AETNA AVE

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)

Health care is a journey …

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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

Small businesses need 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.

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Health/Dental, Life and Disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna). NYC Community Plan[SM] is underwritten by Aetna Health Inc. and/or Aetna Health Insurance Company of New York.

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.

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AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

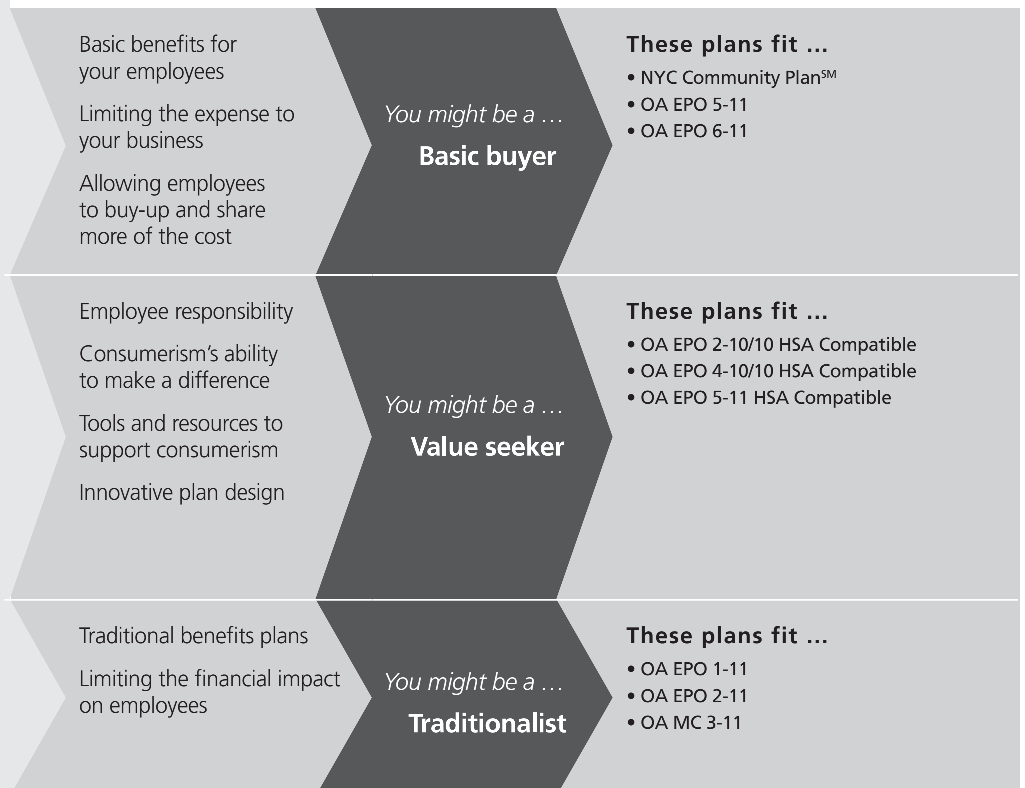
We know that for small business owners, health insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2-50 employees and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for 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 ...



YOUNG SINGLES

NYC Community Plan
EPO plans
HSA-Compatible plans

NYC Community Plan
EPO plans
HSA-Compatible plans
Traditional plans

NYC Community Plan
EPO plans
HSA-Compatible plans
Traditional plans

NYC Community Plan
HSA-Compatible plans

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	•	•	
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.

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

Administrative fees

FEE DESCRIPTION	FEE
HSA	
Initial Set-Up	$0
Monthly Fees	$0
POP*	
Initial Set-Up**	$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

MEMBER'S HSA PLAN

HSA ACCOUNT

- You own your HSA
- Contribute tax free
- You choose how and when to use your dollars
- Roll it over each year and let it grow
- Earns interest, tax free

TODAY
Use for qualified expenses with tax free dollars

FUTURE
Plan for future and retiree health-related costs

HIGH-DEDUCTIBLE HEALTH PLAN

- Eligible in-network preventive care services will not be subject to the deductible
- You pay 100% until deductible is met, then only pay a share of the cost
- Meet out-of-pocket maximum, then plan pays 100%

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[SM] 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.

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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.

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†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*SM 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

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

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 at least 6 weeks 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

<table>
<tr><th></th><th>Medical</th><th>Dental</th><th>Basic Life/AD&D,
Packaged Life and Disability</th></tr>
<tr><td>Employer Contribution</td>
<td>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.</td>
<td>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.</td>
<td>▪ 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.</td></tr>
<tr><td rowspan="2">Late Applicants</td>
<td colspan="3">▪ 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.</td></tr>
<tr><td>▪ 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.</td>
<td>▪ 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.</td>
<td>▪ 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.</td></tr>
</table>

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

	Medical	Dental	Basic Life/AD&D, Packaged Life and Disability
Standard Industrial Classification Code (SIC)	▪ 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.	▪ All industries are eligible if sold with medical. ▪ The following industries are not eligible when Dental is sold standalone or packaged only with Life. (see Dental table below)	Basic Term Life ▪ All industries are eligible. Packaged Life/Disability ▪ The following industries are not eligible. (see Packaged Life/Disability table below)

Dental — not eligible when sold standalone or packaged only with Life

SIC Code	SIC Description
7933	Bowling Centers
8611	Business Associations
7911	Dance Studios, Schools
7361-7363	Employment Agencies
7999	Misc Amusement and Recreation
8699	Misc Membership Organizations
8999	Misc Services
7991	Physical Fitness Facilities
8811	Private Households
7941-7948	Professional Sports Clubs & Producers, Race Tracks
8621-8651	Professional Membership Organizations, Labor Unions, Civic Social & Fraternal Organizations, Political Organizations
7992-7997	Public Golf Courses, Amusements, Membership Sports & Recreation Clubs
8661	Religious Organizations
7922-7929	Theatrical Producers, Bands, Orchestras, Actors

Packaged Life/Disability — not eligible

SIC Code	SIC Description
3291-3292	Asbestos Products
7500-7599	Automotive Repairs/ Services
8010-8043	Doctors Offices Clinics
2892-2899	Explosives, Bombs & Pyrotechnics
3480-3489	Fire Arms & Ammunition
5921	Liquor Stores
8600-8699	Membership Associations
1000-1499	Mining
7800–7999	Motion Picture/ Amusement & Recreation
9999	Non-classified Establishments
3310-3329	Primary Metal Industries
6531	Real Estate — Agents
6211	Security Brokers
7381	Service — Detective Services
8800-8899	Service — Private Household

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.

AETNA AVE

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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**.

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