Aetna®

The Health of Business, Well Planned.

Florida Plan Guide

PLANS EFFECTIVE MARCH 1, 2012

For businesses with 2–100 eligible employees

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Team with Aetna for the health of your business

IN THIS GUIDE:

Introducing a new suite of products and services designed specifically for companies with 2 to 100 eligible employees

Aetna is committed to helping employers build healthy businesses. In today's rapidly changing economy, we recognize the need for less expensive, less complex health plan choices. Now, Aetna offers a variety of newly streamlined medical and dental benefits and life and disability insurance plans to provide more affordable options and to help simplify plan selection and administration.

You can count on Aetna to provide health plans that help simplify decision making and plan administration so you can focus on the health of your business.

Employers and their employees can benefit from…

- Affordable plan options
- Online self-service tools and capabilities
- Enhanced services for consumer-directed health plans
- 24-hour access to Employee Assistance Program services
- Preventive care covered 100%
- Aetna disease management and wellness programs

The federal health care reform legislation, known as the Patient Protection and Affordable Care Act, was signed into law on March 23, 2010. A number of new reforms were effective September 23, 2010, including coverage for dependents up to age 26, elimination of lifetime benefits dollar maximums, restriction of annual dollar maximums on essential health benefits, removal of cost sharing for preventive services and elimination of pre-existing condition exclusions for dependent children under 19 years of age. Your plan guide benefits program ***does comply*** *with the new reform legislation.*

With Aetna, We know it's about…

OPTIONS

We provide a variety of health benefits and insurance plan options to help meet your employees' needs, including medical, dental, disability and life insurance.

And, with access to a wide network of health care providers, you can be sure employees have options in how they access their health care.

Medical plans

- Traditional plans
- Consumer-directed health plans
- 100 percent plans
- Split coinsurance plans (Compass)
- Simply Savings plans

Dental plans

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice plan design option
- Preventive

Life and disability plans

- Basic term life, supplemental life, spouse and child life, and AD&D*
- Short term, long term, and mid-term disability designs*

SIMPLICITY

We know the health of your business is your top priority. Aetna's streamlined plans and variety of services make it easier for you to focus on your business by simplifying administration and management.

Aetna makes it easy to manage health insurance benefits with simplified enrollment, billing, and claims processing so you can focus on what matters most.

TRUST

We work hard to provide health plan solutions you can trust.

Our account executives, underwriters, and customer service representatives are committed to providing businesses and their employees with service and care they can trust.

Aetna resources are designed to fortify the health of your business

- **Track medical claims and take advantage of online services** with your Aetna Navigator® secure member website. It features personal health records and printable temporary member ID cards.
- **Get real cost and health information to help make the right care decision** with an online Cost-of-Care Estimator.
- **Manage health records online** with the Personal Health Record (PHR).
- **Use of the Aetna Health Connections Disease℠ Management Program,** which provides personal support to members to help them manage their conditions.
- **24/7 access to a nurse** to help with personal health-related questions.
- **Help members work toward health goals** with wellness initiatives, such as the Simple Steps To A Healthier Life® online program.
- **Take advantage of discount programs** for vision, dental and general health care that encourage use of plan offerings.

*Aetna has a robust, flexible portfolio of life and disability plans for groups with 51 or more eligible lives. Please contact your Aetna representative for a plan designed to meet your group's needs.

Aetna is committed to the health of your business

At Aetna, we understand that your business has unique needs. That's why we have streamlined our plan options for employers with 2 to 100 eligible employees. We are committed to providing you with value and quality you can count on. Our variety of products and services allows you to focus on the health of your business.

Aetna's health plan options are designed with the health of your business in mind

BASIC

- Basic benefits for your employees
- Limiting the expense to your business
- Allow employees to buy up and share more of the cost

– Consumer-directed health plans

– Simply Savings

– 10K Plans

– Basic Life

– Dental plan options

VALUE

- Encouraging employee responsibility in their health care decisions
- Tools and resources to support consumerism
- Innovative plan design

– Compass Plan

– Consumer-directed health plans

– Packaged life and disability

– Dental plan options

TRADITIONAL

- Standard benefits plans
- Limit the financial impact on employees

– Traditional deductible and coinsurance plans

– 100 percent plans

– Copay plans

– Basic Life and short-term disability

– Dental plan options

Health insurance benefits for every stage of life

For young individuals and couples without children…

- Lower monthly payments
- Modest out-of-pocket costs
- Quality preventive care
- Prescription drug coverage
- Financial protection

Consumer-directed health plans
Traditional plans with a higher deductible
Simply Savings
10K Plans
Dental plan options

For married couples and single parents with young children or teens…

- Lower fees for office visits
- Lower monthly payments
- Caps on out-of-pocket expenses
- Quality preventive care for the entire family

Copay plans
Traditional plans
100% plans
Basic Life and STD
Dental plan options

For married couples and single parents with teens and college-aged children…

- Checkups and care for injuries and illness
- Preventive care and screenings that promote a healthy lifestyle
- National network of health care providers

Consumer-directed health plans
Compass plan
Packaged Life and Disability
Dental plan options

For men and women 55 years of age and over with no children at home…

- Financial security
- Quality prescription drug coverage
- Hospital inpatient/outpatient services
- Emergency care

Consumer-directed health plans
Dental plan options

Medical Overview

WELLNESS ON US℠

Wellness for employees means a healthier business for employers. Our business health benefits and insurance plans in Florida offer $0 copays for in-network eye exams and $0 copay for in-network preventive care. It's one more way to help employees get a step closer to better health.

Preventive Care Benefits:

Immunizations	$0 copay
Routine physicals	$0 copay
Child wellness visits	$0 copay
Routine mammogram	$0 copay
Routine OB/GYN visits	$0 copay

NO–COST HEALTH INCENTIVE CREDIT*

Members can earn $50 in just a few simple steps

Members earn a $50 credit towards their out-of-pocket expenses when they:

- Complete or update their health assessment on Simple Steps To A Healthier Life®, ***and***
- Complete one Online Wellness Program

If the employee's spouse is covered under the plan, he or she is also eligible for the same incentive credit. So a family could save $100 in out-of-pocket expenses each year. Incentive rewards will be credited towards the deductible and maximum out-of-pocket limit. This program is included at no additional cost on all plans except the HSA-compatible plans.

SIMPLE STEPS*

Help employees take a step in the right direction

Simple Steps To A Healthier Life® (Simple Steps) is an interactive online health and wellness program that can help you enhance the health and productivity of your employees.

Simple Steps helps participants turn knowledge about their health into action, through:

- A secure online health assessment
- Tailored health reports
- Personalized online wellness programs

Reaching health goals — one step at a time

Our online wellness programs** target health and wellness goals such as:

- Stress management
- Nutrition and diet
- Quitting smoking
- Weight management/physical activity
- Managing depression
- Sleeping better

These self-paced programs also include interactive tools so employees can feel confident they are making healthy choices that fit into their busy schedules.

*This program is available at no additional cost to you and your Aetna medical employees.
**Online wellness programs are brought to you by HealthMedia, Inc®.

Product Name	Product Description	PCP Required	Referrals Required	Network
Health Network Only (HNOnly) – Open Access HMO	HNOnly is a health maintenance organization (HMO) that uses a network of participating providers. Each family member may select a primary care physician (PCP) participating in the Aetna network to provide routine and preventive care and help coordinate the member's total health care. Members never need a referral when visiting a participating specialist for covered services. Only services rendered by a participating provider are covered, except for emergency or urgently needed care.	No	No	HMO (Open Access)/ Open Access Aetna Health Network Only
Health Network Option (HNOption) – POS Open Access	HNOption is an HMO, two-tiered product that allows members to access care in or out of network. Members have lower out-of-pocket costs when they use the in-network tier of the plan. Member cost sharing increases if members decide to go out of network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care.	No	No	Aetna Choice POS (Open Access)/Open Access Aetna Health Network Option
Aetna Open Access® Managed Choice®	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.	No	No	Managed Choice POS (Open Access)
Traditional Choice®/ 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

PROVIDER NETWORK*

County	HMO/POS	MC/PPO
Alachua	•	•
Baker	•	•
Bay		•
Bradford	•	•
Brevard	•	•
Broward	•	•
Calhoun		•
Charlotte	•	•
Citrus	•	•
Clay	•	•
Collier	•	•
Columbia		•
Duval	•	•
Escambia		•
Flagler	•	•
Gadsden		•
Gilchrist		•
Gulf		•
Hardee		•
Hendry		•

County	HMO/POS	MC/PPO
Hernando	•	•
Highlands	•	•
Hillsborough	•	•
Holmes		•
Indian River		•
Jefferson		•
Lake	•	•
Lee	•	•
Leon	•	•
Levy		•
Liberty		•
Manatee	•	•
Marion	•	•
Martin	•	•
Miami-Dade	•	•
Monroe		•
Nassau	•	•
Okaloosa		•
Okeechobee	•	•
Orange	•	•

County	HMO/POS	MC/PPO
Osceola	•	•
Palm Beach	•	•
Pasco	•	•
Pinellas	•	•
Polk	•	•
Putnam	•	•
Santa Rosa		•
Sarasota	•	•
Seminole	•	•
St. John's	•	•
St. Lucie	•	•
Sumter		•
Suwannee		•
Taylor		•
Union		•
Volusia	•	•
Wakulla		•
Walton		•
Washington		•

*Network subject to change.

WHAT IS VALUEPICK?

*ValuePick** is a suite of health benefits and insurance plans designed specifically for businesses. ValuePick offers reduced minimum participation and employer contribution requirements.

Greater employee choice
Employers can offer up to three of the ValuePick plans.

Flexible and affordable
When employers offer up to three of the ValuePick plans, the minimum participation and employer contribution requirements are reduced to make it easier to offer coverage. Employers who were previously unable to offer or afford coverage are now able to offer benefits to meet the needs of their employees.

Total freedom
Aetna is committed to providing solutions to help meet the needs of businesses. Employers who have not offered health benefits coverage in the past can now offer quality coverage at affordable prices.

Easy administration
Setting up this program is simple:

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

	VALUEPICK
Target audience	Groups 2–100 eligible employees
Plan choices	Up to 3 of the ValuePick plans
Participation	50% participation, with a minimum of 4 enrolled employees Triple Option available
Employer contribution	25% of the employee premium or $50 per employee, whichever is less
Employee participation	50%

*This applies if the employer is offering the ValuePick plans only. If the ValuePick plans are offered in conjunction with any of the non-ValuePick plans, the contribution and participation requirements will be the same as the standard requirements.

WHAT IS CONSUMER FLEX CHOICE?

Consumer Flex Choice makes it possible for an employer to tailor benefits to better meet the needs of their employees. Consumer Flex Choice allows you to offer employees as many medical plan designs as they would like (using the current portfolio). This means you are not limited to offering one, two or even three plan options. You can offer a variety of plan designs that meet your employee's specific health care needs.

What are the advantages of Consumer Flex Choice?

Employers can manage costs.
Employer contribution is based on the least expensive plan in the portfolio, regardless of the plans selected or how many plans are offered.

Employees can manage choice.
Employees can select the benefits plan that meets their individual needs.

Most employers have employees and their families who want different things from their medical plans. For instance, some employees may fit the "basic buyer" profile, who want a medical plan where they share in more of the cost. But employees who are "value seekers" may want a plan with more investment options, such as an HSA-compatible plan. Still other employees may prefer a more traditional plan with fixed costs. With Consumer Flex Choice, you can manage costs and provide flexibility in choice for your employees.

Easy administration

Employer contribution:
50 percent of the employee-only cost of the lowest cost plan in the portfolio (even if the employer does not select that plan).

If the HNOnly plan is not available, contributions will be based upon the Open Access Managed Choice Employee Only cost.

Standard participation underwriting guidelines apply:
For non-contributory plans, 100 percent participation is required, excluding valid waivers.

For contributory plans, 70 percent of eligible employees, excluding valid waivers.

At least one employee must be enrolled in each plan offered.

Annual HSA contributions for 2012 are $3,100 per individual/$6,250 per family. Maximums will be adjusted for the cost of living in future years.

For more information, refer to www.irs.gov.

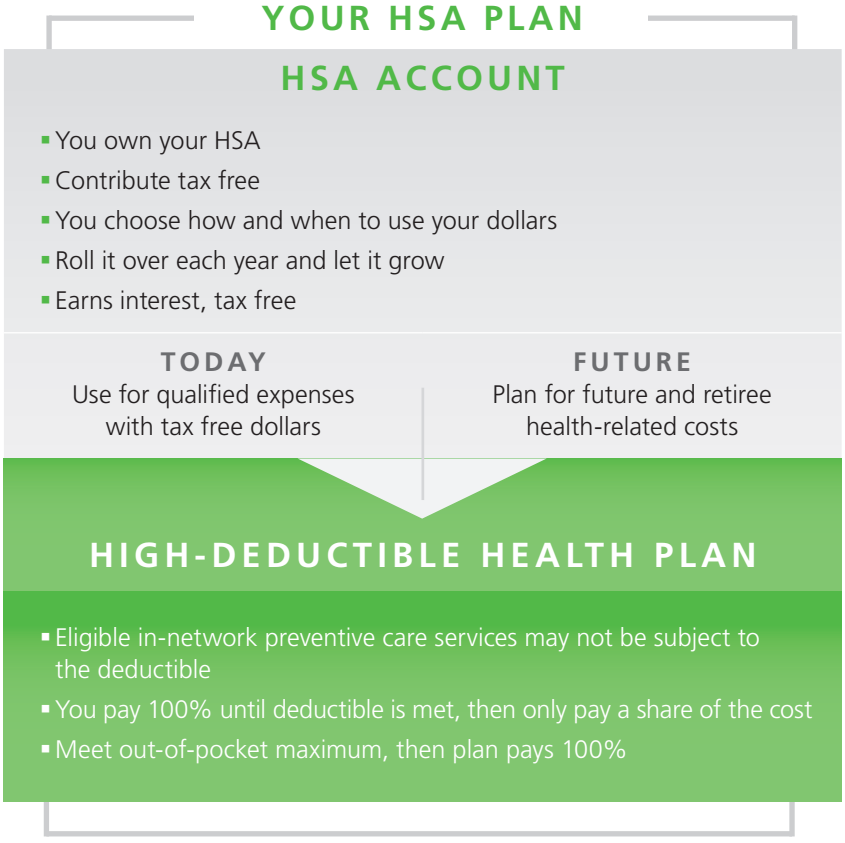
A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

Administrative fees

FEE DESCRIPTION	FEE	
POP*		
Initial Setup**	$175	
Renewal Fee	$100	
HRA and FSA* fees**		
	Initial Setup**	Renewal fee
2–25 Employees	$350	$225
26–50 Employees	$450	$275
51–100 Employees	$550	$325
101–150 Employees	$650	$225
151–200 Employees	$750	$275
201–299 Employees	$4.00 per employee	$2.50 per employee
Monthly Fees†	$5.25 per participant	
Additional Setup 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	
26-100 Employees	$50 per month minimum	
COBRA		
Annual Fee		
20-50 Employees	$100	
51-100 Employees	$175	
101–150 Employees	$250	
151–200 Employees	$325	
201–299 Employees	$430	
Per employee per month		
20-50 Employees	$0.88	
51-100 Employees	$1.02	
Initial Notice Fee	$1.50 per notice (includes notices at time of implementation and during ongoing administration)	
TRA		
Annual Fee	$350	
Transit Monthly Fees	$4.25 per participant	
Parking Monthly Fees	$3.15 per participant	

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/HRA setup fees waived with the purchase of medical with five 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 $100 fee. Nondiscrimination 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. For FSA, the debit card is available for an additional $1 per participant per month. Mailing reimbursement checks direct to employee homes is an additional $1 per participant per month.

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.

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 required for COBRA compliance, while also helping to save them time and money.

STAY ON COURSE WITH AETNA

AETNA COMPASS HNOnly PLAN 12-1500-COMPASS

	Tier 1: Preventive and Primary Care Services	Tier 2: Acute Care Services (hospital based)	Tier 3: Other Medical Care
Deductible	None	$1,500 Individual $3,000 Family	
Coinsurance	None	Aetna pays 90%	Aetna pays 70%
Copay	$25 for primary care physician services $0 copay for Wellness On Us℠ preventive care services and vision exams	$500 per inpatient admission $250 for outpatient surgery	None
Services	▪ Primary care physician visits ▪ Adult wellness exams ▪ Well-child care ▪ Immunizations ▪ Vision examinations ▪ Mammograms ▪ Annual well-woman visit ▪ Colorectal cancer screening	▪ Inpatient hospital admission ▪ Outpatient surgery ▪ Skilled nursing facility ▪ Hospice (inpatient/ outpatient) ▪ Transplants ▪ Mental health inpatient admissions ▪ Substance abuse admissions ▪ Ambulance (Emergency)	▪ Specialist physician visits ▪ Home health care ▪ Rehabilitative therapy ▪ Emergency care and urgent care (emergency care copay waived if admitted) ▪ Outpatient Diagnostics (X-ray, lab, complex imaging) ▪ Durable medical equipment
Out-of-pocket Maximum	$4,000 Individual $8,000 Family Includes deductible, coinsurance and copayments		
Prescription drug copayment	Generic – $5 Brand Name (Preferred) – $40 Brand Name (Non-Preferred) – $60 Self Injectables – 20% (minimum copay - $10, maximum copay - $180)		

Smarter is healthy. And with rising health care costs, smarter is necessary.

The Aetna Compass Plan is a consumer-directed health benefits plan with a traditional concept. It allows employers to offer flexibility, control and choice for employees and their families. And it allows a way for employers to maximize the value of their health care budgets with affordable copays for preventive care, primary care and prescription drugs.

Online tools help members evaluate health care costs and manage their health care. The Aetna Navigator®, our secure member website, is a valuable online resource for personalized benefits and health information.

The Aetna InteliHealth® website provides members with online health and wellness topics. Through the Aetna website (**www.aetna.com**) members can access resources and services designed to help them better manage their health and stay on track. In this new day of increased costs, managing health care expenses can be intimidating for employers and employees. That's why Aetna continues to look for ways to help you make informed decisions.

COMPASS PLAN & 100% PLANS

FLORIDA (2–100 Eligible Employees)	**12-1500-Compass**	**12-2000-100**	**12-3000-100**	**12-5000-100**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES				
Coinsurance	90%/70%	100%	100%	100%
Annual Deductible: Individual/Family	$1,500/$3,000	$2,000/$6,000	$3,000/$9,000	$5,000/$15,000
Type of Deductible	Embedded	3X	3X	3X
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$4,000/$8,000	$2,000/$6,000	$3,000/$9,000	$5,000/$15,000
Wellness On Us™				
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$0, ded waived	$50, ded waived	$60, ded waived	$60, ded waived
Physician Services				
Primary Care Physician Office Visit	$25, ded waived	$25, ded waived	$30, ded waived	$30, ded waived
Specialist Office Visit	70%, ded applies	$50, ded waived	$60, ded waived	$60, ded waived
Walk In Clinic Visit	$25, ded waived	$25, ded waived	$30, ded waived	$30, ded waived
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	70%, ded applies	$50, ded waived	$60, ded waived	$60, ded waived
Inpatient Services				
Hospital Inpatient	90% after $500 copay, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	90% after $500 copay, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Outpatient/Other Services				
Diagnostic Lab	70%, ded applies	$0, ded waived	$0, ded waived	$0, ded waived
Diagnostic X-ray	70%, ded applies	$50, ded waived	$60, ded waived	$60, ded waived
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	70%, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Outpatient Surgery	90% after $250 copay, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Emergency Room (Copay waived if admitted)	70%, ded applies	$300, ded waived	$350, ded waived	$400, ded waived
Urgent Care	70%, ded applies	$75, ded waived	$75, ded waived	$75, ded waived
Ambulance (emergency transport)	90%, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	70%, ded applies	100%, ded applies	100%, ded applies	100%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	70%, ded applies	$50, ded waived	$60, ded waived	$60, ded waived
Pharmacy				
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$5/$40/$60	$10/$45/$65	$10/$45/$65	$20/$50/$75
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $180	80%, max copay $180	80%, max copay $180	80%, max copay $225
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)				
Coinsurance	Out-of-network benefits do not apply to HNOnly plans	70%	70%	Out-of-network benefits do not apply to HNOnly plans
Annual Deductible: Individual/Family		$3,000/$9,000	$4,000/$12,000	
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)		$6,000/$18,000	$6,000/$18,000	
Emergency Room		Paid as in network	Paid as in network	
Ambulance (emergency transport)				
All Other Services		70%, ded applies	70%, ded applies	
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)		Not Covered	70% after copay	
PLAN OPTIONS AVAILABLE				
HNOnly Plan Available (Open Access)	X	X	X	X
HNOption Plan Available (Open Access)		X	X	
MC Open Access Available			X	

For footnotes, see page 19.

TRADITIONAL DEDUCTIBLE AND COINSURANCE PLANS

FLORIDA (2–100 Eligible Employees)	**12-1000-80**	**12-1500-80**	**12-1500-70**
Lifetime Maximum	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES			
Coinsurance	80%	80%	70%
Annual Deductible: Individual/Family	$1,000/$2,000	$1,500/$3,000	$1,500/$3,000
Type of Deductible	Embedded	Embedded	Embedded
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$3,000/$6,000	$4,000/$8,000	$5,000/$10,000
Wellness On Us™			
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$50, ded waived	$50, ded waived	$60, ded waived
Physician Services			
Primary Care Physician Office Visit	$25, ded waived	$25, ded waived	$30, ded waived
Specialist Office Visit	$50, ded waived	$50, ded waived	$60, ded waived
Walk In Clinic Visit	$25, ded waived	$25, ded waived	$30, ded waived
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	$50, ded waived	$50, ded waived	$60, ded waived
Inpatient Services			
Hospital Inpatient	80%, ded applies	80%, ded applies	70%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	80%, ded applies	80%, ded applies	70%, ded applies
Outpatient/Other Services			
Diagnostic Lab	$0, ded waived	$0, ded waived	$0, ded waived
Diagnostic X-ray	$50, ded waived	$50, ded waived	$60, ded waived
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	80%, ded applies	80%, ded applies	70%, ded applies
Outpatient Surgery	80%, ded applies	80%, ded applies	70%, ded applies
Emergency Room (Copay waived if admitted)	$300, ded waived	$300, ded waived	$300, ded waived
Urgent Care	$75, ded waived	$75, ded waived	$75, ded waived
Ambulance (emergency transport)	80%, ded applies	80%, ded applies	70%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	80%, ded applies	80%, ded applies	70%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	80%, ded applies	80%, ded applies	70%, ded applies
Pharmacy			
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$5/$40/$60	$10/$45/$65	$10/$45/$65
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $180	80%, max copay $180	80%, max copay $180
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)			
Coinsurance	50%	50%	50%
Annual Deductible: Individual/Family	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)	$6,000/$12,000	$6,000/$12,000	$8,000/$16,000
Emergency Room	Paid as in network	Paid as in network	Paid as in network
Ambulance (emergency transport)			
All Other Services	50%, ded applies	50%, ded applies	50%, ded applies
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)	70% after copay	70% after copay	70% after copay
PLAN OPTIONS AVAILABLE			
HNOnly Plan Available (Open Access)	X	X	X
HNOption Plan Available (Open Access)	X	X	X
MC Open Access Available	X	X	X

For footnotes, see page 19.

TRADITIONAL DEDUCTIBLE AND COINSURANCE PLANS

FLORIDA (2–100 Eligible Employees)	**12-2000-80**	**12-2000-70**	**12-2500-70**
Lifetime Maximum	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES			
Coinsurance	80%	70%	70%
Annual Deductible: Individual/Family	$2,000/$4,000	$2,000/$4,000	$2,500/$5,000
Type of Deductible	Embedded	Embedded	Embedded
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$5,000/$10,000	$6,000/$12,000	$5,000/$10,000
Wellness On Us™			
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$50, ded waived	$60, ded waived	$60, ded waived
Physician Services			
Primary Care Physician Office Visit	$25, ded waived	$30, ded waived	$30, ded waived
Specialist Office Visit	$50, ded waived	$60, ded waived	$60, ded waived
Walk In Clinic Visit	$25, ded waived	$30, ded waived	$30, ded waived
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	$50, ded waived	$60, ded waived	$60, ded waived
Inpatient Services			
Hospital Inpatient	80%, ded applies	70%, ded applies	70%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	80%, ded applies	70%, ded applies	70%, ded applies
Outpatient/Other Services			
Diagnostic Lab	$0, ded waived	$0, ded waived	$0, ded waived
Diagnostic X-ray	$50, ded waived	$60, ded waived	$60, ded waived
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	80%, ded applies	70%, ded applies	70%, ded applies
Outpatient Surgery	80%, ded applies	70%, ded applies	70%, ded applies
Emergency Room (Copay waived if admitted)	$300, ded waived	$350, ded waived	$350, ded waived
Urgent Care	$75, ded waived	$75, ded waived	$100, ded waived
Ambulance (emergency transport)	80%, ded applies	70%, ded applies	70%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	80%, ded applies	70%, ded applies	70%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	80%, ded applies	70%, ded applies	70%, ded applies
Pharmacy			
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$10/$45/$65	$10/$45/$65	$10/$45/$65
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $180	80%, max copay $180	80%, max copay $180
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)			
Coinsurance	50%	50%	50%
Annual Deductible: Individual/Family	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)	$7,000/$14,000	$10,000/$20,000	$8,000/$6,000
Emergency Room	Paid as in network	Paid as in network	Paid as in network
Ambulance (emergency transport)			
All Other Services	50%, ded applies	50%, ded applies	50%, ded applies
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)	70% after copay	70% after copay	70% after copay
PLAN OPTIONS AVAILABLE			
HNOnly Plan Available (Open Access)	X	X	X
HNOption Plan Available (Open Access)	X	X	
MC Open Access Available	X	X	X

For footnotes, see page 19.

SIMPLY SAVINGS

FLORIDA (2–100 Eligible Employees)	**12-2000-50**	**12-3000A-50**	**12-3000B-50**	**12-5000-50**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES				
Coinsurance	50%	50%	50%	50%
Annual Deductible: Individual/Family	$2,000/$4,000	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$7,000/$14,000	$9,000/$18,000	$9,000/$18,000	$10,000/$20,000
Wellness On Us™				
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$50, ded waived	$35, ded waived	$40, ded waived	$40, ded waived
Physician Services				
Primary Care Physician Office Visit	$25, ded waived	$35, ded waived	$40, ded waived	$40, ded waived
Specialist Office Visit	$50, ded waived	$70, ded waived	$80, ded waived	$80, ded waived
Walk In Clinic Visit	$25, ded waived	$35, ded waived	$40, ded waived	$40, ded waived
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	$50, ded waived	$70, ded waived	$80, ded waived	$80, ded waived
Inpatient Services				
Hospital Inpatient	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Outpatient/Other Services				
Diagnostic Lab	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Diagnostic X-ray	50%, ded waived	50%, ded waived	50%, ded applies	50%, ded applies
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Outpatient Surgery	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Emergency Room (Copay waived if admitted)	$400, ded waived	$400, ded waived	50%, ded applies	50%, ded waived
Urgent Care	$75, ded waived	$100, ded waived	50%, ded applies	$100, ded waived
Ambulance (emergency transport)	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	50%, ded applies	50%, ded applies	50%, ded applies	50%, ded applies
Pharmacy				
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$10/$45/$65	$20/$50/$75	$20/$50/$75	$20/$50 (closed formulary)
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $180	80%, max copay $225	80%, max copay $225	80%, max copay $225
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)				
Coinsurance	Out-of-network benefits do not apply to HNOnly plans	50%	Out-of-network benefits do not apply to HNOnly plans	Out-of-network benefits do not apply to HNOnly plans
Annual Deductible: Individual/Family		$4,000/$8,000		
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)		$12,000/$24,000		
Emergency Room		Paid as in network		
Ambulance (emergency transport)				
All Other Services		50%, ded applies		
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)		70% after copay		
PLAN OPTIONS AVAILABLE				
HNOnly Plan Available (Open Access)	X	X	X	X
HNOption Plan Available (Open Access)				
MC Open Access Available		X		

For footnotes, see page 19.

10K PLANS

FLORIDA (2–100 Eligible Employees)	**12-10K-100C**	**12-10K-100S**	**12-10K-100**	**12-10K-80S**	**12-10K-80**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES					
Coinsurance	100%	100%	100%	80%	80%
Annual Deductible: Individual/Family	$10,000 /$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000	$10,000/$10,000
Type of Deductible	Embedded (1x)	Embedded (1x)	Embedded (1x)	Embedded (1x)	Embedded (1x)
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$10,000 /$10,000	$10,000/$10,000	$10,000/$10,000	$15,000/$15,000	$15,000/$15,000
Wellness On Us™					
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$30, ded waived	$35, ded waived	$35, ded waived	$35, ded waived	$35, ded waived
Physician Services					
Primary Care Physician Office Visit	$30, ded waived	$35, ded waived	$35, ded waived	$35, ded waived	$35, ded waived
Specialist Office Visit	$60, ded waived	$70, ded waived	100%, ded applies	$70, ded waived	80%, ded applies
Walk In Clinic Visit	$30, ded waived	$35, ded waived	$35, ded waived	$35, ded waived	$35, ded waived
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	$60, ded waived	$70, ded waived	100%, ded applies	$70, ded waived	80%, ded applies
Inpatient Services					
Hospital Inpatient	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Outpatient/Other Services					
Diagnostic Lab	$25, ded waived	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Diagnostic X-ray	$75, ded waived	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	$400, ded waived	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Outpatient Surgery	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Emergency Room (Copay waived if admitted)	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Urgent Care	$75, ded waived	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Ambulance (emergency transport)	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	100%, ded applies	100%, ded applies	100%, ded applies	80%, ded applies	80%, ded applies
Pharmacy					
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$20/$50/$75	$20/$50/$75	$20/$50/$75	$10 Generic only	$10 Generic only
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $225	80%, max copay $225	80%, max copay $225	80%, max copay $225	80%, max copay $225
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)					
Coinsurance	70%	70%	Out-of-network benefits do not apply to HNOnly plans	Out-of-network benefits do not apply to HNOnly plans	Out-of-network benefits do not apply to HNOnly plans
Annual Deductible: Individual/Family	$10,000/$10,000	$10,000/$10,000			
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)	$15,000/$30,000	$15,000/$30,000			
Emergency Room	Paid as in network	Paid as in network			
Ambulance (emergency transport)					
All Other Services	70%, ded applies	70%, ded applies			
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)	70% after copay	70% after copay			
PLAN OPTIONS AVAILABLE					
HNOnly Plan Available (Open Access)	X	X	X	X	X
HNOption Plan Available (Open Access)					
MC Open Access Available	X	X			

For footnotes, see page 19.

HSA-COMPATIBLE PLANS

FLORIDA (2–100 Eligible Employees)	**12-1500-80HSA**	**12-2000-90HSA**	**12-2500-80HSA**	**12-3000-80HSA**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES				
Coinsurance	80%	90%	80%	80%
Annual Deductible: Individual/Family	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000
Type of Deductible	Non embedded	Non embedded	Non embedded	Non embedded
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$2,500/$5,000	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000
Wellness On Us™				
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$0, ded waived	$0, ded waived	$0, ded waived	$0, ded waived
Physician Services				
Primary Care Physician Office Visit	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Specialist Office Visit	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Walk In Clinic Visit	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Inpatient Services				
Hospital Inpatient	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Outpatient/Other Services				
Diagnostic Lab	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Diagnostic X-ray	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Outpatient Surgery	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Emergency Room (Copay waived if admitted)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Urgent Care	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Ambulance (emergency transport)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Outpatient Rehabilitative Therapy (30 visits per year)	80%, ded applies	90%, ded applies	80%, ded applies	80%, ded applies
Pharmacy				
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$20/$50/$75 ded applies	$20/$50/$75 ded applies	$20/$50/$75 ded applies	$20/$50/$75 ded applies
Preventive Rx Waiver	Ded waived for certain Preventive Rx	Ded waived for certain Preventive Rx	Ded waived for certain Preventive Rx	Ded waived for certain Preventive Rx
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $225	80%, max copay $225	80%, max copay $225	80%, max copay $225
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)				
Coinsurance	50%	Out-of-network benefits do not apply to HNOnly plans	50%	50%
Annual Deductible: Individual/Family	$3,000/$6,000		$3,000/$6,000	$6,000/$12,000
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)	$6,000/$12,000		$6,000/$12,000	$10,000/$20,000
Emergency Room	Paid as in network		Paid as in network	Paid as in network
Ambulance (emergency transport)				
All Other Services	50%, ded applies		50%, ded applies	50%, ded applies
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)	70% after copay		70% after copay	70% after copay
PLAN OPTIONS AVAILABLE				
HNOnly Plan Available (Open Access)	X	X	X	X
HNOption Plan Available (Open Access)			X	
MC Open Access Available	X		X	X

For footnotes, see page 19.

COPAY AND INDEMNITY PLANS

FLORIDA (2–100 Eligible Employees)	**12-0-100**	**Standard 1-10**	**Standard 2-10**
Lifetime Maximum	Unlimited	Unlimited	Unlimited
IN-NETWORK SERVICES			
Coinsurance	N/A	80%	80%
Annual Deductible: Individual/Family	N/A	$1,000/$3,000	$1,000/$3,000
Type of Deductible	N/A	Non embedded	Non embedded
Annual Out of Pocket (OOP): Individual/Family (deductible included)	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000
Wellness On Us™			
Well-Child Care (Age/Frequency schedules apply, includes coverage for immunizations)	$0	$0, ded waived	$0, ded waived
Preventive Care (including annual adult physicals, well-women visits, mammograms, colorectal cancer screening and other preventive care services.)	$0	$0, ded waived	$0, ded waived
Vision Screening Services (1 time every 24 months)	$50	Not covered	Not covered
Physician Services			
Primary Care Physician Office Visit	$25	80%, ded applies	80%, ded applies
Specialist Office Visit	$50	80%, ded applies	80%, ded applies
Walk In Clinic Visit	$25	80%, ded applies	80%, ded applies
Outpatient Mental Health (20 visits per year - Mental Health Parity applies to groups over 50)	$50	80%, ded applies	80%, ded applies
Inpatient Services			
Hospital Inpatient	$500 copay/day, days 1-4	80%, ded applies	80%, ded applies
Mental Health Inpatient (30 days per year - Mental Health Parity applies to groups over 50)	$500 copay/day, days 1-4	80%, ded applies*	80%, ded applies*
Outpatient/Other Services			
Diagnostic Lab	$0	80%, ded applies	80%, ded applies
Diagnostic X-ray	$50	80%, ded applies	80%, ded applies
Diagnostic Complex Imaging (CAT, MRI, MRA/MRS and PET scans)	70%	80%, ded applies	80%, ded applies
Outpatient Surgery	$500	80%, ded applies	80%, ded applies
Emergency Room (Copay waived if admitted)	$250	80%, ded applies	80%, ded applies
Urgent Care	$75	80%, ded applies	80%, ded applies
Ambulance (emergency transport)	$200	80%, ded applies	80%, ded applies
Durable Medical Equipment ($2,000 maximum per year)	70%	80%, ded applies*	80%, ded applies*
Outpatient Rehabilitative Therapy (30 visits per year)	$50	80%, ded applies*	80%, ded applies*
Pharmacy			
Retail Pharmacy Copay (Mail-order drugs available at 2X copay for a 90-day supply)	$10/$45/$65	80%	80%
Preventive Rx Waiver	Not applicable	Not applicable	Not applicable
Aetna Specialty Pharmacy (after first refill must use Aetna Specialty Pharmacy)	80%, max copay $180	Retail pharmacy coinsurance applies	Retail pharmacy coinsurance applies
OUT-OF-NETWORK (OON) SERVICES (HNOption/MC only - OON services do NOT apply to HNOnly plans)			
Coinsurance	Out-of-network benefits do not apply to HNOnly plans	Same as in-network benefits	Same as in-network benefits
Annual Deductible: Individual/Family			
Annual Out of Pocket (OOP): Individual/Family (deductible applies to OOP)			
Emergency Room			
Ambulance (emergency transport)			
All Other Services			
Retail Pharmacy (Note: OON Pharmacy is not a covered benefit on HNOnly/HNOption plans)			
PLAN OPTIONS AVAILABLE			
HNOnly Plan Available (Open Access)	X		
HNOption Plan Available (Open Access)			
MC Open Access Available		Indemnity only	Indemnity only

For footnotes, see page 19.

PLAN VALUE

PLAN NAME	$	$$	$$$	$$$$
HNOnly 12-10K-80				
HNOnly 12-10K-80S				
HNOnly 12-10K-100				
HNOnly 12-10K-100S				
HNOnly 12-10K-100C				
HNOnly 12-3000-80HSA				
MC OA 12-10K-100S				
HNOnly 12-5000-50				
HNOnly 12-2500-80HSA				
HNOnly 12-3000B-50				
HNOption 12-2500-80HSA				
HNOnly 12-3000A-50				
MC OA 12-10K-100C				
MC OA 12-3000-80HSA				
HNOnly 12-2000-90HSA				
MC OA 12-2500-80HSA				
HNOnly 12-5000-100				
HNOnly 12-2000-50				
HNOnly 12-1500-80HSA				
HNOnly 12-1500-COMPASS				
MC OA 12-3000A-50				
HNOnly 12-2500-70				
HNOnly 12-2000-70				
HNOnly 12-1500-70				
HNOption 12-2000-70				
HNOnly 12-3000-100				
HNOnly 12-2000-80				
MC OA 12-1500-80HSA				
HNOnly 12-1500-80				
HNOption 12-1500-70				
HNOption 12-3000-100				
HNOption 12-2000-80				
MC OA 12-2500-70				
HNOnly 12-2000-100				
MC OA 12-2000-70				
HNOption 12-1500-80				
HNOnly 12-1000-80				
MC OA 12-1500-70				
HNOption 12-2000-100				
MC OA 12-3000-100				
MC OA 12-2000-80				
HNOption 12-1000-80				
MC OA 12-1500-80				
MC OA 12-1000-80				
HNOnly 12-0-100				

FOOTNOTES

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

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain prior approval for certain services such as nonemergency hospital care. For a summary list of Limitations and Exclusions, refer to pages 44–45.

Copays apply to the out-of-pocket maximum (OOP) on all plans except plan 12-2000-100, 12-3000-100 and 12-5000-100. Members must continue to pay applicable copays after OOP is met under these plans. Prescription drug cost sharing does not apply to the OOP, and members must continue to pay applicable prescription drug cost sharing after the OOP is met on all plans except HSA Compatible Plans (prescription drug cost sharing applies to the HSA Compatible plan's OOP).

For all HSA Compatible plans, the full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan, however the deductible is waived for certain preventive medications. A full list of these drugs is available on Aetna Navigator®.

*Standard Indemnity Plan 1-10 and 2-10 are subject to different benefit limits as follows:
Inpatient mental Health is limited to 10 days coverage per calendar year (except where Federal Mental Health Parity applies).
Durable Medical Equipment is not subject to an annual benefit maximum.
Rehabilitative Therapy (PT, OT, ST) has a combined limit of 20 visits per calendar year.

You may choose providers in our network (physicians and facilities), or you may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor or hospital. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums. This benefit applies when you choose to get care out of network.

When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

Dental Overview

AETNA DENTAL® PLANS

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*SM

Research suggests that serious gum disease, known as periodontitis, may be associated with many health problems. This is especially true if gum disease continues without treatment.[1,2] Now, here's the good news. Researchers are discovering that a healthy mouth may be important to your overall health.[1,2]

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

The Dental Maintenance Organization (DMO®)

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

Preferred Provider Organization (PPO) plan

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

[1] MayoClinic.com. "Oral health: A window to your overall health." Available online at www.mayoclinic.com/health/dental/DE00001. Accessed May 2010.

[2] R.C. Williams, A.H. Barnett, N. Claffey, M. Davis, R. Gadsby, M. Kellett, G.Y.H. Lip, and S. Thackray. "The potential impact of periodontal disease on general health: a consensus view." Current Medical Research and Opinion, Vol. 24, No. 6, 2008, 1635-1643.

*DMI may not be available in all states.

PPO Max plan

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

Freedom-of-Choice plan design option

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

Dual Option plan

In the Dual Option plan design the DMO must 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 for 2–9 size. It can be entirely member-paid or employers can contribute up to 50 percent. Voluntary is an entirely member-paid plan for 10+.

AETNA STANDARD DENTAL PLANS 2–9†

	Option 1 DMO	Option 2 Freedom-of-Choice – Monthly selection between DMO and PPO Max		Option 3 Freedom-of-Choice – Monthly selection between DMO and PPO	
	DMO Plan Copay Plan 64	DMO Plan Copay Plan 64	PPO Max Plan 100/70/40	DMO Plan 100/90/60	PPO Plan 100/70/40
Office Visit Copay	$5	$5	N/A	$5	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$50; 3X Family Maximum	None	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	Unlimited	$1,000
DIAGNOSTIC SERVICES					
Oral Exams					
Periodic oral exam	No charge	No charge	100%	100%	100%
Comprehensive oral exam	No charge	No charge	100%	100%	100%
Problem-focused oral exam	No charge	No charge	100%	100%	100%
X-rays					
Bitewing — single film	No charge	No charge	100%	100%	100%
Complete series	No charge	No charge	100%	100%	100%
PREVENTIVE SERVICES					
Adult Cleaning	No charge	No charge	100%	100%	100%
Child Cleaning	No charge	No charge	100%	100%	100%
Sealants — per tooth	No charge	No charge	100%	100%	100%
Fluoride application — with cleaning	No charge	No charge	100%	100%	100%
Space maintainers — fixed	$75	$75	100%	100%	100%
BASIC SERVICES					
Amalgam filling — 2 surfaces permanent	$12	$12	70%	90%	70%
Resin filling — 2 surfaces, anterior	$21	$21	70%	90%	70%
Oral Surgery					
Extraction — exposed root or erupted tooth	$11	$11	70%	90%	70%
Extraction of impacted tooth — soft tissue	$46	$46	70%	90%	70%
MAJOR SERVICES*					
Complete upper denture	$275	$275	40%	60%	40%
Partial upper denture	$275	$275	40%	60%	40%
Crown — Porcelain with noble metal**	$255	$255	40%	60%	40%
Pontic — Porcelain with noble metal**	$255	$255	40%	60%	40%
Inlay — Metallic (3 or more surfaces)	$195	$195	40%	60%	40%
Oral Surgery					
Removal of impacted tooth — partially bony	$58	$58	40%	60%	40%
Endodontic Services					
Bicuspid root canal therapy	$109	$109	40%	90%	40%
Molar root canal therapy	$280	$280	40%	60%	40%
Periodontic Services					
Scaling & root planing — per quadrant	$51	$51	40%	90%	40%
Osseous surgery — per quadrant	$300	$300	40%	60%	40%
ORTHODONTIC SERVICES*	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

†Pending State approval.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. Does not apply to the DMO in Plan Options 1, 2 and 3. There is no waiting period for any covered service on the DMO.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in DMO options 1 and 2.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Options 1, 2 and 3 and on the PPO in Option 6.

Plan Options 2 and 4; PPO Max nonpreferred (Out-of-Network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Plan Option 1 DMO cannot be sold standalone as full-replacement coverage. It must be combined with any one of the PPO plans in Plan Options 4, 5 or 6 in a dual option offering.

Options 1 and 2 DMO Copay Plan 64 amounts listed are the total patient responsibility for the services indicated. The $5 office visit copay is additional.

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 46.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

AETNA STANDARD DENTAL PLANS 2–9†

	Option 4 PPO Max	Option 5 Active PPO Plan		Option 6 Passive PPO
	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Nonpreferred Plan 80/60/40	PPO 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	$1,500	$1,500	$1,000	$2,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing — single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	80%	100%
Child Cleaning	100%	100%	80%	100%
Sealants — per tooth	100%	100%	80%	100%
Fluoride application — with cleaning	100%	100%	80%	100%
Space maintainers — fixed	100%	100%	80%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces permanent	80%	80%	60%	80%
Resin filling — 2 surfaces, anterior	80%	80%	60%	80%
Oral Surgery				
Extraction — exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth — soft tissue	80%	80%	60%	80%
MAJOR SERVICES*				
Complete upper denture	50%	50%	40%	50%
Partial upper denture	50%	50%	40%	50%
Crown — Porcelain with noble metal**	50%	50%	40%	50%
Pontic — Porcelain with noble metal**	50%	50%	40%	50%
Inlay — Metallic (3 or more surfaces)	50%	50%	40%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	50%	50%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	40%	80%
Molar root canal therapy	50%	50%	40%	50%
Periodontic Services				
Scaling & root planing — per quadrant	50%	50%	40%	80%
Osseous surgery — per quadrant	50%	50%	40%	50%
ORTHODONTIC SERVICES*	Not covered	Not covered	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

†Pending State approval.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in Plan Options 1, 2 and 3. There is no waiting period for any covered service on the DMO.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in DMO options 1 and 2.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Options 1, 2 and 3 and on the PPO in Option 6.

Plan Options 2 and 4; PPO Max nonpreferred (Out-of-Network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Plan Option 1 DMO cannot be sold standalone as full-replacement coverage. It must be combined with any one of the PPO plans in Plan Options 4, 5 or 6 in a dual option offering.

Options 1 and 2 DMO Copay Plan 64 amounts listed are the total patient responsibility for the services indicated. The $5 office visit copay is additional.

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 46.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

AETNA VOLUNTARY DENTAL PLANS 2–9†

	Option 1 DMO	Option 2 Freedom-of-Choice – Monthly selection between DMO and PPO Max		Option 3 Freedom-of-Choice – Monthly selection between DMO and PPO		Option 4 PPO Max
	DMO Plan Copay Plan 64	DMO Plan Copay Plan 64	PPO Max Plan 100/70/40	DMO Plan 100/90/60	PPO Plan 100/70/40	PPO Max Plan 100/80/50
Office Visit Copay	$10	$10	N/A	$10	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$75; 3X Family Maximum	None	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	Unlimited	$1,000	$1,500
DIAGNOSTIC SERVICES						
Oral Exams						
Periodic oral exam	No charge	No charge	100%	100%	100%	100%
Comprehensive oral exam	No charge	No charge	100%	100%	100%	100%
Problem-focused oral exam	No charge	No charge	100%	100%	100%	100%
X-rays						
Bitewing — single film	No charge	No charge	100%	100%	100%	100%
Complete series	No charge	No charge	100%	100%	100%	100%
PREVENTIVE SERVICES						
Adult Cleaning	No charge	No charge	100%	100%	100%	100%
Child Cleaning	No charge	No charge	100%	100%	100%	100%
Sealants — per tooth	No charge	No charge	100%	100%	100%	100%
Fluoride application — with cleaning	No charge	No charge	100%	100%	100%	100%
Space maintainers — fixed	$75	$75	100%	100%	100%	100%
BASIC SERVICES						
Amalgam filling — 2 surfaces permanent	$12	$12	70%	90%	70%	80%
Resin filling — 2 surfaces, anterior	$21	$21	70%	90%	70%	80%
Oral Surgery						
Extraction — exposed root or erupted tooth	$11	$11	70%	90%	70%	80%
Extraction of impacted tooth — soft tissue	$46	$46	70%	90%	70%	80%
MAJOR SERVICES*						
Complete upper denture	$275	$275	40%	60%	40%	50%
Partial upper denture	$275	$275	40%	60%	40%	50%
Crown — Porcelain with noble metal**	$255	$255	40%	60%	40%	50%
Pontic — Porcelain with noble metal**	$255	$255	40%	60%	40%	50%
Inlay — Metallic (3 or more surfaces)	$195	$195	40%	60%	40%	50%
Oral Surgery						
Removal of impacted tooth — partially bony	$58	$58	40%	60%	40%	50%
Endodontic Services						
Bicuspid root canal therapy	$109	$109	40%	90%	40%	50%
Molar root canal therapy	$280	$280	40%	60%	40%	50%
Periodontic Services						
Scaling & root planing — per quadrant	$51	$51	40%	90%	40%	50%
Osseous surgery — per quadrant	$300	$300	40%	60%	40%	50%
ORTHODONTIC SERVICES*	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

†Pending State approval.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in Plan Options 1, 2 and 3. There is no waiting period for any covered service on the DMO.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in DMO options 1 and 2.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Options 1, 2 and 3.

Plan Options 2 and 4; PPO nonpreferred (Out-of-Network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Plan Option 1 DMO cannot be sold standalone as full-replacement coverage. It must be combined with the PPO plan, Option 4 in a dual option offering.

Options 1 and 2 DMO Copay Plan 64 amounts listed are the total patient responsibility for the services indicated. The $10 office visit copay is additional.

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.

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 46.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

AETNA STANDARD AND VOLUNTARY DENTAL PLANS 10–100†

	Option 1A DMO Copay 51	**Option 2A** DMO Copay 65	**Option 3A** Freedom-of-Choice – Monthly selection between DMO and PPO Max	
	DMO Plan Copay Plan 51	DMO 65	DMO Plan 100/100/60	PPO Max Plan 100/70/40
Office Visit Copay	$5	$5	$5	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	None	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	No charge	No charge	100%	100%
Comprehensive oral exam	No charge	No charge	100%	100%
Problem-focused oral exam	No charge	No charge	100%	100%
X-rays				
Bitewing — single film	No charge	No charge	100%	100%
Complete series	No charge	No charge	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	$12	No charge	100%	100%
Child Cleaning	$10	No charge	100%	100%
Sealants — per tooth	$10	No charge	100%	100%
Fluoride application — child	$10	No charge	100%	100%
Space maintainers — fixed	$100	No charge	100%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces	$32	No charge	100%	70%
Resin filling — 2 surfaces, anterior	$55	No charge	100%	70%
Endodontic Services				
Bicuspid root canal therapy	$195	$70	100%	70%
Periodontic Services				
Scaling & root planing — per quadrant	$65	$50	100%	70%
Oral Surgery				
Extraction — exposed root or erupted tooth	$30	No charge	100%	70%
Extraction of impacted tooth — soft tissue	$80	No charge	100%	70%
MAJOR SERVICES*				
Complete upper denture	$350	$275	60%	40%
Partial upper denture (resin base)	$375	$275	60%	40%
Crown — Porcelain with noble metal[1]	$325	$225	60%	40%
Pontic — Porcelain with noble metal[1]	$325	$225	60%	40%
Inlay — Metallic (3 or more surfaces)	$275	$190	60%	40%
Oral Surgery				
Removal of impacted tooth — partially bony	$100	$45	60%	40%
Endodontic Services				
Molar root canal therapy	$295	$175	60%	40%
Periodontic Services				
Osseous surgery — per quadrant	$340	$250	60%	40%
ORTHODONTIC SERVICES*	$2,300 copay	$2,300 copay	$2,300 copay	50%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	$1,000

†Pending State approval.

*Coverage Waiting Period applies to PPO and PPO Max Voluntary plans: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. There is no waiting period for any covered service on the Standard Plan Options or on the DMO Voluntary Plan Options.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Options 1A and 2A.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Plan Options 1A–4A, and on the PPO in Plan Options 3A, 5A, 7A and 8A. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in Options 4A, 6A and 9A. General Anesthesia along with all oral surgery, endodontic and periodontic services are covered as basic on Plan Option 10A.

Plan Options 3A, 5A - 7A; PPO Max nonpreferred (Out-of-Network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 4A, 8A - 10A to the prevailing fees at the 80th percentile.

Plan Options 1A and 2A: DMO cannot be sold standalone as full-replacement coverage. It must be combined with any one of the PPO plans in Plan Options 5A - 10A in a dual option offering.

PPO Option 5A can be combined in a dual option offering with any one of the following PPO Plan Options: 6A, 8A - 10A.

Fixed dollar amounts including office visit and ortho copays on the DMO in Plan Options 1A - 4A are member responsibility.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Orthodontic coverage is available for dependent children only on Plan Options 1A to 8A, and adult and child in Plan Options 9A and 10A.

Voluntary Plans: 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.

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 46.

AETNA STANDARD AND VOLUNTARY DENTAL PLANS 10–100†

	Option 4A Freedom-of-Choice – Monthly selection between DMO and PPO		Option 5A PPO Max Low	Option 6A PPO Max High
	DMO Plan 100/90/60	PPO Plan 100/70/40	PPO Max Plan 80/70/40	PPO Max Plan 100/80/50
Office Visit Copay	$5	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	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	$1,000	$1,000	$1,500
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing — single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	80%	100%
Child Cleaning	100%	100%	80%	100%
Sealants — per tooth	100%	100%	80%	100%
Fluoride application — child	100%	100%	80%	100%
Space maintainers — fixed	100%	100%	80%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces	90%	70%	70%	80%
Resin filling — 2 surfaces, anterior	90%	70%	70%	80%
Endodontic Services				
Bicuspid root canal therapy	90%	70%	70%	80%
Periodontic Services				
Scaling & root planing — per quadrant	90%	70%	70%	80%
Oral Surgery				
Extraction — exposed root or erupted tooth	90%	70%	70%	80%
Extraction of impacted tooth — soft tissue	90%	70%	70%	80%
MAJOR SERVICES*				
Complete upper denture	60%	40%	40%	50%
Partial upper denture (resin base)	60%	40%	40%	50%
Crown — Porcelain with noble metal[1]	60%	40%	40%	50%
Pontic — Porcelain with noble metal[1]	60%	40%	40%	50%
Inlay — Metallic (3 or more surfaces)	60%	40%	40%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	60%	70%	40%	80%
Endodontic Services				
Molar root canal therapy	60%	70%	40%	80%
Periodontic Services				
Osseous surgery — per quadrant	60%	70%	40%	80%
ORTHODONTIC SERVICES*	$2,300 copay	50%	40%	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000	$1,000	$1,000

†Pending State approval.

*Coverage Waiting Period applies to PPO and PPO Max Voluntary plans: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. There is no waiting period for any covered service on the Standard Plan Options or on the DMO Voluntary Plan Options.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Options 1A and 2A.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Plan Options 1A–4A, and on the PPO in Plan Options 3A, 5A, 7A and 8A. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in Options 4A, 6A and 9A. General Anesthesia along with all oral surgery, endodontic and periodontic services are covered as basic on Plan Option 10A.

Plan Options 3A, 5A - 7A; PPO Max nonpreferred (Out-of-Network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 4A, 8A - 10A to the prevailing fees at the 80th percentile.

Plan Options 1A and 2A: DMO cannot be sold standalone as full-replacement coverage. It must be combined with any one of the PPO plans in Plan Options 5A - 10A in a dual option offering.

PPO Option 5A can be combined in a dual option offering with any one of the following PPO Plan Options: 6A, 8A - 10A.

Fixed dollar amounts including office visit and ortho copays on the DMO in Plan Options 1A - 4A are member responsibility.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Orthodontic coverage is available for dependent children only on Plan Options 1A to 8A, and adult and child in Plan Options 9A and 10A.

Voluntary Plans: 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.

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 46.

AETNA GROUP DENTAL PLANS 10–100†

	Option 7A Active PPO Max Plan		Option 8A PPO 1000	Option 9A PPO 1500	Option 10A PPO 2000
	Preferred Plan 100/80/50	Nonpreferred Plan 80/60/40	PPO Plan 100/80/50	PPO Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	N/A	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	$50; 3X Family Maximum
Annual Maximum Benefit	$1,500	$1,000	$1,000	$1,500	$2,000
DIAGNOSTIC SERVICES					
Oral Exams					
Periodic oral exam	100%	80%	100%	100%	100%
Comprehensive oral exam	100%	80%	100%	100%	100%
Problem-focused oral exam	100%	80%	100%	100%	100%
X-rays					
Bitewing — single film	100%	80%	100%	100%	100%
Complete series	100%	80%	100%	100%	100%
PREVENTIVE SERVICES					
Adult Cleaning	100%	80%	100%	100%	100%
Child Cleaning	100%	80%	100%	100%	100%
Sealants — per tooth	100%	80%	100%	100%	100%
Fluoride application — child	100%	80%	100%	100%	100%
Space maintainers — fixed	100%	80%	100%	100%	100%
BASIC SERVICES					
Amalgam filling — 2 surfaces	80%	60%	80%	80%	80%
Resin filling — 2 surfaces, anterior	80%	60%	80%	80%	80%
Endodontic Services					
Bicuspid root canal therapy	80%	60%	80%	80%	80%
Periodontic Services					
Scaling & root planing — per quadrant	80%	60%	80%	80%	80%
Oral Surgery					
Extraction — exposed root or erupted tooth	80%	60%	80%	80%	80%
Extraction of impacted tooth — soft tissue	80%	60%	80%	80%	80%
MAJOR SERVICES*					
Complete upper denture	50%	40%	50%	50%	50%
Partial upper denture (resin base)	50%	40%	50%	50%	50%
Crown — Porcelain with noble metal[1]	50%	40%	50%	50%	50%
Pontic — Porcelain with noble metal[1]	50%	40%	50%	50%	50%
Inlay — Metallic (3 or more surfaces)	50%	40%	50%	50%	50%
Oral Surgery					
Removal of impacted tooth — partially bony	50%	40%	50%	80%	80%
Endodontic Services					
Molar root canal therapy	50%	40%	50%	80%	80%
Periodontic Services					
Osseous surgery — per quadrant	50%	40%	50%	80%	80%
ORTHODONTIC SERVICES*	50%	50%	50%	50%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,000	$1,500

†Pending State approval.

*Coverage Waiting Period applies to PPO and PPO Max Voluntary plans: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. There is no waiting period for any covered service on the Standard Plan Options or on the DMO Voluntary Plan Options.

**There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Options 1A and 2A.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in Plan Options 1A–4A, and on the PPO in Plan Options 3A, 5A, 7A and 8A. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in Options 4A, 6A and 9A. General Anesthesia along with all oral surgery, endodontic and periodontic services are covered as basic on Plan Option 10A.

Plan Options 3A, 5A - 7A; PPO Max nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 4A, 8A - 10A to the prevailing fees at the 80th percentile.

Plan Options 1A and 2A: DMO cannot be sold standalone as full-replacement coverage. It must be combined with any one of the PPO plans in Plan Options 5A - 10A in a dual option offering.

PPO Option 5A can be combined in a dual option offering with any one of the following PPO Plan Options: 6A, 8A - 10A.

Fixed dollar amounts including office visit and ortho copays on the DMO in Plan Options 1A - 4A are member responsibility.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Orthodontic coverage is available for dependent children only on Plan Options 1A to 8A, and adult and child in Plan Options 9A and 10A.

Voluntary Plans: 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.

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 46.

Life and Disability Overview

For groups of 51 and above, Aetna offers a robust portfolio of Life and Disability products with flexible plan features. Please consult your sales representative for a plan designed to meet your group's needs:

- Basic Life
- Supplemental Life
- AD&D Ultra
- Supplemental AD&D Ultra
- Dependent Life
- Short Term Disability
- Long Term Disability

LIFE INSURANCE

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

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

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

Giving you (and your employees) what you want

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

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

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

Premium waiver provision —
Employee coverage may stay in effect up to age 65 without premium payments if an employee becomes permanently and totally disabled while insured due to an illness or injury before 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 life and disability package, and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. 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 services for you and your employees isn't difficult. Many companies offer them. The challenge is finding the right plan … one that will meet the distinct needs of your business. Aetna understands this.

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

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

INTEGRATED HEALTH AND DISABILITY

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

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

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

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.

TERM LIFE PLAN OPTIONS FOR 2-50 LIVES

	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
Disability 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
Conversion	Included	Included
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 period	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss period
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	$5,000
Child Amount	Not Available	$2,000

DISABILITY PLAN OPTIONS FOR 2-50 LIVES

SHORT TERM BENEFITS	Plan Option 1	Plan Option 2
Plan Amount	Choice of flat $100 increments to a maximum of $500 weekly	Choice of flat $100 increments to a maximum of $500 weekly
Benefits Start — Accident	1 day	8 days
Benefits Start — Illness	8 days	8 days
Maximum Benefit Period	26 weeks	26 weeks
Maternity Benefit	Maternity treated same as any other disability but is subject to preexisting. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.	Maternity treated same as any other disability but is subject to preexisting. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.
Pre-Existing Conditions Rule	3/12	3/12
Actively at Work Rule	Applies	Applies
Other Income Offset Integration	N/A	N/A
Definition of Disability	Earnings Loss of 20% or more	Earnings Loss of 20% or more

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.

PACKAGED LIFE AND DISABILITY PLAN OPTIONS FOR 2-50 LIVES

TERM LIFE PLAN OPTIONS	Low Option	Low Option 2	Medium Option	Medium Option 2	High Option
Benefit	Flat $10,000	Flat $15,000	Flat $20,000	Flat $25,000	Flat $50,000
Guaranteed Issue **2-9 Lives** **10-50 Lives**	 $10,000 $10,000	 $15,000 $15,000	 $20,000 $20,000	 $20,000 $25,000	 $20,000 $50,000
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	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	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Disability Provision	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Conversion	Included	Included	Included	Included	Included
Dependent Life	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000
AD&D ULTRA					
AD&D Ultra	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit
AD&D Ultra Additional Features	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss period				
DISABILITY PLAN OPTIONS					
Monthly Benefit	Flat $500; No offsets		Flat $1,000; Offsets are Workers' Compensation, any State Disability Plan and Primary and Family Social Security benefits		
Elimination Period	30 days	30 days	30 days	30 days	30 days
Definition of Disability	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	First 24 months of benefits: Own occupation: Earnings Loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss
Benefit Duration	24 months	24 months	24 months	24 months	60 months
Pre-Existing Condition Limitation	3/12	3/12	3/12	3/12	3/12
Types of Disability	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational
Separate Periods of Disability	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter
Mental Health/Substance Abuse	24 months	24 months	24 months	24 months	24 months
Waiver of Premium	Included	Included	Included	Included	Included
OTHER PLAN PROVISIONS					
Eligibility	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees
Rate Guarantee	1 year	1 year	1 year	1 year	1 year
Rates PEPM	$8.00	$10.00	$15.00	$16.00	$27.00

For groups of 51 and above, Aetna offers a robust portfolio of Life and Disability product with flexible plan features. Please consult your sales representative for a plan designed to meet your group's needs:

- Basic Life
- Supplemental Life
- AD&D Ultra
- Supplemental AD&D Ultra
- Dependent Life
- Short Term Disability
- Long Term Disability

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.

Florida Underwriting Guidelines

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 eligibles, including Enrolled, Waivers (with spousal waivers notated) and COBRA eligible and/or State Continuation employees. Include name, date of birth, date of hire, gender, dependent status, and residence zip code. ▪ Retirees are eligible in accordance with the Medicare-Retiree Underwriting guidelines. ▪ COBRA/Continuation eligibles should be included on the census and noted as COBRA/Continuation. ▪ If both husband and wife work for the same company and apply under one contract, rate will be based on the older adult. ▪ Rates are quoted on a 4-tier structure: single, couple, employee plus child(ren), family.
Case Submission Dates	▪ Groups with 3 or fewer enrolled must have all completed paperwork into Aetna Underwriting 60 calendar days prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date. ▪ Groups with 4 or more enrolled must have all completed paperwork into Aetna Underwriting 5 business days prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date. ▪ Any case received after the cut-off date will be considered on an exception basis only, as approved by the Underwriting Unit Manager. If not approved, the effective date will be moved to the next available effective date with potential rate impact
COBRA/Mini-COBRA Continuees	▪ COBRA eligible enrollees are required to be included on the census for medical and dental (not eligible for Life or Disability). ▪ Mini-COBRA eligible enrollees are required to be included on the census for medical (not eligible for Life, Disability or Dental). ▪ Health questions must be answered. ▪ COBRA/mini-COBRA qualifying event, length, start and end date must be provided. ▪ Mini-COBRA continuees are not eligible for Life, Disability or Dental. ▪ Note: COBRA/mini-COBRA continuees are not to be included for purposes 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/mini-COBRA continuees can be included for coverage, subject to normal underwriting guidelines.
Consumer Flex Choice	Employers may select Consumer Flex Choice (all plans) which allows employers to select an unlimited number of plan options within the current product portfolio New Business ▪ Available to groups with 4–100 eligible employees ▪ Employer Contribution – 50% of the employee-only cost of the lowest cost plan in the portfolio (even if the employer does not select that plan) ▪ Participation – non-contributory plans: 100% participation is required, excluding valid waivers ▪ Participation – contributory plans – 2–50 group size: 70% participation is required, excluding valid waivers – 51–100 groups size: 70% participation is required, excluding valid waivers ▪ Each plan chosen must have a minimum of one employee enrolled for the plan to be offered and available for newly hired employees, until the Employer's next renewal. Renewing Business ▪ Employer may select Consumer Flex choice at renewal ▪ Same rules apply as New Business
Deductible Credit	▪ Employees who are eligible and want to receive credit for any amounts paid toward the deductible with their prior carrier should submit a copy of the Explanation of Benefits (EOBs) no later than 90 days after the effective date. ▪ EOBs may be submitted with the initial submission, with the first claim, or can be faxed to claims at **1-866-474-4040** no later than 90 days after the effective date. If you choose to fax, please include "ECHS Category: SFRE" in the subject line with the Group/Control Number in order to direct the information to the correct area for processing.

Dependent Eligibility	▪ Eligible dependents include an employee's spouse. If both husband and wife work for the same company, they may enroll together or separately. If both husband and wife work for the same company and apply under one contract, rate will be based on the older adult. ▪ 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. ▪ At the election of an employer offering group medical coverage or the subscriber, a dependent child between the ages of 26 and 30 may request to continue medical coverage as a dependent on his or her parent's group coverage even after the child reaches the limiting age under the terms of the policy if he or she: is not yet 30 years of age; is unmarried; has no dependents of his or her own; is a resident of FL, or if not a resident of FL, is a full-time or part-time student; is not eligible for Medicare; and is not actually covered under another group, blanket or individual health plan. ▪ Domestic Partners are eligible for groups with 10–100 employees. A declaration or signed statement is required upon enrollment of a domestic partner and upon termination of the relationship. – An affidavit will be required – Coverage is available to eligible dependents who are same sex or opposite sex partners ▪ Dependents must enroll in the same benefit option as the employee. ▪ 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. ▪ Children eligible for coverage through both parents cannot be covered by both parents under the same plan. ▪ Dependents are not eligible for AD&D or Disability coverage ▪ For dependent life, dependents are eligible from 14 days of age up to their 19th birthday, or to up to their 23rd birthday, if a full or part-time student at an accredited institution of higher education. ▪ 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.
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. ▪ After the group is issued payment may be made online or by calling an automated phone number, 1.866.350.7644. This eliminates the need for checks, envelopes and postage, while also ensuring that payments have been received
Employee Eligibility (2–50 group size)	▪ Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 25 hours, and who have met any authorized waiting period requirements. An employer may not set eligibility rules that would require an employee to work more than 25 hours a week to obtain small group coverage. As long as the employee meets the 25-hour per week standard, they are considered full-time for purposes of coverage and vice versa. ▪ This includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer. ▪ 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. While they must be included in the count in determining whether or not the group meets the definition of a small employer and is subject to SGR rules, the employer may carve out union employees as an excluded class. ▪ Employees are eligible to enroll in the dental plan even if they do not select medical coverage. Likewise, employees may enroll in the medical plan even if they do not elect dental. Retirees ▪ Retiree coverage is not available except for any county, municipality, community college or district school board, which requires the provision of coverage to retirees and their dependents. ▪ Medicare-Retiree coverage is available for Medicare-eligible retirees and/or active Medicare eligibles in accordance with the Medicare-Retiree Underwriting Guidelines. ▪ Retirees are not eligible for Life or Disability coverage. ▪ Medicare-eligible retirees who are enrolled in an Aetna Medicare Plan are eligible to enroll in Dental; refer to Medicare-Retiree Underwriting guidelines for details.
Employee Eligibility (51–100 group size)	▪ Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 25 hours, and who have met any authorized waiting period requirements. Retirees ▪ Retiree coverage is available for groups with 51–100 eligible employees ▪ Retirees cannot comprise more than 10% of the group. ▪ If there were no retirees covered by the prior carrier the employee must be covered as an employee on the bill roster. ▪ The retiree must be currently covered with present carrier (must be shown on the bill roster or provide a copy of the ID card). If there were no retirees covered by the prior carrier the employee must be covered as an employee on the bill roster.

Employer Eligibility	▪ 2–50 group size - Any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met. ▪ Group applicants that do not meet the above definition of a small employer are not eligible for coverage. ▪ Groups with 51–100 eligible employees are not subject to Small Group Reform (SGR) and are therefore not Guaranteed Issue. ▪ Medical plans can be offered to sole proprietors, partnerships or corporations. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage. ▪ Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible. ▪ Dental and Disability have ineligible industries which are listed separately. ▪ 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. ▪ Electronic Funds Transfer option is available for the initial premium payment. ▪ The initial premium check is not a binder check and does not bind Aetna to provide coverage. ▪ 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 payment 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 employer group being submitted.
Municipalities and Townships (2-50 group size)	▪ 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 for groups of 2–50 eligibles – 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. In that case, obtain a copy of their prior year W2. – If elected officials are to be covered, request 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)	For group sizes of 2–50, the following documentation must be provided for consideration: ▪ 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 that includes 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 I.D. 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 UC018/UC020 be filed? If so, when? ▪ Groups that are not subject to Guarantee Issue may require Individual health Statements and can be declined. (Pertains to 51–100 size groups)
PEO (Professional Employer Organization)	▪ A group under a PEO may be considered subject to underwriting approval. Complete the PEO questionnaire.
Prior Aetna Coverage	▪ Groups that have been terminated for non-payment by Aetna must pay all premiums owed before a new plan will be issued ▪ Medical claims may be reviewed for any individuals who had prior Aetna coverage and used along with the health information included on the employee application(s) and/or Group Medical Questionnaire, and included in the overall medical assessment of the group.

Rates	▪ 2–9 eligibles – tabular rating ▪ 10–100 eligibles – composite rating ▪ For Life and disability, rates can be tabular or composite depending on size of group ▪ Rates are based on final enrollment. ▪ All quotes are subject to change based upon additional information that becomes available in the quoting process and during the case submission/installation, including but not limited to any change in census.
Rating Information	▪ Rates are based on final enrollment and require that: – No portion of the member's cost sharing, including but not limited to, copayments, deductibles and/or coinsurance balances will be subsidized or funded by the employer, with the exception of a federally-qualified Health Reimbursement Account (HRA), or Health Savings Account (HSA), whether insured or self-funded, including but not limited to a partially self-funded Section 105 wrap around, now or in the future; and – Employer is not funding the deductible of the quoted health plan through an HRA or HSA arrangement in excess of 50% annually. ▪ If both husband and wife work for the same company and apply under one contract, rate will be based on the age of the oldest adult ▪ All quotes are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in census. ▪ All rates will be quoted on a 4-tier structure: single, couple, employee plus child(ren), family. ▪ If any of the information Aetna receives is determined to be incomplete or incorrect, we reserve the right to adjust rates and/or rescind the offer.
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 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 guarantee issue with the following: ▪ A letter from the group or agent 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 spinning-off or otherwise separating from an existing 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.

<table>
<tr><td>Tax Information / Documents
(for groups with 2-20 eligibles and 21-50 eligibles without prior coverage)</td><td>

The following must be provided for all groups with 2–9 eligible and 10+ eligible without prior group coverage:
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.
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 the Underwriter deems acceptable to establish eligibility.

<table>
<tr><td>Sole Proprietor
Franchise
Limited Liability Company (operating as a Sole Proprietor)</td><td>

IRS Form 1040 along with Schedule C (Form 1040)
IRS Form 1040 along with Schedule SE (Form 1040)
IRS Form 1040 along with Schedule F (Form 1040)
IRS 1040 along with Schedule K1 (Form 1065)
Any other documentation the owner feels may assist the Underwriter in determining eligibility

</td></tr>
<tr><td>Partner
Partnership
Limited Liability Partnership</td><td>

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 assist the Underwriter in determining eligibility

</td></tr>
<tr><td>Corporate Officer
Limited Liability Company (operating as C Corp)
C-Corporation
Personal Service Corporation
S-Corporation</td><td>

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 assist the Underwriter in determining eligibility

</td></tr>
</table>
</td></tr>
<tr><td>Tax Information / Documents
(for groups with 21–50 eligibles WITH prior GROUP coverage)</td><td>

A QWTS is not needed if a bill roster is provided and at least 70% of the eligible 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.
Reconciling the bill roster

New hires can be written in by the employer, agent or underwriter.
Employees not on the prior bill who are enrolling now can be enrolled without documentation unless there are questionable aspects.
The underwriter may request QWTS, payroll, etc., if warranted in questionable situations.

When both a QWTS and bill roster are submitted, the underwriter will reconcile both

</td></tr>
<tr><td>Two or more companies – Affiliated, Associated or Multiple Companies, Common Ownership
(2–50 group size and 51–100 group size)</td><td>
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 51% or more ownership in all associated companies
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 and will not be eligible.
A completed Common Ownership form is submitted.

</td></tr>
<tr><td>Value Pick</td><td>

Value Pick is the Aetna plan designed specifically for small businesses.
Offers reduced minimum participation and employer contribution requirements.
May select up to three plans.
Groups of 2–50 eligible employees and 51–100 eligible employees.

</td></tr>
</table>

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. ▪ 2–50 size groups, only 1 waiting period is allowed. ▪ 51–100 size groups may select two waiting periods ▪ The benefit waiting period for future employees may be 0, 1, 2, 3, 4, 5, 6 or 12 months. ▪ A change to the benefit waiting period may only be made on the plan anniversary date. ▪ No retroactive changes will be 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	Life/AD&D and Packaged Life & Disability Disability
Product Availability	▪ Groups of 2–50 eligibles and 51–100 eligibles. ▪ May be written standalone or with ancillary coverage as noted in the following columns. ▪ Only non-occupational injuries and disease will be covered.	2 eligible employees ▪ Standard Dental available with Medical. ▪ Voluntary Dental not available. ▪ Orthodontic coverage not available 3–100 eligible employees ▪ Standard and Voluntary Dental plans are available with or without Medical. ▪ Standalone available. Standalone Dental has ineligible Industries. Retirees (51–100 size groups) ▪ Standard plans – eligible, can comprise no more than 10% of the group ▪ Voluntary plans – not eligible Orthodontia coverage ▪ Available with 10 or more eligible employees with a minimum of 5 enrolled employees for dependent children only for both standard and voluntary plans.	Life and/or Disability ▪ 2–9 eligibles - if packaged with medical ▪ 10–50 eligibles - if packaged with medical or dental. ▪ 26–50 eligible employees on a standalone basis ▪ 51–100 contact your Aetna Account Executive. Packaged Life and Disability ▪ 2–50 eligible employees if packaged with medical ▪ 10–50 eligible employees on a standalone basis. ▪ A plan sponsor cannot purchase both Life and Packaged Life and Disability plans Disability ▪ 2–50 groups are ineligible for coverage if 60% or more of eligible employees or 60% or more of eligible payroll are for employees over 50 years old. ▪ 51–100 contact your Aetna Account Executive.
Excluded Class/Carve Outs	▪ Union employees are the only class of employees that may be excluded. However, union employees are included in the total count of eligible employees in determining the case size. ▪ Management carve outs are not permitted. ▪ 51–100 group size: Management carve outs may be permitted with underwriting management approval.	▪ Union employees if packaged/sold with medical	▪ Union employees if packaged/sold with medical
Employer Contribution (monthly)	▪ 2–3 eligibles - 100% employer contribution of employee only cost ▪ 4–100 eligibles - 50% of the employee cost of the lowest cost plan in the portfolio (even if the employer does not select that plan) ALL ▪ HRA plans - The employer cannot fund the deductible in excess of 50% annually whether through a HRA, HSA or any other arrangement. ▪ Coverage can be denied based on inadequate contributions.	Standard Dental ▪ 2 to 3 eligibles, 100% employer contribution of employee only cost ▪ 4 to 50 eligibles, 25% of the total cost of the plan or 50% of the cost of employee only coverage ▪ 51 to 100 eligibles, employer contribution of less than 50% of the cost of employee only coverage ▪ Coverage can be denied based on inadequate contributions. Voluntary Dental 3 to 9 eligibles ▪ Employer contribution of less than 50% of the cost of the employee only coverage. ▪ Coverage can be denied based on inadequate contributions. 10 to 100 eligibles ▪ Employee pay all plans, employee pays 100% ▪ The employer can not contribute to the cost of the employee rate.	▪ 2–9 eligible employees - 100% of the total cost of the life and disability plans. ▪ 10–100 eligible employees - at least 50% of the total cost of the plans excluding Optional Dependent Term Life. ▪ Coverage can be denied based on inadequate contributions.

Late Applicants	▪ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. Applicants without a qualifying life event (i.e., loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing) are subject to the Late Entrant guidelines as noted below. ▪ Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added.		
	▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.	▪ An employee or dependent may enroll at any time; however, coverage is limited to Preventive & Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics). ▪ Late Entrant provision does not apply to enrollees under 5 years of age.	▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. ▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability. ▪ 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.
Medical Underwriting	2–50 size groups ▪ A group that is wholly domiciled within the state with 2–50 eligibles, including COBRA and mini-COBRA eligibles cannot be denied based on medical conditions; however, rates may be adjusted for known medical conditions. ▪ Employees residing outside the state cannot be denied based on medical conditions; however, may have rates adjusted to the maximum allowed in that state. 51–100 size groups ▪ Must complete a Group Medical Questionnaire (GMQ). These cases may be declined or rated up. ▪ Virgin groups seeking coverage for the first time will be required to provide Individual Health Statements. These cases may be declined or rated up. ALL ▪ Medical conditions of COBRA and/or state continuees are included in this rating calculation. ▪ Medical claims may be reviewed for any individuals who had prior Aetna coverage and used along with the health information included on the employee application(s) and/or Group Medical Questionnaire, and included in the overall medical assessment of the group.	▪ 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	▪ Out-of-state employees must be enrolled in a MC/PPO plan if available, otherwise an indemnity plan. ▪ PPO is not available in the following states: HI, ID, MN, MT, ND, NM, RI, UT, VT, WI and WY. ▪ Indemnity is not available in HI or VT. ▪ 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.	▪ Members who reside out of state (OOS) will receive the same plan as instate members (based on state rules and network availability). This applies to DMO, PPO and FOC Dental plans. ▪ If an OOS member resides in a state that does not allow the instate plan — those members will be placed into an available PPO or Indemnity Plan.	▪ Employees are eligible for Basic Term Life and Packaged Life/Disability.

*Valid waivers include spousal/parental group coverage, Medicare/Medicaid, Champus/ChampVA, Military coverage, Retiree coverage, or Association coverage (for doctors/lawyers covered under an association who want to cover their employees). Individual coverage and Limited Liability plans do not constitute valid waivers.

Participation	Non-contributory Plans ▪ 100% of eligibility must enroll, excluding valid waivers. Contributory Plans ▪ 2–3 eligibles - 100% of eligibles must enroll, excluding valid waivers ▪ 4–100 eligibles - 70% of eligibles must enroll, excluding valid waivers, rounding down to the nearest whole number. Example: 12 minus 3 valid waivers = 9; 9 x 70%= 6.30 = 6 must enroll Value Pick Plans ▪ 50% participation, with a minimum of 4 enrolled employees. Waivers 2–50 group size ▪ Valid waivers include spousal/parental group coverage, Medicare/Medicaid, Champus/ChampVA, Military coverage, Retiree coverage, or Association coverage (for doctors/lawyers covered under an association who want to cover their employees). ▪ Individual coverage is not a valid waiver. 51–100 group size ▪ Valid Waivers include spousal/parental group coverage, Medicare/Medicaid, Champus/ChampVA, Military Coverage, Retiree coverage through a prior employer or Association coverage (for doctors/lawyers covered under an association who want to cover their employees). ▪ Individual coverage is not a valid waiver. All ▪ Dependent participation is not required. ▪ Coverage can be denied based on inadequate participation.	Noncontributory Plans ▪ 100% participation is required, excluding those with other qualifying dental coverage. Standard ▪ 2–3 eligibles 100% participation is required excluding those with other qualifying dental coverage. Example: 3 eligibles, 1 spousal dental 3 minus 1 = 2 x 100% = 2 must enroll ▪ 4–9 eligibles ▪ 70% participation is required excluding those with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the dental plan. ▪ 10–100 eligibles 30% participation of total eligibles excluding those with other qualifying dental coverage. ▪ A minimum of two (2) employees must enroll Voluntary Dental ▪ 3–9 eligible employees 30% participation excluding those with other qualifying existing dental coverage or a minimum of 3 enrollees (5 enrollees for orthodontia coverage) whichever is greater is required. ▪ 10–100 eligibles 30% participation of total eligibles excluding those with other qualifying dental coverage. Standalone Dental ▪ 70% participation excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan. Voluntary and Standalone ▪ 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.	Non-contributory Plans ▪ 100% participation is required. Contributory Plans ▪ 2–9 eligibles - 100% participation ▪ 10–50 eligibles - 70% participation ▪ 51–100 contact your Aetna Account Executive. Standalone Life ▪ 26–50 eligibles 70% participation is required. ▪ 51–100 contact your Aetna Account Executive. All ▪ COBRA and state continuees are not eligible ▪ Retirees are not eligible ▪ 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. Example: 9 employees 3 waiving medical 9 must enroll for life ▪ Coverage can be denied based on inadequate participation

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/AD&D and Packaged Life & Disability Disability
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. ▪ The future renewal date of the change will be the same as the medical 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 but must be received in Aetna underwriting by the 15th to be effective the next month.	▪ 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).
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. ▪ Standalone dental or dental packaged with life only have ineligible industries	51–100 size groups ▪ Contact your Aetna Account Executive. 2–50 size groups ▪ Basic Term Life ▪ All industries are eligible ▪ Packaged Life/Disability or Disability Only ▪ The following industries are not eligible.

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

DENTAL ONLY

Coverage Waiting Period	Standard 2–9 and Voluntary 3 to 100 eligible employees ▪ 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. ▪ Future hires - waiting period applies regardless if takeover for Voluntary 3 to 100 eligibles. ▪ 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 Standard 10–100 eligible employees ▪ No waiting period
Product Packaging	Voluntary ▪ DMO cannot be sold as standalone and must be packaged with any PPO Option as a Dual Option. ▪ 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. ▪ Option to include ortho for adults is available for 10–100 eligibles. Refer to Dental plan description for availability. ▪ Dual option not available for voluntary, preventive or consumer directed plans. Standard ▪ DMO cannot be sold as standalone and must be 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, excluding Preventive Plans. ▪ 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. ▪ Option to include ortho for adults is available for 10–100 eligibles. Refer to Dental plan description for availability. ▪ Dual option is DMO and another non-FOC product with a minimum of 2 enrolled. ▪ Triple option not available.
Open Enrollment	Standard 2–9 eligibles ▪ Not allowed. ▪ 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. 10–100 eligibles ▪ Allowed Voluntary ▪ Not allowed. ▪ 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	▪ 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 (2–50 ELIGIBLE EMPLOYEES)

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

Guarantee 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.

Actively-at-work

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

Continuity of Coverage (no loss/no gain)

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

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 Guaranteed Issue Limit. Example: Group has $50,000 life with $20,000 Guaranteed 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

These plans do not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered.

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

- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents

All plans pre-existing conditions exclusion provisions

These plans impose a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 180 days.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 180-day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days 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 **1-800-80-AETNA** 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 an individual 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.

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
- Late entrants: Members who do not enroll within the first 31 days of becoming eligible may be subject to a late entrant penalty
- Waiting period: 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 & 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 criminal act
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician, an accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel; this does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

DISABILITY

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from person committing or attempting to commit a criminal act
- 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)
- Is caused by an occupational illness or injury (STD only)
- Results from driving an automobile while 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 365 days of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines 90 days 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.

Other exclusions and limitations apply and may vary from state to state; please consult your plan documents for details of you policy.

2–100 Enrollment Checklist

Email addresses for New Business groups with 2-100 eligible employees:

Submission for a standard quote:
FL2-100Quote@aetna.com

Submission for a medical prescreen:
FL2-100Prescreen@aetna.com

Submission for a Sold Case:
FL2-100NBUnderwriting@aetna.com

To ensure your requests are directed to the correct Underwriting team for groups of over 50 eligible employees, please start the subject line with: 51-100.

For questions or assistance, please contact our Sales Support Department at 1-888-422-2128 or your local Aetna Sales Department.

We want to process your request as quickly as possible. You can help by submitting all the necessary paperwork listed below.

- ❑ Employer/Company Application
- ❑ Employee Enrollment Applications/Waivers
- ❑ Workers compensation declaration page (not required for 51 to 100)
- ❑ Initial premium check payable to Aetna Health Management LLC. Electronic fund transfer available for initial premium payment only
- ❑ Copy of initial quote and census or quote ID
- ❑ Copy of medical prescreen evaluation (if applicable)
- ❑ Copy of current group billing statement that includes the account summary
- ❑ Groups with 2 to 20 eligible employees and groups with 21 to 50 eligible employees without prior group coverage:
  - – Last quarterly wage and tax statement; or
  - – Payroll records

Any missing information will result in the effective date being moved forward to the next available date with potential rate impact.

This checklist may not be all inclusive. Refer to the underwriting guidelines.

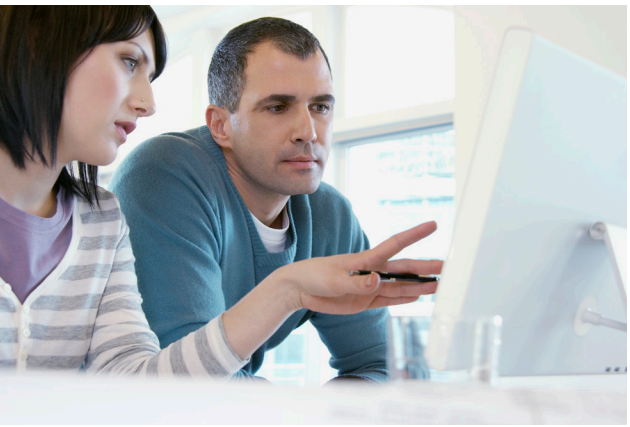
Effective dates may be the 1st or 15th of the month only.

Groups with 3 or fewer must have all completed paperwork into Aetna Underwriting 60 calendar days prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date.

Groups with 4 or more enrolled must have all completed paperwork to Aetna Underwriting 5 business days prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date.

Aetna®

The Health of Business, Well Planned.



This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits plans, health/dental 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. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. 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. 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, life 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 the Aetna Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity. 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.**

14.02.318.1-FL (5/12)