AETNA AVENUE℠

COLORADO PLAN GUIDE

Your destination for small business solutions℠

We want you to know®

Aetna®

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Health care is a journey...

AETNA AVENUE℠ IS THE WAY

IN THIS GUIDE:

Plans effective August 1, 2008

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

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

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

CHOICE

For business owners and employees.

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

Medical Plans – supporting members on their health care journey.

- Value Plans
- Consumer Directed Health Plans (CDHP)
- Split Coinsurance Plans
- Traditional Plans

Dental, Life and Disability Plans – providing valuable protection.

- DMO
- PPO
- PPO Max
- Freedom of Choice
- Preventive
- Basic Term Life Insurance
- Disability Plans
- Packaged Life and Disability Plans

EASE

Allowing you to focus on your business.

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

Administration – making it work for your business.

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

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

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

Aetna Navigator™ – our online resource for employers, members and providers.

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

Knowledgeable Customer Service – a valuable resource for members.

- Ready to answer questions
- Online access 24 hours a day, 7 days a week
- Email access for answers to your questions

Aetna Health Connections℠ disease management – Our newly redesigned capabilities offer support for over 30 conditions as well as integrated care for members with multiple conditions. The program includes cutting-edge technology that helps improve patient safety, doctor communication and more.

REPUTATION

In business it's everything.

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

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

We want you to know that Aetna delivers.

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that small business owners' insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 1 – 50 employees and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for your business and assist you through implementation.

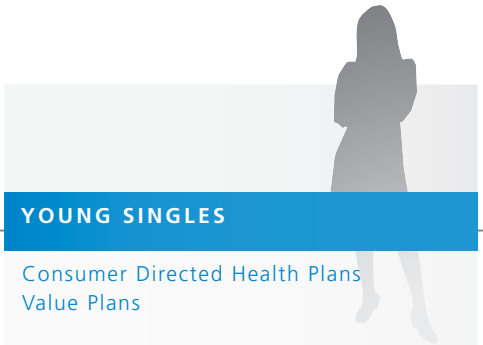
AETNA'S MARKET MAP

Guiding your small business health care journey

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

DO YOU VALUE...

Basic benefits for your employees Limiting the expense to your business Allowing employees to buy-up and share more of the cost	*You might be a...* **Basic Buyer**	**These plans fit...** **Value Plans** • MC Value Plus $750 50/50 $25/$50 • MC Value $1,500 70/50 $25 (3-visit limit) • MC Value Limited $1,000 50/50 $35
Employee responsibility Consumerism's ability to make a difference Tools and resources to support consumerism Innovative plan design	*You might be a...* **Value Seeker**	**These plans fit...** **Consumer Directed Health Plans** • MC HDHP $2,800 100/50 HSA-Compatible • MC HDHP $3,500 100/50 HSA-Compatible • MC HDHP $2,000 100/50 HRA-Compatible • MC HDHP $2,500 100/50 HRA-Compatible • MC HDHP $5,000 100/50 HRA-Compatible **Split Coinsurance Plans** • MC $750 90/50/50 $15/$30 • MC $1,500 80/50/50 $20/$40
Traditional benefits plans Limiting the financial impact on employees	*You might be a...* **Traditionalist**	**These plans fit...** **Traditional Plans** • MC $500 90/60 $15/$30 • MC $1,500 100/60 $20/$40 • MC $1,000 80/60 $20/$40 • MC $3,000 100/60 $25/$50



YOUNG SINGLES

Consumer Directed Health Plans
Value Plans

YOUNG FAMILIES

Traditional Plans

ESTABLISHED FAMILY

Consumer Directed Health Plans
Split Coinsurance Plans

EMPTY NESTERS

Consumer Directed Health Plans

HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Includes singles and couples without children

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

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

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

ESTABLISHED FAMILIES

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

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

EMPTY NESTERS

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

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

Aetna Avenue

MEDICAL OVERVIEW

Aetna Managed Choice® Open Access plan provider network

More than 10,000 doctors and 287 facilities

Available in these Colorado counties:*

Adams
Alamosa
Arapahoe
Archuleta
Baca
Bent
Boulder
Broomfield
Chaffee
Cheyenne
Clear Creek
Conejos
Costilla
Crowley
Custer
Delta
Denver
Dolores
Douglas
Eagle
El Paso
Elbert
Fremont
Garfield
Gilpin
Grand
Gunnison
Hinsdale
Huerfano
Jackson
Jefferson
Kiowa
Kit Carson
La Plata
Lake
Larimer
Las Animas
Lincoln
Logan
Mesa
Mineral
Moffat
Montezuma
Montrose
Morgan
Otero
Ouray
Park
Phillips
Pitkin
Prowers
Pueblo
Rio Blanco
Rio Grande
Routt
Saguache
San Juan
San Miguel
Sedgwick
Summit
Teller
Washington
Weld
Yuma

*Network subject to change.

WHAT ARE PICK-A-PLAN 3 AND VALUEPICK?

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

Pick-A-Plan 3 offers the following advantages:

Greater employee choice
Employers can offer any 3 of the 19 available plan designs.

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

Total freedom
Aetna offers 19 plan choices that range in price and benefits to help meet each individual employee's needs, whether they are lower premiums or lower out-of-pocket costs at the time services are received.

Easy administration
Setting up this program is simple:

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

	Pick-A-Plan 3	ValuePick
Target Audience	Every small business with 2+ enrolled employees	Uninsured small businesses and newly formed businesses
Plan Choices	Up to 3 of the 19 available plans	Up to 3 of the 3 Value plans
Minimum Participation		
2 or more enrolled employees	70% of eligible employees required	60% of eligible employees required
Employer Contribution	50% of the employee rate or $120	25% of the employee rate or $50
Rating Options	2-9 employees — tabular; 10-50 employees — option of tabular or composite	2-9 employees — tabular; 10-50 employees — option of tabular or composite

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

ValuePick offers reduced minimum participation and employer contribution requirements.

ValuePick offers the following advantages:

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

Greater employee choice
Employers can offer up to 3 of the Value plans.

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

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

Easy administration
Setting up this program is simple:

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

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

HEALTH SAVINGS ACCOUNT (HSA)

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

Annual HSA contributions for 2009 are $3,000 per individual/$5,950 per family. Maximums will be adjusted for the cost of living in future years.

Administrative Fees

Fee Description	Fee
HSA	
Initial Set-Up	$0
Monthly Fees	$0
POP*	
Initial Set-Up**	$150
Renewal	$75
HRA AND FSA***	
Initial Set-Up**	
2 – 25 Employees	$350
26 – 50 Employees	$450
51 – 100 Employees	$550
101 – 150 Employees	$650
151 – 200 Employees	$750
201 – 299 Employees	$4.00 per employee
Renewal Fee	50% of the initial set-up fee
Monthly Fees†	$5.00 per participant
Additional Set-Up Fee for "stacked" plans (those electing an Aetna HRA and FSA simultaneously)	$150
Participation Fee for "stacked" participants	$9.75 per participant
Minimum Fees	
0 – 25 Employees	$10 per month minimum
26 – 299 Employees	$50 per month minimum
TRA	
Annual Fee	$350
Transit Monthly Fees	$4.25 per participant
Parking Monthly Fees	$3.15 per participant

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

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

SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

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

Premium Only Plans (POP)

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

Flexible Savings Account (FSA)

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

Transit Reimbursement Account (TRA)

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

*First year POP fees waived with the purchase of medical with 5-plus enrolled employees.
**Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for $75 fee. Non-discrimination testing only available for FSA and POP products.
***Aetna FSA pricing is inclusive for POP. Debit cards are available for FSA only. Contact Aetna for further information.
†For HRA, if the employer opts out of Streamline, the fee is increased $1.50 per participant.

Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information subject to change.
Aetna reserves the right to change any of the above fees and to impose additional fees upon prior written notice.

TRADITIONAL PLANS

Aetna Managed Choice Open Access Plan Options	MC $500 90/60 $15/$30*		MC $1,000 90/60 $15/$30*		MC $1,000 80/60 $20/$40*	
PCP Referrals Required	No	N/A	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	90%	60%	90%	60%	80%	60%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$500 per member (two-member maximum)	$1,500 per member (two-member maximum)	$1,000 per member (two-member maximum)	$3,000 per member (two-member maximum)	$1,000 per member (two-member maximum)	$3,000 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$2,500 per member (two-member maximum)	$5,500 per member (two-member maximum)	$3,500 per member (two-member maximum)	$10,500 per member (two-member maximum)	$4,000 per member (two-member maximum)	$12,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	$15 copay, ded waived	60%; after ded	$15 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded
Specialist Office Visit	$30 copay, ded waived	60%; after ded	$30 copay, ded waived	60%; after ded	$40 copay, ded waived	60%; after ded
Outpatient Lab	$15 copay, ded waived	60%; after ded	$15 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded
Outpatient X-ray	$30 copay, ded waived	60%; after ded	$30 copay, ded waived	60%; after ded	$40 copay, ded waived	60%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	90%; after ded	60%; after ded	90%; after ded	60%; after ded	80%; after ded	60%; after ded
Well-Child Exams (Age and frequency schedules apply)	$15 copay, ded waived	60%, ded waived	$15 copay, ded waived	60%, ded waived	$20 copay, ded waived	60%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	$15 copay, ded waived	60%; after ded	$15 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded
Inpatient Hospital	90%; after ded	60%; after ded	90%; after ded	60%; after ded	80%; after ded	60%; after ded
Outpatient Surgery	90%; after ded	60%; after ded	90%; after ded	60%; after ded	80%; after ded	60%; after ded
Emergency Room (Copay waived if admitted)	$250 copay, deductible waived		$250 copay, deductible waived		$250 copay, deductible waived	
Urgent Care	$50 copay, deductible waived		$50 copay, deductible waived		$50 copay, deductible waived	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$15/$30/$50	Not covered	$15/$30/$50	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included		Included	
Medicare Creditable	Yes		Yes		Yes	

*Payment for out-of-network care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply as such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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

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Standard and Basic plans are available upon request.

All services subject to deductible, unless noted otherwise.

Notes: The dollar amount copayments indicate what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visits maximums. Members or providers may be required to precertify or obtain approval for certain services such as outpatient complex imaging and non-emergency hospital care.

For a list of Limitations and Exclusions, refer to page 36.

TRADITIONAL PLANS

Aetna Managed Choice Open Access Plan Options	MC $1,500 90/60 $20/$40*		MC $2,000 80/60 $20/$40*		MC $2,500 80/50 $25/$50*	
PCP Referrals Required	No	N/A	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	90%	60%	80%	60%	80%	50%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$1,500 per member (two-member maximum)	$4,500 per member (two-member maximum)	$2,000 per member (two-member maximum)	$6,000 per member (two-member maximum)	$2,500 per member (two-member maximum)	$7,500 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$4,000 per member (two-member maximum)	$12,000 per member (two-member maximum)	$5,500 per member (two-member maximum)	$16,500 per member (two-member maximum)	$6,500 per member (two-member maximum)	$19,500 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	$20 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded	$25 copay, ded waived	50%; after ded
Specialist Office Visit	$40 copay, ded waived	60%; after ded	$40 copay, ded waived	60%; after ded	$50 copay, ded waived	50%; after ded
Outpatient Lab	$20 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded	$25 copay, ded waived	50%; after ded
Outpatient X-ray	$40 copay, ded waived	60%; after ded	$40 copay, ded waived	60%; after ded	$50 copay, ded waived	50%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	90%; after ded	60%; after ded	80%; after ded	60%; after ded	80%; after ded	50%; after ded
Well-Child Exams (Age and frequency schedules apply)	$20 copay, ded waived	60%, ded waived	$20 copay, ded waived	60%, ded waived	$25 copay, ded waived	50%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	$20 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded	$25 copay, ded waived	50%; after ded
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Outpatient Surgery	90%; after ded	60%; after ded	80%; after ded	60%; after ded	80%; after ded	50%; after ded
Emergency Room (Copay waived if admitted)	$250 copay, deductible waived		$250 copay, deductible waived		$250 copay, deductible waived	
Urgent Care	$50 copay, deductible waived		$50 copay, deductible waived		$50 copay, deductible waived	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$20/$40/$70	Not covered	$20/$40/$70	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included		Included	
Medicare Creditable	Yes		Yes		Yes	

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Member Benefits	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	100%	60%	100%	60%	100%	60%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$1,500 per member (two-member maximum)	$3,000 per member (two-member maximum)	$2,500 per member (two-member maximum)	$5,000 per member (two-member maximum)	$3,000 per member (two-member maximum)	$6,000 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$1,500 per member (two-member maximum)	$6,000 per member (two-member maximum)	$2,500 per member (two-member maximum)	$10,000 per member (two-member maximum)	$3,000 per member (two-member maximum)	$12,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	$20 copay, ded waived	60%; after ded	$20 copay, ded waived	60%; after ded	$25 copay, ded waived	60%; after ded
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Inpatient Hospital	100%; after ded	60%; after ded	100%; after ded	60%; after ded	100%; after ded	60%; after ded
Outpatient Surgery	100%; after ded	60%; after ded	100%; after ded	60%; after ded	100%; after ded	60%; after ded
Emergency Room (Copay waived if admitted)	$250 copay, deductible waived		$250 copay, deductible waived		$250 copay, deductible waived	
Urgent Care	$50 copay, deductible waived		$50 copay, deductible waived		$50 copay, deductible waived	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$20/$40/$70	Not covered	$20/$40/$70	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included		Included	
Medicare Creditable	Yes		Yes		Yes	

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

Standard and Basic plans are available upon request.

All services subject to deductible, unless noted otherwise.

Notes: The dollar amount copayments indicate what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visits maximums. Members or providers may be required to precertify or obtain approval for certain services such as outpatient complex imaging and non-emergency hospital care.

For a list of Limitations and Exclusions, refer to page 36.

SPLIT COINSURANCE PLANS

Aetna Managed Choice Open Access Plan Options	MC $750 90/50/50 $15/$30*		MC $1,500 80/50/50 $20/$40*	
PCP Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	90% professional; 50% facility	50%	80% professional; 50% facility	50%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$750 per member (two-member maximum)	$2,250 per member (two-member maximum)	$1,500 per member (two-member maximum)	$4,500 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$3,750 per member (two-member maximum)	$8,250 per member (two-member maximum)	$5,000 per member (two-member maximum)	$15,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000	
Primary Physician Office Visit	$15 copay, ded waived	50%; after ded	$20 copay, ded waived	50%; after ded
Specialist Office Visit	$30 copay, ded waived	50%; after ded	$40 copay, ded waived	50%; after ded
Outpatient Lab	$15 copay, ded waived	50%; after ded	$20 copay, ded waived	50%; after ded
Outpatient X-ray	$30 copay, ded waived	50%; after ded	$40 copay, ded waived	50%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	50%; after ded	50%; after ded	50%; after ded	50%; after ded
Well-Child Exams (Age and frequency schedules apply)	$15 copay, ded waived	50%, ded waived	$20 copay, ded waived	50%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	$15 copay, ded waived	50%; after ded	$20 copay, ded waived	50%; after ded
Inpatient Hospital	90% professional, 50% facility; after ded	50%; after ded	80% professional, 50% facility; after ded	50%; after ded
Outpatient Surgery	90% professional, 50% facility; after ded	50%; after ded	80% professional, 50% facility; after ded	50%; after ded
Emergency Room (Copay waived if admitted)	$250 copay, deductible waived		$250 copay, deductible waived	
Urgent Care	$50 copay, deductible waived		$50 copay, deductible waived	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$15/$30/$50	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included	
Medicare Creditable	Yes		Yes	

*Payment for out-of-network care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply as such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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

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

Standard and Basic plans are available upon request.

All services subject to deductible, unless noted otherwise.

Notes: The dollar amount copayments indicate what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visits maximums. Members or providers may be required to precertify or obtain approval for certain services such as outpatient complex imaging and non-emergency hospital care.

For a list of Limitations and Exclusions, refer to page 36.

CONSUMER DIRECTED HEALTH PLANS

Aetna Managed Choice Open Access Plan Options	MC HDHP $2,800 100/50 HSA-Compatible*		MC HDHP $3,500 100/50 HSA-Compatible*		MC HDHP $2,000 100/50 HRA-Compatible*	
PCP Referrals Required	No	N/A	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	100%	50%	100%	50%	100%	50%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$2,800 individual $5,600 family	$5,600 individual $11,200 family	$3,500 individual $7,000 family	$7,000 individual $14,000 family	$2,000 per member (two-member maximum)	$6,000 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$3,300 individual $6,600 family	$10,500 individual $21,000 family	$4,000 individual $8,000 family	$10,500 individual $21,000 family	$2,000 per member (two-member maximum)	$10,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Specialist Office Visit	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Lab	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient X-ray	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Well-Child Exams (Age and frequency schedules apply)	100%, ded waived	50%, ded waived	100%, ded waived	50%, ded waived	$20 copay, ded waived	50%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	100%, ded waived	50%, after ded	100%, ded waived	50%, after ded	$20 copay, ded waived	50%, after ded
Inpatient Hospital	100%; after ded	50%; after ded	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Surgery	100%; after ded	50%; after ded	100% after ded	50%; after ded	100%; after ded	50%; after ded
Emergency Room (Copay waived if admitted)	100% after ded		100% after ded		100% after ded	
Urgent Care	100% after ded		100% after ded		100% after ded	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$20/$40/$70 after integrated medical/ rx deductible	Not covered	$20/$40/$70 after integrated medical/ rx deductible	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250 after integrated medical/ rx deductible	Not covered	30% copay, max copay $250 after integrated medical/ rx deductible	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included		Included	
Medicare Creditable	Yes		Yes, except carve out		Yes	

*Payment for out-of-network care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply as such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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

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

Standard and Basic plans are available upon request.

All services subject to deductible, unless noted otherwise.

Notes: The dollar amount copayments indicate what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visits maximums. Members or providers may be required to precertify or obtain approval for certain services such as outpatient complex imaging and non-emergency hospital care.

For a list of Limitations and Exclusions, refer to page 36.

CONSUMER DIRECTED HEALTH PLANS

Aetna Managed Choice Open Access Plan Options	MC HDHP $2,500 100/50 HRA-Compatible*		MC HDHP $5,000 100/50 HRA-Compatible*	
PCP Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	100%	50%	100%	50%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$2,500 per member (two-member maximum)	$7,500 per member (two-member maximum)	$5,000 per member (two-member maximum)	$7,500 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$2,500 per member (two-member maximum)	$10,000 per member (two-member maximum)	$5,000 per member (two-member maximum)	$10,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000	
Primary Physician Office Visit	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Specialist Office Visit	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Lab	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient X-ray	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Well-Child Exams (Age and frequency schedules apply)	$20 copay, ded waived	50%, ded waived	$20 copay, ded waived	50%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	$20 copay, ded waived	50%; after ded	$20 copay, ded waived	50%, after ded
Inpatient Hospital	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Outpatient Surgery	100%; after ded	50%; after ded	100%; after ded	50%; after ded
Emergency Room (Copay waived if admitted)	100% after ded		100% after ded	
Urgent Care	100% after ded		100% after ded	
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$20/$40/$70	Not covered	$20/$40/$70	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	30% copay, max copay $250/30 days; ded waived	Not covered	30% copay, max copay $250/30 days; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included	
Medicare Creditable	Yes		Yes	

*Payment for out-of-network care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply as such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

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

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

Standard and Basic plans are available upon request.

All services subject to deductible, unless noted otherwise.

Notes: The dollar amount copayments indicate what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visits maximums. Members or providers may be required to precertify or obtain approval for certain services such as outpatient complex imaging and non-emergency hospital care.

For a list of Limitations and Exclusions, refer to page 36.

VALUE PLANS

Aetna Managed Choice Open Access Plan Options	MC Value Plus $750 50/50 $25/$50*		MC Value $1,500 70/50 $25 (3-visit limit)*		MC Value Limited $1,000 50/50 $35*	
PCP Referrals Required	No	N/A	No	N/A	No	N/A
Member Benefits	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Plan Coinsurance (applies to most services)	50%	50%	70%	50%	50%	50%
Calendar Year Deductible (Accumulates Separately In/Out of Network)	$750 per member (two-member maximum)	$2,250 per member (two-member maximum)	$1,500 per member (two-member maximum)	$4,500 per member (two-member maximum)	$1,000 per member (two-member maximum)	$3,000 per member (two-member maximum)
Calendar Year Out-of-Pocket Maximum (Includes deductible; Copayments and certain payments do not apply; Accumulates Separately In/Out of Network)	$4,750 per member (two-member maximum)	$12,250 per member (two-member maximum)	$5,500 per member (two-member maximum)	$12,500 per member (two-member maximum)	$4,000 per member (two-member maximum)	$12,000 per member (two-member maximum)
Lifetime Maximum Benefit (Combined In/Out of Network)	$5,000,000		$5,000,000		$50,000 Annual Max	
Primary Physician Office Visit	$25 copay, ded waived	50%; after ded	$25 copay, ded waived (limited to 3 visit per mem per cal year)	50%; after ded (limited to 3 visit per mem per cal year)	50%; after ded	50%; after ded
Specialist Office Visit	$50 copay, ded waived	50%; after ded	$25 copay, ded waived (limited to 3 visit per mem per cal year)	50%; after ded (limited to 3 visit per mem per cal year)	50%; after ded	50%; after ded
Outpatient Lab	$25 copay, ded waived	50%; after ded	$25 copay, ded waived (limited to $300 per mem per cal year; combined with X-ray and complex imaging)	Not covered	50%; after ded	50%; after ded
Outpatient X-ray	$50 copay, ded waived	50%; after ded	$25 copay, ded waived (limited to $300 per mem per cal year; combined with lab and complex imaging)	Not covered	50%; after ded	50%; after ded
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	50%; after ded	50%; after ded	70%; after ded (limited to $300 per mem per cal year; combined with lab and X-ray)	Not covered	50%; after ded	50%; after ded
Well-Child Exams (Age and frequency schedules apply)	$25 copay, ded waived	50%, ded waived	70%; ded waived if not one of 3 office visits	50%; ded waived if not one of 3 office visits	$35 copay, ded waived	50%, ded waived
Physical Exams — Adults (Limited to one exam every 12 months)	$25 copay, ded waived	50%; after ded	70%; ded waived if not one of 3 office visits	50%; after ded if not one of 3 office visits	$35 copay, ded waived	50%; after ded
Inpatient Hospital	50%; after ded	50%; after ded	70%; after ded	50%; after ded	50%; after ded	50%; after ded
Outpatient Surgery	50%; after ded	50%; after ded	70%; after ded	50%; after ded	50%; after ded	50%; after ded
Emergency Room (Copay waived if admitted)	50%; after ded		70%; after ded		50%; after ded	
Urgent Care	$50 copay, deductible waived		Not covered		50%; after ded	50%; after ded
Prescription Drugs** (Retail: per 30-day supply Mail Order: two times retail copay, 31- to 90-day supply, includes insulin)	$15 Generic Only	Not covered	$15 Generic Only	Not covered	$15 Generic Only	Not covered
Self-Injectables (Retail and mail order; does not include insulin)	50%; ded waived	Not covered	50%; ded waived	Not covered	50%; ded waived	Not covered
90-Day Rx Transition of Coverage (TOC) for Prior Certification***	Included		Included		Included	
Medicare Creditable	No		No		No	

Aetna Avenue

DENTAL OVERVIEW

AETNA DENTAL® PLANS

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

The Mouth Matters℠

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

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

The Dental Maintenance Organization (DMO®)

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

Preferred Provider Organization (PPO) plan

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

PPO Max plan

While the PPO Max 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

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

Dual Option plan*

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

Voluntary Dental option

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

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

DMI may not be available in all states.

*Dual Option does not apply to Voluntary Dental plans.

SMALL GROUP PPO

08/01/2008

	Option 1 DMO Access	Option 2 Freedom of Choice Monthly selection between the DMO and PPO		Option 3 PPO Max 1000	Option 4 Active PPO	
	DMO Access	DMO Plan 100/90/60	PPO Plan 100/70/40	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40
Office Visit Copay	$10	$10	N/A	N/A	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	$1,000	$1,500	$1,000
DIAGNOSTIC SERVICES						
Oral Exams						
Periodic oral exam	No Charge	100%	100%	100%	100%	80%
Comprehensive oral exam	No Charge	100%	100%	100%	100%	80%
Problem-focused oral exam	No Charge	100%	100%	100%	100%	80%
X-rays						
Bitewing - single film	No Charge	100%	100%	100%	100%	80%
Complete series	No Charge	100%	100%	100%	100%	80%
PREVENTIVE SERVICES						
Adult Cleaning	No Charge	100%	100%	100%	100%	80%
Child Cleaning	No Charge	100%	100%	100%	100%	80%
Sealants - per tooth	$10	100%	100%	100%	100%	80%
Fluoride application - with cleaning	No Charge	100%	100%	100%	100%	80%
Space maintainers	$100	100%	100%	100%	100%	80%
BASIC SERVICES						
Amalgam filling - 2 surfaces	$32	90%	70%	80%	80%	60%
Resin filling - 2 surfaces, anterior	$55	90%	70%	80%	80%	60%
Oral Surgery						
Extraction - exposed root or erupted tooth	$30	90%	70%	80%	80%	60%
Extraction of impacted tooth - soft tissue	$80	90%	70%	80%	80%	60%
***MAJOR SERVICES**						
Complete upper denture	$500	60%	40%	50%	50%	40%
Partial upper denture (resin base)	$513	60%	40%	50%	50%	40%
Crown - Porcelain with noble metal**	$488	60%	40%	50%	50%	40%
Pontic - Porcelain with noble metal**	$488	60%	40%	50%	50%	40%
Inlay - Metallic (3 or more surfaces)	$463	60%	40%	50%	50%	40%
Oral Surgery						
Removal of impacted tooth - partially bony	$175***	60%	40%	50%	50%	40%
Endodontic Services						
Bicuspid root canal therapy	$195	90%	40%	50%	50%	40%
Molar root canal therapy	$435***	60%	40%	50%	50%	40%
Periodontic Services						
Scaling & root planing - per quadrant	$65	90%	40%	50%	50%	40%
Osseous surgery - per quadrant	$445***	60%	40%	50%	50%	40%
***ORTHODONTIC SERVICES**	$2300 copay	$2300 copay	Not covered	Not covered	50%	40%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	$1,000	$1,000

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

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

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

Copayments shown on the DMO in DMO Plan Options 1 & 2 are member responsibility.

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

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1 & 2 and on the PPO Plan in Option 6. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Option 7.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 2, 4, 5, 6 & 8 to the prevailing fees at the 80th percentile and the 90th percentile in Plan Option 7.

Plan Option 3: PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO Plan Option 1 can be offered with any one of the PPO plans in Plan Options 3 – 7 in a Dual Option package.

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 36.

SMALL GROUP PPO

08/01/2008

	Option 5 PPO 1500	Option 6 PPO 2000	Option 7 PPO 2000 High	Option 8 Aetna Dental Preventive Care℠ Indemnity
	PPO Plan 100/80/50	PPO Plan 100/80/50	PPO Plan 100/80/50	Indemnity Plan 100/0/0
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	None
Annual Maximum Benefit	$1,500	$2,000	$2,000	Unlimited
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing - single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%
Fluoride application - with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
BASIC SERVICES				
Amalgam filling - 2 surfaces	80%	80%	80%	0%
Resin filling - 2 surfaces, anterior	80%	80%	80%	0%
Oral Surgery				
Extraction - exposed root or erupted tooth	80%	80%	80%	0%
Extraction of impacted tooth - soft tissue	80%	80%	80%	0%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	50%	0%
Partial upper denture (resin base)	50%	50%	50%	0%
Crown - Porcelain with noble metal**	50%	50%	50%	0%
Pontic - Porcelain with noble metal**	50%	50%	50%	0%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	0%
Oral Surgery				
Removal of impacted tooth - partially bony	50%	50%	80%	0%
Endodontic Services				
Bicuspid root canal therapy	50%	80%	80%	0%
Molar root canal therapy	50%	50%	80%	0%
Periodontic Services				
Scaling & root planing - per quadrant	50%	80%	80%	0%
Osseous surgery - per quadrant	50%	50%	80%	0%
***ORTHODONTIC SERVICES**	50%	50%	50%	0%
Orthodontic Lifetime Maximum	$1,000	$1,500	$1,500	Does not apply

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

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

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

Copayments shown on the DMO in DMO Plan Options 1 & 2 are member responsibility.

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

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1 & 2 and on the PPO Plan in Option 6. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Plan Option 7.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Options 2, 4, 5, 6 & 8 to the prevailing fees at the 80th percentile and the 90th percentile in Plan Option 7.

Plan Option 3: PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO Plan Option 1 can be offered with any one of the PPO plans in Plan Options 3 – 7 in a Dual Option package.

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 36.

VOLUNTARY PLANS

08/01/2008

	Voluntary Option 1 DMO Access	Voluntary Option 2 Freedom of Choice Monthly selection between the DMO and PPO		Voluntary Option 3 PPO Max	Voluntary Option 4 Aetna Dental Preventive Care Indemnity
	DMO Access	DMO Plan 100/90/60	PPO Plan 100/70/40	PPO Max Plan 100/80/50	Indemnity Plan 100/0/0
Office Visit Copay	$15	$15	N/A	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$75; 3X Family Maximum	$75; 3X Family Maximum	None
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	$1,000	Unlimited
DIAGNOSTIC SERVICES					
Oral Exams					
Periodic oral exam	No Charge	100%	100%	100%	100%
Comprehensive oral exam	No Charge	100%	100%	100%	100%
Problem-focused oral exam	No Charge	100%	100%	100%	100%
X-rays					
Bitewing - single film	No Charge	100%	100%	100%	100%
Complete series	No Charge	100%	100%	100%	100%
PREVENTIVE SERVICES					
Adult Cleaning	No Charge	100%	100%	100%	100%
Child Cleaning	No Charge	100%	100%	100%	100%
Sealants - per tooth	$10	100%	100%	100%	100%
Fluoride application - with cleaning	No Charge	100%	100%	100%	100%
Space maintainers	$100	100%	100%	100%	100%
BASIC SERVICES					
Amalgam filling - 2 surfaces	$32	90%	70%	80%	0%
Resin filling - 2 surfaces, anterior	$55	90%	70%	80%	0%
Oral Surgery					
Extraction - exposed root or erupted tooth	$30	90%	70%	80%	0%
Extraction of impacted tooth - soft tissue	$80	90%	70%	80%	0%
***MAJOR SERVICES**					
Complete upper denture	$500	60%	40%	50%	0%
Partial upper denture (resin base)	$513	60%	40%	50%	0%
Crown - Porcelain with noble metal**	$488	60%	40%	50%	0%
Pontic - Porcelain with noble metal**	$488	60%	40%	50%	0%
Inlay - Metallic (3 or more surfaces)	$463	60%	40%	50%	0%
Oral Surgery					
Removal of impacted tooth - partially bony	$175***	60%	40%	50%	0%
Endodontic Services					
Bicuspid root canal therapy	$195	90%	40%	50%	0%
Molar root canal therapy	$435***	60%	40%	50%	0%
Periodontic Services					
Scaling & root planing - per quadrant	$65	90%	40%	50%	0%
Osseous surgery - per quadrant	$445***	60%	40%	50%	0%
***ORTHODONTIC SERVICES**	$2,400 copay	$2,400 copay	Not covered	Not covered	0%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

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

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

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

Copayments shown on the DMO in DMO Voluntary Plan Options 1 & 2 are member responsibility.

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

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.

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

Voluntary Plan Option 3: PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 36.

OUT-OF-STATE PPO

	Low Option No Ortho	Low Option Ortho	Medium Option No Ortho	Medium Option Ortho	High Option No Ortho	High Option Ortho
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	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	$50; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000	$1,500	$1,500	$2,000	$2,000
DIAGNOSTIC SERVICES						
Oral Exams						
Periodic oral exam	100%	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%	100%
X-rays						
Bitewing - single film	100%	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%	100%
PREVENTIVE SERVICES						
Adult Cleaning	100%	100%	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%	100%	100%
Fluoride application - with cleaning	100%	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%	100%
BASIC SERVICES						
Amalgam filling - 2 surfaces	80%	80%	80%	80%	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%	80%	80%	80%	80%
Oral Surgery						
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	80%	80%
***MAJOR SERVICES**						
Complete upper denture	50%	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	50%	50%	50%
Oral Surgery						
Removal of impacted tooth - partially bony	50%	50%	50%	50%	50%	50%
Endodontic Services						
Bicuspid root canal therapy	50%	50%	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%	50%	50%
Periodontic Services						
Scaling & root planing - per quadrant	50%	50%	50%	50%	50%	50%
Osseous surgery - per quadrant	50%	50%	50%	50%	50%	50%
***ORTHODONTIC SERVICES**	Not covered	50%	Not covered	50%	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000	Does not apply	$1,000	Does not apply	$1,000

Available with an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees
Available without an Aetna Medical Plan (Dental standalone) to Groups with 10 –50 Eligible Employees

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

Access to negotiated discounts: On all PPO Max plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 36.

For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.

OUT-OF-STATE PPO

	Voluntary Option No Ortho	Voluntary Option Ortho
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
X-rays		
Bitewing - single film	100%	100%
Complete series	100%	100%
PREVENTIVE SERVICES		
Adult Cleaning	100%	100%
Child Cleaning	100%	100%
Sealants - per tooth	100%	100%
Fluoride application - with cleaning	100%	100%
Space maintainers	100%	100%
BASIC SERVICES		
Amalgam filling - 2 surfaces	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%
Oral Surgery		
Extraction - exposed root or erupted tooth	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%
***MAJOR SERVICES**		
Complete upper denture	50%	50%
Partial upper denture (resin base)	50%	50%
Crown - Porcelain with noble metal	50%	50%
Pontic - Porcelain with noble metal	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%
Oral Surgery		
Removal of impacted tooth - partially bony	50%	50%
Endodontic Services		
Bicuspid root canal therapy	50%	50%
Molar root canal therapy	50%	50%
Periodontic Services		
Scaling & root planing - per quadrant	50%	50%
Osseous surgery - per quadrant	50%	50%
***ORTHODONTIC SERVICES**	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000

Available with an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees
Available without an Aetna Medical Plan (Dental standalone) to Groups with 10 –50 Eligible Employees

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.
Access to negotiated discounts: On all PPO Max plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.
Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.
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 36.
For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

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***℠ program. So what's the bottom line? A portfolio of value-added 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 (minimum of $5,000).

Premium waiver provision — If an employee becomes permanently or totally disabled because of an illness or injury before age 60, employee coverage may stay in effect up to age 65 without premium.

Optional dependent life — Employers with 10 or more employees can offer this feature, which allows employees to add optional supplemental coverage for eligible spouses and children. 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 important 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®

Routinely included with our small group life and disability insurance package, AD&D Ultra insurance provides employees and their families with the same coverage as a typical accidental death and dismemberment plan— and then some. It includes features such as coverage for education or dependent child-care expenses upon the death of the employee.

Benefits include:

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

DISABILITY INSURANCE

Finding disability insurance plans 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 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 when applicable with the employee to help address medical and disability issues.
- Referrals between health case managers and their disability counterparts when applicable 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 pages 36.

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

TERM LIFE PLAN OPTIONS

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

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

DISABILITY PLAN OPTIONS

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

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

PACKAGED LIFE AND DISABILITY PLAN OPTIONS

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

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

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

For groups with 1 to 50 eligible employees, Colorado

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

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

CENSUS DATA

- Census data must be provided on all eligible employees, including COBRA and state continuees. Include name, date of birth, date of hire, gender, dependent status and residence zip code (when multi-site/multi-state).
- Retirees are not eligible.
- COBRA eligibles should be included on the census and noted as COBRA.

CASE SUBMISSION

- All new business submissions must be received in our Greenwood Village office by end of business day on the requested effective date. Any cases received after the cut-off date will be considered on an exception basis only as approved by the Underwriting Unit Manager.
  For example:
  Requested effective date 11/1.
  All new business paperwork should be received in Underwriting by the end of business on 11/1.
- One-life groups must have all completed paperwork into Aetna Underwriting by the 5th of the month prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date.

DEPENDENT ELIGIBILITY

- Eligible dependents include an employee's spouse and unmarried children up to age 25. Coverage for unmarried children may be continued to age 25 who are not full-time students as long as the child has the same legal residence as the parent OR is financially dependent on the parent.
- Coverage is available to Domestic Partners (affidavits required) electing a Managed Choice® (MC) product.
- If both the husband and wife work for the same company they may enroll together or separately. Children can only be covered under one parent's plan.
- For dependent life, dependents are eligible from 14 days to age 25 as noted above.
- Dependents are not eligible for AD&D Ultra or Disability coverage.
- For Medical and Dental, dependents must enroll in the same benefits as the employee (participation not required). Employees may select coverage for eligible dependents under the Dental plan even if they selected Single coverage under the Medical Plan. See product-specific Life/ AD&D and Disability guidelines under Product Specifications.

PICK-A-PLAN 3/ VALUE PICK

- Allows employers to offer up to three medical plans to the employees.
- Employees who choose to enroll in the richer plan are responsible for the difference in premium.
- The plans are priced based on the full census of the group so actual enrollment in each plan will not cause the rates to change; however, if the sold case has a different overall census than the quote they will need to be rerated (i.e., a case quoted with 20 employees but sold with 17 employees would need to be rerated with the new census).
- The group must have 2 or more enrolled employees. All employees will be rated for each plan.

- One person must enroll in each plan.
- Groups with 1 to 9 eligibles are tabular rated; 10 to 50 eligibles has the option of tabular or composite rates.

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.
- When replacing an employer-sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period. For example, if the other plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.

EMPLOYEE ELIGIBILITY

- An employee who has a regular workweek of 24 or more hours.
- This includes a sole proprietor and a partner of a partnership if they are actively engaged on a full-time basis in the small employer's business and if included as employees under a health benefit plan of a small employer.
- Employees reported on the IRS 1099 forms who meet Aetna's standard criteria for determining 1099 status may be considered; and only if all 1099 employees are offered coverage; and as long as the 1099 employees comprise less than 25% of total eligibles in the group.
- Part-time, temporary, seasonal or substitute employees are not eligible.
- An employer may establish a maximum weekly work requirement greater than 24 hours as a requirement for an employee's participation in a health benefit plan. Also, the employer may establish different hours for different classes of employees. For example, management versus non-management.
- If the employer's Employee Eligibility Criteria definition differs from the above definition (for example more than 24 hours), the employer's actual definition must be provided on the Employer Application at the time of new business submission. Note, the normal workweek cannot be less than 24 hours.
- Employees are eligible to enroll in the Dental plan even if they do not select medical coverage and vice versa.

Retirees

- Retiree coverage is not available.

COBRA/State continuees

- COBRA/State eligible enrollees are required to be included on the census (not eligible for Life or Disability).
- COBRA/State qualifying event, length, start and end date must be provided.
- Health questions must be answered.

Note: Employees reported on the IRS 1099 forms, COBRA and State continuees are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, 1099 employees and COBRA/State continuees can be included for coverage subject to normal underwriting guidelines.

EMPLOYER ELIGIBILITY

A small employer means any person, firm, including a corporation, partnership or association actively engaged in business that on at least 50% of its working days during the preceding calendar quarter, employed at least **1** and no more than **50** eligible employees, the majority of whom were employed within the state of Colorado and that the small employer was not formed primarily for the purpose of purchasing insurance. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Groups that do not meet the above definition of a small employer are not eligible for coverage.

In order to be classified as a small employer with more than one employee when only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. The employer group shall also meet the participation requirements as noted below.

- Coverage can be offered to sole proprietorships, partnerships or corporations.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Taft Hartley groups, Professional Employer Organizations (PEO) and closed groups are not eligible. However, employers who belong to an employee leasing company who are not offered benefits by the employee leasing

company (and are being offered coverage directly through Aetna) must submit a letter stating that they were not offered coverage through the PEO.

- Dental and Disability have ineligible industries which are listed separately.

INITIAL PREMIUM CHECK

- The initial premium check should be in the amount of the first month's premium and drawn on a company check.
- The initial premium check is not a binder check.
- 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.

NEWLY FORMED BUSINESS

(in operation less than 3 months)

- One-life groups — refer to the one-life guidelines
- Newly formed businesses that do not have two or more employees working 50% of the prior quarter are not eligible for coverage as they do not meet the definition of a small employer as defined by Small Group Reform laws.
- Newly formed businesses that employed two or more employees 50% of the prior quarter may be considered subject to underwriting approval. The following documentation must be provided:
  - Business License (not a professional license). If not available, provide a copy of the Partnership Agreement or Articles of Organization; and
  - Employer Identification Number/Federal Tax ID Number; and
  - Quarterly Wage and Tax statement. If not available, when will one be filed; and
  - The most recent two consecutive weeks worth of payroll records which includes hours worked, taxes withheld, check number and wages earned; or
  - A letter from Certified Public Accountant listing the names of all employees (full- and part-time), the number of hours worked each week, dates of hire and weekly salary. Have payroll records been established? If not, when?
  - Will a quarterly wage and tax statement be filed? If so, when?

NON-PAYMENT OF PREMIUM FOR PRIOR AETNA COVERAGE

An application may be denied when Aetna has terminated coverage due to non-payment of premium.

- For groups of 2 to 50 eligibles, the application may be denied for six months after termination for non-payment or at the end of the original policy period, whichever is greater; AND the group must pay all prior-owed Aetna premiums before the new business case will be considered.
- For a business group of one, the application may be denied for six months after termination or until the next open enrollment period, whichever is greater.

PLAN CHANGE ANCILLARY ADDITIONS

- Packaged Life/Disability must be requested 30 days prior to the desired effective date.
- Dental plans must be requested 30 days prior to the desired effective date.
- The future renewal date of the ancillary products will be the same as the medical plan renewal date.
- Non-packaged plan changes are available upon renewal.

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.

TAX DOCUMENTATION

- As part of the application process, the employer must provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list. Supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, must also be provided.
- In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, a copy of the payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof.
- When a UITR or payroll records are submitted:
  - Employees who have terminated, work part-time or are newly hired should be noted accordingly on the document.
  - Any handwritten comments added to the UITR or payroll must be signed and dated by the employer. This may be requested at the discretion of the underwriter.
  - Newly hired employees not listed on the document must provide a copy of the first and last payroll stub for each employee and letter from employer verifying the number of hours worked.
- Churches must provide Form 941 including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.
- When there is more than one employee and only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees.
- Proprietors, Partners or Officers of the business who do not appear on the UITR or payroll must submit one of the following identified documents:

Proprietors, Partners or Officers of:	Documents
C-Corporation	W2
S-Corporation	IRS Form 1120 S Schedule K-1 along with Schedule E (Form1040)
Partnership	IRS Form 1065 schedule K-1; or IRS Form 1120S Schedule K1 along with Schedule E (Form1040)
Limited Liability Company (LLC)	May file as either C Corporation or Partnership
Sole Proprietor	IRS Schedule SE and Schedule C filed with Form 1040; or IRS Form 1040 Schedule F or K1

TWO OR MORE COMPANIES

Single employer groups with multiple Employer Tax ID Numbers may be considered together as long as:

- There are 50 or fewer employees in the combined employer groups.
- One owner controls the majority of each separate business. For example:
  - Business 1 – John owns 75% and Mike owns 25%.
  - Business 2 – John owns 55% and Mike owns 45%.
  - Both businesses can be written as one group since John has controlling interest in both companies.

- Businesses with equal controlling interest may be considered if the owners of the company designate one individual to act on behalf of all the groups.
- A copy of current 1120 S (Schedule K-1 Form) must be provided for each company to be included; and
- A copy of most recent Quarterly Wage and Tax Statement or payroll records must be provided for all groups requesting coverage.
- The two or more groups may have different Standard Industrial Classification Codes (SIC), however, rates will be based on the SIC code for the group with the majority of employees.

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.
- Only one benefit waiting period is allowed.
- The waiting period for future employees may be 0, 30, 60, 90, 120 or 180 days.
- A change to the waiting period can only be made on the anniversary date.
- No retroactive changes will be allowed.
- For new hires, the eligibility date will be the first day of the policy month following the waiting period.

ONE-LIFE GROUPS

- A business group of one means for purposes of qualification, an individual, a sole proprietor or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company or partnership who:
  - works 24 hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage;
  - has gross income as indicated on federal internal revenue service forms 1040, schedule C, F or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes which generated gross income from which that individual, sole proprietor or single full-time employee has derived at least a substantial part of such individual's income for one year out of the most recent consecutive 3-year period.
  - A substantial part of such individual's income means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.
- A business group of one may be rejected for group coverage if they had in place, within 30 days prior to the application for group coverage, an individual health policy. An individual health benefit policy shall not include one or more short-term limited duration health insurance policies issued within 6 months before the date of application for the group coverage. If the individual plan has been in force for 3 years or more this section would not apply and they may be considered for the one-life plan.

- A business group of one includes a full-time household employee who works 24 hours or more a week on a permanent basis as a household employee, if that employee:
  - has derived at least a substantial part of such employee's earned income for one year out of the preceding 3-year period from household employment, and
  - if the employee's employer, on at least 50% of the days in a normal workweek during the preceding calendar quarter, employed at least one household employee.
- For purposes of determining whether an applicant meets the requirements of the definition, the following forms of documentation must be provided:
  1. Documentation of significant business activity and gross income sufficient to pay for annual health insurance premium;
  2. Tax documentation of gross income;
  3. Information showing the individual works full-time (24 hours or more per week on a permanent basis), including:
     a. Invoices, billing records, general ledgers or similar information;
     b. Additional tax documentation indicating business activities are not passive activities;
     c. Organizational documents including business license, articles of incorporation and by-laws; and
     d. In the absence of above, business collateral materials including marketing materials, business forms or website addresses.
- If only gross income is insufficient for the specific plan requested, the carrier must determine if income is sufficient for another small group plan and provide an opportunity to enroll in another plan for the same effective date.
- Medical evidence is required on groups of one that are true sole proprietors. A corporation with two or more employees with an excluded class resulting in only one person enrolling for coverage will not require medical evidence for that one employee.
- If the group of one is medically unacceptable, the standard and basic plans must be offered during their applicable open enrollment period (31 days following their birth date), or a qualifying event (such as end of COBRA period.)
- Any group of one that is medically acceptable and meets both medical and contractual business requirements can apply for any Colorado Health Plan at any time. If the group of one individual does not medically qualify for a "regular" plan, outside of their birth date, they are eligible to reapply for a standard or basic plan during their applicable open enrollment period which is 31 days following their birthday. A copy of their driver's license or birth certificate must be sent with the enrollment application. The effective date will be the 1st of the month after the enrollment application is signed as long as all requirements are received through the 31st day following the birth date. If all requirements are not received within 31 days after the birth date coverage cannot be considered again until the next birthday.
- Carriers who use open enrollment periods shall also accept applications from a business group of one and issue the basic or standard plans as provided by law, if such applications are submitted within 31 days of any one of the following qualifying events:
  - A person qualifying as a business group of one exhausts state or federal continuation coverage; or
  - A person qualifying as a business group of one involuntarily loses other creditable coverage. (This provision does not apply in cases of failure to pay premium, fraud or a voluntary decision on the part of such person to terminate the other creditable coverage.), or
  - The date the person initially meets the definition of a business group of one (works 24 hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year) prior to application for coverage; and whose birth date is more than 31 days of so doing.
- Group Life, Disability and Dental not available for one-life groups

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/AD&D and Packaged Life & Disability	Disability
Product Availability	▪ 1 to 50 eligibles ▪ May be written standalone or with ancillary coverages as noted in the following columns.	▪ 1 Life groups Dental not available ▪ 2 eligible employees – Standard – all plans if packaged with Medical – Voluntary – not available ▪ 3 to 50 eligible employees – All plans available – Standalone available – Voluntary Dual Option plans are not permitted. Orthodontic coverage available for dependent children only to groups with 10 to 50 eligible employees with a minimum of 5 enrolled employees for both standard and voluntary plans.	▪ 1 Life groups Life not available ▪ 2 to 9 eligible employees if packaged with Medical ▪ 10 to 50 eligible employees if packaged with Medical, Dental or standalone Packaged Life and Disability: ▪ 2 to 50 eligibles if packaged with medical ▪ 10 to 50 eligibles on a standalone basis Life and Packaged Life: ▪ A plan sponsor cannot purchase both the Life and Packaged Life and Disability plan. ▪ Employees may elect Life coverage even if they do not elect Medical coverage.	▪ 1 Life groups Disability not available ▪ 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. ▪ 2 to 9 eligible employees if packaged with Medical. ▪ 10 to 25 eligible employees if packaged with Medical or Dental. ▪ 26 to 50 eligible employees on a standalone basis. ▪ Available to employees only. ▪ A plan sponsor cannot purchase both the Disability and Packaged Life and Disability plan. ▪ Employees may elect Disability coverage even if they do not elect Medical coverage. ▪ Available to employees only.
Employer Contribution	Groups with 1 to 50 eligible employees ▪ The employer must contribute at least 50% of the employee only premium or flat $120 per employee. ▪ For Pick-A-Plan 3 the employer must contribute 50% employee-only premium or flat $120 per employee. ▪ For ValuePick the employer must contribute 25% employee-only premium or a flat $50 per employee. ▪ Coverage can be denied based on inadequate contributions.	▪ Standard – Employer must contribute at least 25% of the total cost of the plan or 50% of the cost of employee-only coverage. ▪ Voluntary – Employer contribution of less than 50% of employee only premium. – Employee pay all plans are permitted. ▪ Coverage can be denied based on inadequate contributions.	▪ 2 to 9 eligible employees 100% of the total cost. ▪ 10 to 50 eligible employees At least 50% of the total cost (excluding Optional Dependent Term Life). ▪ Coverage can be denied based on inadequate contributions.	▪ 2 to 9 eligible employees 100% of the total cost. ▪ 10 to 50 eligible employees At least 50% of total cost of the plan. ▪ Coverage can be denied based on inadequate contributions.
Participation	▪ For non-contributory plans, 100% participation is required, excluding spousal waivers or those with other group creditable coverage (except for those in another plan sponsored by the employer), or individual coverage that has been consistently maintained and that was in force prior to the individual's eligibility for group coverage, must participate in Aetna's plan. ▪ For contributory plans groups with 1 to 50 eligibles 70% of eligibles, rounding up, excluding spousal waivers, or those with other group creditable coverage (except for those in another plan sponsored by the employer), or individual coverage that has been consistently maintained and that was in force prior to the individual's eligibility for group coverage, must participate in Aetna's plan. Example: 12 employees; 3 covered under spouse 3 covered under ind plan = 6 12 minus 6 = 6 6 x 70% = 4.2 = 5 must enroll ▪ Pick-A-Plan 3 – 70% participation with a minimum of 2 enrolled. ▪ ValuePick – 60% participation with a minimum of 2 enrolled. ▪ Dependent participation is not required. ▪ Coverage can be denied based on inadequate participation.	▪ Non-contributory plans - 100% participation is required. ▪ Employees may select coverage for eligible dependents under the Dental plan even if they selected single coverage on the Medical plan or vice versa. ▪ Standard – 2 to 3 eligible employees 100% participation is required, excluding those with other qualifying existing dental coverage. Example: 3 eligibles; 1 covered under spouse Dental plan 3 minus 1 = 2 X 100% = 2 must enroll in Aetna Dental plan – 4 to 50 eligible employees 70% participation is required, excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan. Example 1: 6 eligibles; 2 covered under spouse Dental plan 6 minus 2 = 4 x 70% = 2.8 = 3 must enroll in Aetna Dental plan Example 2: 5 eligibles; 2 covered under spouse Dental plan 5 minus 2 = 3 x 70% = 2.10 = 3 3 must enroll in Aetna Dental plan because 2 would not meet the 70% test or the 50% minimum test)	▪ For non-contributory plans, 100% participation is required. ▪ 2 to 9 eligible employees 100% participation is required. ▪ 10 to 50 eligible employees 70% must participate when the plan is Contributory. ▪ Standalone Life: 75% participation is required. ▪ COBRA continuees are not eligible for Life. ▪ Employees may elect Life or Packaged Life and Disability 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 1: 9 employees 3 waiving Medical 9 must enroll for Life Example 2: 15 employees 5 waiving Medical 10 enrolling for Medical 11 must enroll for Life (15 x 75% = 11.2) ▪ Coverage can be denied based on inadequate participation.	▪ For non-contributory plans, 100% participation is required. ▪ 2 to 9 employees 100% of eligibles must enroll. ▪ 10 to 50 employees 70% of eligibles must enroll. ▪ Standalone Disability: 75% participation is required. ▪ COBRA continuees are not eligible for Disability. ▪ Employees may elect Disability or Packaged Life and Disability coverage even if they do not elect medical coverage. ▪ The group must meet the required participation percentage. If not, then Disability will be declined for the group. Example: 9 employees 3 waiving Medical 9 must enroll for Disability ▪ Coverage can be denied based on inadequate participation.

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/AD&D and Packaged Life & Disability	Disability
Participation (continued)	▪ All employees waiving coverage must complete the waiver section and provide the name and group number of the carrier. ▪ Proof of other coverage is needed for the percentage to meet participation.	▪ Standalone Dental: 75% participation is required excluding those with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan. ▪ Voluntary 3 to 50 eligible employees 25% 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. Example 1: 6 eligibles; 2 covered under spouse Dental plan 6 minus 2 = 4 x 25% = 1 1 is below the 3 enrollee minimum so 3 must enroll in the Dental plan to meet minimum enrollment. Example 2: 20 eligibles; 2 covered under spouse Dental plan 20 minus 2 = 18 x 25% = 4.5 5 must enroll in the Dental plan ▪ All plans – coverage can be denied based on inadequate participation.		
Excluded Class/Carve Outs	Carve-outs/excluded classes are allowed when sold with Medical plans or Medical with ancillary products. The employer must provide: ▪ A copy of the UITR with the job titles next to each employee, signed and dated by the employer; or ▪ A letter from their attorney with the job titles and number of hours worked; or ▪ List the employees and their titles on the employer application or on a separate piece of paper signed and dated by the employer.	▪ Allowed only if packaged with Medical.	▪ Allowed only if packaged with Medical.	▪ Allowed only if packaged with Medical.
Medical Underwriting	▪ Groups with 1 to 50 eligibles, including COBRA eligibles and continuees, may be considered for a discount depending on the medical conditions of the overall group.	Not applicable	▪ All timely entrants will be issued the Guaranteed Issue amount. ▪ Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit Evidence of Insurability (EOI) which means they must complete an individual health statement and medically qualify for coverage.	All timely entrants will be issued the Guaranteed Issue amount unless: ▪ Reinstatement or restoration of coverage is requested, and/or ▪ they are a late entrant.
Out-of-State Employees (residing outside of Colorado)	▪ All out-of-state employees that live/work in an out-of-state network will receive in-state rates and products (inclusive of any required Extraterritorial Benefits). ▪ All out-of-state employees that do not live/work in an out-of-state network area will receive the in-state Standard Indemnity product (inclusive of any required Extraterritorial Benefits). ▪ Indemnity is not available in HI or VT. ▪ MC is not available in AK, HI, ME, MT, NE, PR, RI, SD, WY.	▪ Out-of-State employees can only be offered one of the specific out-of-state Dental plans. One out-of-state PPO plan is selected for the group. Employees who fall outside a PPO network area will default to a comparable indemnity plan. Maximum out-of-state employee percentage (and/or number of employees) will agree with the medical guideline. ▪ Plans with out-of-state employees must be submitted to Regional Underwriting for quotation. ▪ Out-of-state PPO Dental is not available in AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, WY, VT.	Not applicable	Not applicable

PRODUCT SPECIFICATIONS

<table>
<tr><th></th><th>Medical</th><th>Dental</th><th>Life/AD&D and Packaged Life & Disability</th><th>Disability</th></tr>
<tr><td>Late Applicants</td><td colspan="4">▪ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee. Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below.
▪ Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to enroll.
▪ Life late enrollee example: Group has $50,000 life with $20,000 guarantee issue limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late they must medically qualify for the entire $50,000.</td></tr>
<tr><td></td><td>▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.</td><td>▪ An employee or dependent may enroll at any time, however, coverage is limited to Preventive & Diagnostic Services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).
▪ Late Entrant provision does not apply to enrollees less than age 5.</td><td>▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.
▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).</td><td>▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.
▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).</td></tr>
<tr><td>Standard Industrial Classification Code (SIC)</td><td>▪ All industries are eligible.
▪ The employer must provide the SIC code (four-digit number) or NAIC state code (6-digit code) filed with the state on the business tax return and/or the workers' compensation form.</td><td>▪ Ineligible industry list applies only when Dental is sold standalone or packaged only with Group Insurance.
▪ This list does not apply when Dental is sold in combination with Medical.
<table><tr><th>SIC Range</th><th>SIC Description</th></tr><tr><td>0761-0783</td><td>Seasonal Employees</td></tr><tr><td>4111-4121</td><td>Passenger Transportation</td></tr><tr><td>5271</td><td>Mobile Home Dealers</td></tr><tr><td>5800-5899</td><td>Restaurants</td></tr><tr><td>6500-6799</td><td>Real Estate</td></tr><tr><td>7000-7099</td><td>Hotels</td></tr><tr><td>7221</td><td>Photo Studios</td></tr><tr><td>7231-7241</td><td>Beauty & Barber Shops</td></tr><tr><td>7251-7299</td><td>Repairs, Cleaning, Pers Svc</td></tr><tr><td>7319</td><td>Advertising, Misc</td></tr><tr><td>7331-7338</td><td>Direct Mailing, Secretarial</td></tr><tr><td>7361-7363</td><td>Employment Agencies</td></tr><tr><td>7379</td><td>Misc Computer Services</td></tr><tr><td>7389</td><td>Misc Business Services</td></tr><tr><td>7381-7382</td><td>Security Sys, Armored Cars</td></tr><tr><td>7384</td><td>Photofinishing Labs</td></tr><tr><td>7631</td><td>Watch, Clock & Jewelry Rpr</td></tr><tr><td>7692-7699</td><td>Misc Repair</td></tr><tr><td>7800-7999</td><td>Amusement, Recreation & Entertainment</td></tr><tr><td>8000-8059</td><td>Medical Groups</td></tr><tr><td>8071-8099</td><td>Medical Groups</td></tr><tr><td>8100-8199</td><td>Legal</td></tr><tr><td>8211-8299</td><td>Schools, Libraries, Education</td></tr><tr><td>8300-8499</td><td>Social Services – Museums, Art Galleries, Botanical Gardens</td></tr><tr><td>8400-8499</td><td>Museum/Art Galleries, Botanical Gardens</td></tr><tr><td>8600-8699</td><td>Associations & Trusts</td></tr><tr><td>8700-8799</td><td>Engineering & Mgmt Svcs</td></tr><tr><td>8800-8899</td><td>Service – Private Households</td></tr><tr><td>8999</td><td>Misc Services</td></tr><tr><td>9721</td><td>International Affairs</td></tr></table></td><td>▪ Basic Term Life – All industries are eligible.
▪ Packaged Life/Disability – See Disability column for list of ineligible industries.</td><td>▪ The following industries are not eligible:
<table><tr><th>SIC Range</th><th>SIC Description</th></tr><tr><td>1000-1499</td><td>Mining</td></tr><tr><td>2892-2899</td><td>Explosives, Bombs & Pyrotechnics</td></tr><tr><td>3291-3292</td><td>Asbestos Products</td></tr><tr><td>3310-3329</td><td>Primary Metal Ind</td></tr><tr><td>3480-3489</td><td>Fire Arms/Ammunition</td></tr><tr><td>5921</td><td>Liquor Stores</td></tr><tr><td>6211</td><td>Security Brokers</td></tr><tr><td>6531</td><td>Real Estate – Agents</td></tr><tr><td>7381</td><td>Service – Detective</td></tr><tr><td>7500-7599</td><td>Auto Repair & Service</td></tr><tr><td>7800-7999</td><td>Motion Picture Amusement/Recreation</td></tr><tr><td>8010-8043</td><td>Medical Doctors/Clinics</td></tr><tr><td>8600-8699</td><td>Membership Assoc</td></tr><tr><td>8800-8899</td><td>Ser-Private Household</td></tr><tr><td>9999</td><td>Nonclassified Estab</td></tr></table></td></tr>
</table>

DENTAL ONLY

PRODUCT PACKAGING

- Voluntary
  - Dental Dual Option sales are not permitted. All voluntary plans must be a single plan sold.
  - All Voluntary plans require a minimum of 3 to enroll.
  - Orthodontic coverage is available on the DMO in Plan Options 1 & 2 to groups with 10 or more eligibles and for dependent children only. A minimum of 5 employees must enroll.
- Standard
  - DMO can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled.
  - PPO can be sold standalone or packaged with the DMO as a Dual Option with a minimum of 2 enrolled.
  - Freedom-of-Choice can not be packaged with any other option. It must be the only plan sold.

COVERAGE WAITING PERIOD

- On PPO and Indemnity plans, for Major and Orthodontic Services must be an enrolled member of plan for 1 year before eligible.
- There is no Coverage Waiting Period on the DMO.
- Waiting Period is waived separately for Major or Ortho for employees who were covered by the group's immediately preceding Dental plan.
- To waive Waiting Period for Ortho, the group's immediately preceding plan must have included Ortho coverage.
- To waive the waiting period for Major Services, the group's immediately preceding plan must have included Major Services. Example: Prior Major coverage but no Ortho coverage. New plan has both Major and Ortho coverage. The waiting period is waived for Major Services but not for Ortho Services.
- 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) – 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.

OPEN ENROLLMENT

- Open enrollments are prohibited.
- An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible unless a qualifying life event has occurred or the enrollee is less than age 5.

OPTION SALES

- Option sales alongside another Dental carrier are not allowed.
- All Dental plans must be sold on a full-replacement basis.

REINSTATEMENT

(applies to Voluntary plans only)

- Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.

LIFE AND DISABILITY ONLY

JOB CLASSIFICATION (POSITION) SCHEDULES

- Varying levels of coverage based on job classifications are available for groups with 10 or more lives.
- Up to 3 separate classes are allowed with a minimum requirement of three 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 two 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
Managers, Supervisors	$20,000	Flat $300	Medium
All other employees	$10,000	Flat $200	Low

ACTIVELY-AT-WORK (NON-REPLACEMENT)

- 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 (REPLACEMENT – 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.

GUARANTEE ISSUE AMOUNTS

- Aetna provides certain amounts of Life insurance 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 submit to a medical exam.
- 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.

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.

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

Services and supplies that are generally not covered include, but are not limited to:

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- Infertility services including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Medical expenses for a pre-existing condition have a maximum of 6 month limitation period, except for a business group of 1, which has a 12 month limitation period, after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 6 months prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special duty nursing
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

DENTAL

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

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

Specific service limitations

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

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 you committing, or attempting to commit a criminal act
- Is due to war or any act of war (declared or not declared)
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Is not a non-occupational disease (STD only)
- Is not a non-occupational 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 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three (3) months prior to coverage effective date.

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

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