsibility on the part of Custodian.
- To reinvest all dividends paid from Member's mutual funds in the same fund which initially paid the dividends.
- To collect any income generated from the Investment Account or the Cash Account; to make payments, disbursements or distributions from the HSA as directed by Member or authorized agent, and in conformity with the terms of this Agreement and federal regulations of HSAs.
- To perform any and all other acts, which in its judgment may be necessary or appropriate for the proper administration of the HSA and the custodial assets, including correcting errors made by either Custodian or employer, or employing such attorneys, agents, and vendors as Custodian feels appropriate without notice to Member.
- To seek, at the expense of the HSA, direction or approval from a court of competent jurisdiction whenever Custodian shall, in its sole discretion, deem it appropriate.
- To request such documentation and certification deemed appropriate within Custodian's discretion to verify and establish the identity of the beneficiary or the estate upon death of Member, if the assets are to be distributed to Member's estate.
- To pay any estate, inheritance, income, or other tax or assessment attributable to any property, or interest held in the HSA out of the assets of the HSA upon such information or direction as Custodian may require.
- To require releases or other related documentation from the taxing authority, beneficiaries or other payee and require indemnification from such payee as may be necessary for Custodian's protection against tax liability.
- To close the Account in Custodian's sole discretion if the Account is delinquent in the payment of any Account fees.

12.02 **Binding Effect.**

The terms of this Agreement shall be binding upon Custodian and Member and their respective successors and assigns.

12.03 **Indemnification.**

Member, and his/her authorized agents and representatives, and Member's designated beneficiaries shall at all times fully indemnify and hold harmless Custodian and its affiliates, successors, and assigns, from any liability arising from withdrawals so made or actions so taken, and from any and all other liability, damages, losses (including losses on the Investment Account), costs, legal fees, taxes, penalties, and expenses (collectively, Damages) whatsoever that may arise in connection with this Agreement, except Damages arising from the negligence or willful misconduct of Custodian. Custodian shall not be responsible for any taxes, penalties, judgments, and expenses incurred by Member's HSA.

Custodian shall have the right to bring suit against Member in a court of competent jurisdiction for the recovery of any sums owed to Custodian under this Agreement, including, but not limited to, fees, costs, overdrafts, expenses, and sums paid by Custodian in error to or for the benefit of the Account. In such event all court costs, legal expenses, reasonable compensation of time expended by Custodian in the performance of its duties, and other appropriate and pertinent expenses and costs may be collected by Custodian from the HSA.

Article XIII. Records, Reports and Valuation of Custodial Accounts

13.01 **Statements and Reporting Written Objections or Exceptions.**

Custodian shall furnish or cause to be furnished to Member statements concerning the status of the Account at least quarterly. Member can access and retrieve the statements through Custodian's web site or other Internet portal, or choose to have such statements mailed at an additional cost as provided for on the written schedule of fees provided in the Welcome Kit.

Member shall have sixty (60) days after either (a) the date of mailing of a paper HSA statement or (b) the posting of an HSA statement online at Custodian's web site to file any written or verbal objections or exceptions with Custodian. Written objections should be sent to HealthEquity, Inc., Attn: Account Inquiry, 15 W Scenic Point Dr, Ste 400, Draper, UT 84020; oral objections should also be made to Member Services, which can be reached by calling the member's dedicated toll-free phone number or 866.346.5800. The failure to file any objections or exceptions concerning errors or transactions within said sixty (60) day period shall signify Member's approval of the statement and preclude Member from making future objections or exceptions regarding the statement. Such approval by Member shall be a full release and discharge to Custodian of such statement and all transactions, deposits, and disbursements disclosed on such statement.

13.02 **Web Site Access.**

Custodian may grant Member online access to the Account through Custodian's web site. The web site may be made available for view access only, or to allow Member to place trades in an Investment Account, as well as execute certain other services online. Custodian does not guarantee and is not liable for the performance or privacy of the online system, web site or the Internet. Web site access may be unavailable at times such as when (a) systems require regular maintenance or upgrades; (b) unforeseen maintenance is necessary; or (c) major unforeseen events occur, such as earthquakes, fires, floods, computer failures, interruption in telephone service, electrical outages, civil unrest or riots, war, or acts or threatened acts of terrorism, or other circumstances beyond Custodian's control. Custodian is not under any circumstance liable for the unavailability of access to the web site, data entry errors and other errors made by Member, or for any loss for any reason associated with web site or online access or use.

Member shall have a password that will allow Member access to his/her HSA online. It shall be Member's responsibility to keep the password private. Member shall be responsible for all actions taken by any person using Member's password whether or not such use was authorized by Member.

13.03 **Prevention of Account Owner Pledging Assets.**

Member shall have no right to pledge, assign, anticipate, hypothecate, or in any manner create a lien upon any assets, payments, or benefits while such are held in the HSA. The assets in Member's Account shall not be subject to or responsible for the debts, contracts, or torts of any person whether or not entitled to distributions under this Agreement.

Article XIV. Removal and Appointment of Successor Custodian

14.01 **Termination.**

Either Member or Custodian may terminate this Agreement for any reason at any time by giving written notice to the other. If Custodian terminates this Agreement, Member must make arrangements to transfer the Account to another custodian. If Member does not complete a transfer of the Account within thirty (30) days from the date of the termination notice to Member, Custodian has the right to 1) transfer the Account to another HSA custodian or 2) pay the Account to Member in a single sum. If this Agreement is terminated, Custodian may hold back from Member's Account a reasonable amount of money that Custodian believes is necessary to cover any fees, account closure fees, and expenses or taxes chargeable against Member's Account or any penalties associated with the early withdrawal of any savings instrument or other investment in Member's Account. If the Account is terminated and funds had been placed in an Investment Account, that Account will be closed at the then current market value.

Pursuant to Custodian's IRS-awarded non-bank trustee license, if the IRS Commissioner notifies Custodian that a substitution is required due to Custodian failing to comply with the requirements of §1.408-2(e) of the regulations or not keeping such records, or making such returns or rendering such statements as are required by forms or regulations, Custodian will substitute another trustee or custodian.

Article XV. Privacy

15.01 **Information Kept Confidential.**

Custodian believes in maintaining the confidentiality of Member information, which is collected and retained when such information assists Custodian in (1) administering Member's Account, (2) providing relevant products and services, and (3) complying with applicable laws and regulations.

15.02 **Treatment of Personal Information.**

Custodian understands that Member expects that personal information will be handled with great care. Custodian does not disclose any non-public personal information (such as information about Member's Account balance, HealthEquity Visa Debit Card use, medical claims, and any Account transaction) about Members or former Members to anyone, except as necessary to provide the services contemplated herein or as otherwise permitted or required by law unless requested specifically by Member.

15.03 **Privacy Statement.**

Custodian's full Privacy Statement is provided to Member as part of the Welcome Kit and can also be viewed online at www.healthequity.com.

Article XVI. Consent to the Terms of Custodial Agreement

By accessing Member's Account by telephone, Internet, check, EFT, or HealthEquity Visa Debit Card, Member consents to the terms of this Custodial Agreement, including any amendments hereto.

Aetna HealthFund® HSA

ROLLOVER/TRANSFER REQUEST FORM

The Health Savings Account Rollover/Transfer Request Form can be used to:
1) Rollover funds into your Aetna HealthFund HSA which have already been distributed to you from another custodian, or to
2) Transfer monies directly from another custodian into your Aetna HealthFund HSA. We recommend you contact your current custodian to ensure that all of their requirements for transferring funds are met. If your current custodian allows this form, it can be mailed to 15 West Scenic Pointe Drive, Suite 400, Draper, Utah 84020 or faxed to 801-727-1005. If you have questions, please call member services at 866-382-3512.

Part I - Account Holder Information - Please Print

Account Holder Full Legal Name:	Social Security Number:		Date of Birth:
Address:	City:	State:	ZIP:
Contact Phone:	Health Insurance Company:		
Email Address:	Coverage Effective Date:	Coverage Type: ☐ Single ☐ Family	

Please select one of the following:

☐ I already have an Aetna HealthFund HSA at HealthEquity. Account No._____

☐ I am currently setting up an Aetna HealthFund HSA through my employer.

Employer Name: _____ Phone: _____

☐ I am enclosing an enrollment form together with this transfer form to establish a new Aetna HealthFund HSA.

Part II – Rollover Amount $_____ (Do not complete for Transfer)

Part III - Transfer Information (Do not complete for Rollover)

This request is for a custodian-to-custodian transfer or an employer-to-custodian transfer. The monies currently held by another custodian/employer are to be directly transferred to an Aetna HealthFund HSA at HealthEquity.

Current Custodian Info (for HSA/IRA/MSA Transfer) | Current Employer Info (for FSA/HRA Transfer)

Financial Institution (or Employer Name for FSA/HRA):		Phone:	
Address:	City:	State:	ZIP:
Current HSA/IRA/MSA/HRA/FSA Account Number:	Dollar Amount to be transferred (if known): $		
This transfer ☐**WILL** ☐**WILL NOT** close my existing account.			

Please indicate the current account type that the monies will be coming from:

☐ IRA (Individual Retirement Account)
☐ MSA (Medical Savings Account)
☐ HRA (Health Reimbursement Account)
☐ FSA (Flexible Spending Account)
☐ Another HSA (Health Savings Account)

Part IV - Account Holder Signature	(Do not complete for Rollover)
I authorize the transfer of the account assets in the manner described above, and certify that all of the information provided by me is accurate.	
Account Holder - Signature Required:	Date:
Notary Seal (when required by current custodian):	

CURRENT CUSTODIAN INFORMATION:
Check Option: Make a check payable to HealthEquity and mail it along with this form to: HealthEquity Inc. 15 West Scenic Pointe Drive, Suite 400 Draper, UT 84020

RULES AND CONDITIONS APPLICABLE TO ROLLOVERS AND TRANSFERS

ROLLOVERS

A rollover is a way to move money or property from a Medical Savings Account (MSA) or existing Health Savings Account (HSA) to an Aetna HealthFund HSA. The Internal Revenue Code (IRC) limits how many rollovers may be taken, how quickly rollovers must be completed, and how the custodian must report the transaction. By properly completing this form you are certifying to the custodian that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover.

1. **Timelines**
   The funds you receive from an MSA or HSA must be deposited into an HSA within 60 days after you receive them. When counting the 60 days, include weekends and holidays. Receipt generally means the day you actually have the funds in hand. For example, the 60 days would begin on the day you pick up the check from the Custodian or you receive the check in the mail. The 60 day rule is set by the IRS and cannot be changed by HealthEquity.

2. **Twelve-Month Restriction**
   You are entitled to one distribution per year per HSA which may be rolled over. Twelve (12) months must pass after receipt of one distribution which you rollover before you may take another distribution from the same HSA to rollover. The focus is on distributions out of an HSA.

TRANSFERS

If you instruct the custodian of your HSA or MSA to transfer funds directly to the custodian of another HSA, the transfer is not considered a rollover. There is no limit on the number of these transfers.

If your employer instructs the custodian of your HRA/FSA to transfer funds directly to the custodian of another HSA, the transfer is not considered a rollover.

Beginning in 2007, individuals can make a one-time transfer from their IRA to an HSA, subject to the contribution limits applicable for the year of the transfer. Additional information can be found at www.IRS.gov.

NY-NNJ Employer Funding Certification and Statement of Understanding for Small Employers

Aetna considers underlying plans or arrangements that either partially or completely subsidize any member cost sharing, including, but not limited to, copayments, deductibles and/or member coinsurance balances [excluding Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA) plans, whether administered by Aetna or another party] and the Employer's funding of the deductible in excess of 50% to be material to the provision of coverage. In setting the premium rate for the plan selected, Aetna has assumed both that there are no underlying plans or arrangements subsidizing any portion of the members' cost-sharing responsibilities and that the Employer will not put in place any plan or arrangement that funds the deductible in an amount exceeding 50%. As such, it is important for us to understand when underlying plans or arrangements are in use and/or when the Employer implements a plan or arrangement that funds the deductible in excess of 50%.

Underlying plan or arrangement offered? Yes____ No____

If "yes," please attach a complete description of the underlying plan or arrangement and confirm the following:

Employer further represents and certifies that it is not funding the deductible of the quoted health plan in excess of 50% (whether through an HSA, HRA or any other arrangement created or purchased for this purpose). Yes ___ No___

By signing below, you are certifying that the information provided above is true and complete, and that you will notify us immediately if you intend to use an underlying plan or arrangement to subsidize your employees' cost-sharing responsibilities, or if you intend to put in place any plan or arrangement that funds employees' deductibles in excess of 50%.

_____
Employer

_____
Signature of Officer

_____
Title

_____
Date

New Jersey Small Employer Funding Certification and Statement of Understanding Attestation Form

Aetna considers an underlying plan to be any employer-funded arrangement or plan that, directly or indirectly, subsidizes, funds or reimburses (or is intended, directly or indirectly, to subsidize, fund or reimburse) any part of an individual or single subscriber's network deductible expenses. In setting the premium rate for benefits plans with a network deductible of $1,000 or more, Aetna assumes that the employer may fund 50% or less of an individual or single subscriber's network deductible. If the employer is funding the network deductible in excess of 50%, it can be material to the development of pricing for coverage. As such, it is important for us to understand when underlying plans are in use and/or when the Employer implements an underlying plan that funds the network deductible in excess of 50%.

1. **Is an underlying plan or arrangement offered, made available or utilized by your company?**
   _____Yes _____No

2. **If yes, to 1 above, what percentage (%) of the network deductible is funded by the underlying plan? _____%**

If "yes," to 1 above, please attach a complete description of the underlying plan.

By signing below, you are certifying and agreeing that:

(1) The information provided above is true and complete.

(2) You will notify Aetna immediately in the event that such information is incorrect or incomplete, or you implement or purchase (or you intend to implement or purchase) any underlying plan to fund the network individual or single subscriber deductible in excess of 50% as described above (if you are not already funding in excess of 50%).

NJ Small Group HMO and POS HSA Compatible Plans:
You must complete this form when your group's HSA Compatible benefits plans are effective with Aetna initially; you decide (or intend) to implement or purchase an underlying plan that funds the network single subscriber deductible in excess of 50% during the year; and annually thereafter prior to the renewal effective date of your group's plans.

You are required to select one of the following deductible funding options for HMO and/or POS HSA Compatible benefits plans: (i) funding 50% or less; or (ii) funding more than 50% of the network single subscriber deductible per year. Benefit plan(s) and premiums will differ depending on the selected deductible funding option. Higher premiums will apply if you choose to fund more than 50% of the network single subscriber deductible per year. Please consult your final rate document.

_____
Company Name

_____ _____
Signature of Officer Title

_____ _____
Name of Officer (Please Print) Date

14.32.902.1-NJ A (2/10)

Aetna

New York Employer Funding Certification and Statement of Understanding for Small Employers

Aetna considers underlying plans or arrangements that either partially or completely subsidize any member cost sharing, including, but not limited to, copayments, deductibles and/or member coinsurance balances and the Employer's funding of the deductible in excess of 50% to be material to the provision of coverage. In setting the premium rate for the plan selected, Aetna has assumed both that there are no underlying plans or arrangements subsidizing any portion of the members' cost-sharing responsibilities and that the Employer will not put in place any plan or arrangement that funds the deductible in an amount exceeding 50%. As such, it is important for us to understand when underlying plans or arrangements are in use and/or when the Employer implements a plan or arrangement that funds the deductible in excess of 50%.

Underlying plan or arrangement offered? Yes____ No____

If "yes," please attach a complete description of the underlying plan or arrangement and confirm the following:

Employer further represents and certifies that it is not funding the deductible of the quoted health plan in excess of 50% (whether through an HSA, HRA or any other arrangement created or purchased for this purpose). Yes ___ No___

By signing below, you are certifying that the information provided above is true and complete, and that you will notify us immediately if you intend to use an underlying plan or arrangement to subsidize your employees' cost-sharing responsibilities, or if you intend to put in place any plan or arrangement that funds employees' deductibles in excess of 50%.

_____
Employer

_____
Signature of Officer

_____
Title

_____
Date

14.32.902.1-NY (5/10)

Connecticut Employer / Broker Funding Certification for Small Group Plans with an In-Network Deductible

Aetna considers an underlying plan to be any employer-funded arrangement or plan that, directly or indirectly, subsidizes, funds or reimburses (or is intended, directly or indirectly, to subsidize, fund or reimburse) any part of a member's out-of-pocket expenses. In setting the premium rate for benefits plans, Aetna assumes there are no underlying plans in place. If the employer is funding a member's deductible in excess of 50%, it can be material to the development of pricing for coverage. Whether the member has any specific financial responsibility before the underlying plan can be used also contributes to the development of pricing for coverage. As such, it is important for us to understand when underlying plans are in use when the employer implements an underlying plan that funds the deductible in excess of 50%, and whether the member needs to first satisfy any specific level of financial responsibility.

For Employers:

1. Is an underlying plan or arrangement offered, made available or used by your company?
_____ Yes No _____

2. If "yes" to Question 1, what percentage (%) of the in-network deductible is funded by the underlying plan? _____%

3. If "yes" to Question 1, is the member required to contribute a certain level of financial responsibility to his/her deductible before funds from the underlying plan are available for use?
_____ Yes No _____

4. If "yes" to Question 3, what is the threshold of member responsibility? $_____ or ____%

For Brokers:

1. Did you offer, make available or sell an underlying plan or arrangement to the employer?
_____ Yes No _____

2. If "yes" to Question 1, what percentage (%) of the in-network deductible is funded by the underlying plan?
_____%

3. If "yes" to Question 1, is the member required to contribute a certain level of financial responsibility to his/her deductible before funds from the underlying plan are available for use?
_____ Yes No _____

4. If "yes" to Question 3, what is the threshold of member responsibility? $_____ or ____%

ATTESTATION

By signing below, you are certifying and agreeing the information provided above is true and complete, and you will notify Aetna immediately in the event such information is incorrect or incomplete, or the employer implements or purchases (or intends to implement or purchase) an underlying plan to subsidize the member deductible in excess of 50% as described above (if not already funding in excess of 50%).

Employer	**Broker**
Company Name	Broker Company
Name of Officer (please print)	Name of Broker (please print)

Connecticut Employer / Broker Funding Certification for Small Group Plans with an In-Network Deductible

Signature	Signature
Title	Title
Date	Date

14.32.902.1-CT B (12/10)

HSA Fee Schedule

HealthEquity®

Below are the fees associated with the administration of your Aetna HealthFund® Health Savings Account (HSA). With your current high deductible health plan (HDHP), you benefit from having your account setup and monthly fees paid for you by your health plan or employer. In addition, you receive the discounted price associated with our other fees. If you choose to leave your current high deductible health plan (HDHP) you may be subject to additional fees.

Health Savings Account Administration Fees	
Account Setup	Paid by plan sponsor
Monthly Maintenance	Paid by plan sponsor*
Reimbursement Check	$2.00 for paper check. No fee for electronic funds transfer.
Check Directed to Provider	No Fee
Replacement Card Fee	$5.00 for each Card replaced if lost/stolen/damaged.
Return Deposited Item	$20.00 per item
Overdraft or Non-Sufficient Funds	$20.00 per item
Stop Payment Request	$20.00 per item
Excess Contribution Refund Request	$20.00
Investments	No Fee
Account Closing	$25.00

* Monthly maintenance fees are paid by your plan sponsor. If you change health plans or employers your account may be directly charged up to $4.95 per month.

HSA balances are FDIC insured and interest bearing. Interest is compounded and calculated monthly, based on an average daily collected balance, for each tier of account balances as outlined in the table below. Interest is credited to the HSA monthly as of the last business day of the statement cycle. If the HSA is closed before the accrued interest is credited, no interest will be paid for that month. The interest rate for each Tier is subject to change at any time.

Refer to your account statements or call a HealthEquity Specialist for current rates and conditions.

Health Savings Account Interest Rates			
Tier	**Daily Account Balance**	**Interest Rate***	**APY****
1	$0 - $2,000	0.10%	0.10%
2	$2,001 - $5,000	0.25%	0.25%
3	$5,001 - $10,000	1.00%	1.01%
4	Over $10,000	1.25%	1.26%

Fees may reduce earnings.

* Rates in effect as of January 1, 2011.
**APY means Annual Percentage Yield.