AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions℠

TEXAS PLAN GUIDE

For businesses with 2 – 50 eligible employees

Plans effective November 1, 2009

14.02.970.1-TX (4/09)

Aetna®

Health care is a journey …

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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

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

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

CHOICE

For business owners and employees

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

Medical plans — supporting members on their health care journey

- Consumer-directed health plans (CDHP)
- Traditional plans
- Value plans
- HSA-Compatible plans

Dental, life and disability plans — providing valuable protection

- DMO®
- Participating Dental Network (PDN)
- PDN Max
- Freedom-of-Choice plan design
- Dual Option
- Voluntary
- Term Life Insurance
- Packaged Life and Disability
- Packaged Dental, Life and Disability

EASE

Allowing you to focus on your business

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

Administration — making it work for your business

Aetna's plan designs automatically process health claim reimbursements, provide a password-protected website to keep track of accounts and are supported by knowledgeable service representatives. Secure and online, Aetna Enroll℠ makes managing health benefits easy and eliminates time-consuming, expensive paper-based processes.

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

- Look up rates for providers, facilities and hospitals for common services and treatment
- 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

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.

REPUTATION

In business it's everything

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

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

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that small business owners' insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2 – 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. The market map asks specific questions related to the business and employee need in order 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 ...** • OAMC 2500 • OAMC 5000 80% Value • OAMC $10,000 Family
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 ...** • OAMC 2500 80% Value • CPOS 3000 80% Value • OAMC 4000 100% HSA
Traditional benefits plans Limiting the financial impact on employees	*You might be a ...* **Traditionalist**	**These plans fit ...** • OAMC 1000 100% • OAMC 2000 100% • OAMC 3000 100% HSA

YOUNG SINGLES

Consumer-directed health plans (CDHP)
HSA-Compatible plans
Value plans

YOUNG FAMILIES

Traditional plans
Value plans
HSA-Compatible plans

ESTABLISHED FAMILIES

Traditional plans
Value plans

EMPTY NESTERS

Consumer-directed health plans
Traditional plans

HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Includes singles and couples without children

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

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

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

ESTABLISHED FAMILIES

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

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

EMPTY NESTERS

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

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

PROVIDER NETWORK*

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Anderson	•	
Andrews	•	
Angelina	•	
Aransas		•
Archer	•	
Armstrong	•	
Atascosa		•
Austin		•
Bailey	•	
Bandera	•	
Bastrop		•
Baylor	•	
Bee		•
Bell		•
Bexar		•
Blanco	•	
Borden	•	
Bosque	•	
Brazoria		•
Brazos	•	
Brewster	•	
Briscoe	•	
Brooks	•	
Brown	•	
Burleson	•	
Burnet	•	
Caldwell		•
Calhoun	•	
Callahan	•	
Cameron	•	
Camp	•	
Carson	•	
Castro	•	
Chambers		•
Cherokee	•	
Childress	•	
Clay	•	
Cochran	•	
Coke	•	
Coleman	•	
Collin		•
Collingsworth	•	
Colorado		•

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Comal		•
Comanche	•	
Concho	•	
Cooke		•
Cottle	•	
Crane	•	
Crosby	•	
Crockett	•	
Culberson	•	
Dallam	•	
Dallas		•
Dawson	•	
De Witt	•	
Deaf Smith	•	
Delta		•
Denton		•
Dickens	•	
Dimmit	•	
Donley	•	
Duval		•
Eastland	•	
Ector	•	
Edwards	•	
El Paso		•
Ellis		•
Erath		•
Falls	•	
Fannin		•
Fayette	•	
Fisher	•	
Floyd	•	
Foard	•	
Fort Bend		•
Franklin	•	
Freestone	•	
Frio	•	
Gaines	•	
Galveston		•
Garza	•	
Gillespie	•	
Glasscock	•	
Goliad	•	
Gonzales	•	

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Gray	•	
Grayson		•
Gregg	•	
Grimes		•
Guadalupe		•
Hale	•	
Hall	•	
Hamilton	•	
Hansford	•	
Hardeman	•	
Hardin		•
Harris		•
Harrison	•	
Hartley	•	
Haskell	•	
Hays		•
Hemphill	•	
Henderson		•
Hidalgo	•	
Hill		•
Hockley	•	
Hood		•
Hopkins		•
Houston	•	
Howard	•	
Hudspeth	•	
Hunt		•
Hutchinson	•	
Irion	•	
Jack	•	
Jackson	•	
Jasper	•	
Jim Hogg	•	
Jeff Davis	•	
Jefferson		•
Jim Wells		•
Johnson		•
Jones	•	
Karnes	•	
Kaufman		•
Kendall		•
Kenedy	•	
Kent	•	

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Kerr	•	
Kimble	•	
King	•	
Kinney	•	
Kleberg		•
Knox	•	
La Salle	•	
Lamar	•	
Lamb	•	
Lavaca	•	
Lee	•	
Leon	•	
Liberty		•
Limestone	•	
Lipscomb	•	
Live Oak		•
Llano	•	
Loving	•	
Lubbock	•	
Lynn	•	
Madison	•	
Marion	•	
Martin	•	
Mason	•	
Matagorda		•
Maverick	•	
McCullough	•	
Mclennan	•	
McMullen	•	
Medina		•
Menard	•	
Midland	•	
Milam	•	
Mills	•	
Mitchell	•	
Montague	•	
Montgomery		•
Moore	•	
Morris	•	
Motley	•	
Nacogdoches	•	
Navarro		•
Newton	•	

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Nolan	•	
Nueces		•
Ochiltree	•	
Oldham	•	
Orange		•
Palo Pinto		•
Panola	•	
Parker		•
Parmer	•	
Pecos	•	
Polk	•	
Presidio	•	
Potter	•	
Rains		•
Randall	•	
Reagan	•	
Real	•	
Red River	•	
Reeves	•	
Refugio	•	
Roberts	•	
Robertson	•	
Rockwall		•
Runnels	•	
Rusk	•	
Sabine	•	
San Augustine	•	
San Jacinto		•
San Patricio		•
San Saba	•	
Schleicher	•	
Scurry	•	
Shackelford	•	
Shelby	•	
Sherman	•	
Smith	•	
Somervell		•
Starr	•	
Stephens	•	
Sterling	•	
Stonewall	•	
Sutton	•	
Swisher	•	

Texas Counties	OAMC/ Preferred Provider Benefits Plan (PPO) Network	OAMC/PPO/ CPOS/HMO Network
Tarrant		•
Taylor	•	
Terrell	•	
Terry	•	
Throckmorton	•	
Titus	•	
Tom Green	•	
Travis		•
Trinity	•	
Tyler	•	
Upshur	•	
Upton	•	
Uvalde	•	
Val Verde	•	
Van Zandt		•
Victoria	•	
Walker		•
Waller		•
Ward	•	
Washington	•	
Webb	•	
Wharton		•
Wheeler	•	
Wichita	•	
Wilbarger	•	
Willacy	•	
Williamson		•
Wilson		•
Winkler	•	
Wise		•
Wood	•	
Yoakum	•	
Young	•	
Zapata	•	
Zavala	•	

*Network subject to change.

Aetna Avenue

MEDICAL OVERVIEW

WELLNESS ON US℠

Wellness for your employees means a healthier business for you. Now your employees can get in-network preventive care for $0! Our small business health benefits and insurance plans in Texas now include $0 copay in-network for preventive care. It's one more way for us to help your employees get a step closer to better health. Check out what your employees can get for $0:

- Routine vision screening – $0 copay
- Routine physicals – $0 copay
- Child wellness visits – $0 copay
- Routine mammogram – $0 copay
- Routine ob/gyn visits – $0 copay
- Immunizations – $0 copay

AETNA OPEN ACCESS® MANAGED CHOICE® (OAMC) PLAN

For those who want the advantages of a managed care insurance plan while giving employees flexibility to access any providers without a referral.

- No PCP selection required (members who prefer to have their family physician coordinate their care may designate a PCP if they choose).
- No referrals required.
- Members can choose any provider from Aetna's extensive network for a covered service.
- Members may visit any out-of-network recognized provider for a covered service.
- For certain plans, members pay office visit copay each time member goes to a participating specialist or non-specialist physician.

AETNA CHOICE® POS (CPOS) PLAN

No need for referrals; freedom to select provider of choice

The Aetna Choice POS plan offers all the health plan benefits of a point-of-service plan with two easy ways to access care when members need it. Members have the freedom to visit the participating doctor or hospital of their choice for covered services. Best of all, members seeking health care do not need referrals. This plan allows members to:

- Visit a participating physician of primary care and pay the plan's copayment for covered benefits.
- Go directly to any specialist from within Aetna's network of providers and pay the applicable specialist copayment for covered benefits.
- Go directly to any licensed out-of-network physician, subject to payment of a deductible and coinsurance.
- Large provider networks.

WHAT MAKES AETNA'S HDHP PLANS UNIQUE?

All of our HSA plans include an embedded deductible which means lower out-of-pocket costs!

WHAT IS AN EMBEDDED DEDUCTIBLE?

Unlike many HSA plans, with an Aetna HSA plan each covered family member only needs to satisfy his or her individual deductible before plan coinsurance applies, not the entire family deductible. Many HSA plans in today's marketplace do not include embedded deductibles, thereby requiring enrolled members to satisfy the entire family deductible before plan coinsurance applies.

AETNA HIGH-DEDUCTIBLE OPEN ACCESS MANAGED CHOICE (OAMC) (HSA-COMPATIBLE)

The Aetna Open Access Managed Choice benefits plan insurance options that are compatible with a Health Savings Account (HSA) provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

- Employees can build a savings fund to assist in covering their future medical and dental expenses. HSA accounts can be funded by the employer or employee and are portable.
- Fund contributions may be tax deductible (limits apply).
- When funds are used to cover qualified out-of-pocket medical and dental expenses, they are not taxed.

AETNA PREFERRED PROVIDER BENEFITS PLAN (PPO)

The Aetna Preferred Provider Benefits plan insurance offers members the freedom to go directly to any recognized provider for covered services, including specialists. No referrals are required.

- Emergency care coverage anywhere, anytime, 24 hours a day.
- Large provider network.
- No claim forms in-network.
- If members choose a provider from Aetna's network of participating physicians and hospitals, out-of-pocket costs will be lower.
- If members choose a physician or hospital outside of the network, out-of-pocket costs will be higher.

AETNA HMO PLUS PLAN

This health benefits plan values the role of the physician of primary care to serve as the coordinator of the member's health care. For preferred services and supplies, the member must elect a physician of primary care. Members seeking health care have the flexibility to access care in or out of the network. Except for certain direct access benefits, members self-referring to network Specialists or seeking out-of-network care will share more of the cost of care through a deductible and coinsurance.

The Aetna HMO Plus plan provides:

- Flexibility to self-refer. Physician of primary care election is required to access preferred benefits.
- No lifetime dollar maximums in-network.
- Large provider networks.
- For preferred services and supplies, members are encouraged to choose a physician of primary care from Aetna's network of participating providers.
- Members visit a physician of primary care for routine care or for injury or illness; members pay applicable copay each time covered benefits are accessed within the network with a physician of primary care referral.
- Members may visit any out-of-network licensed provider, without a physician of primary care referral for a covered benefit; members share the cost of care through deductible/coinsurance.

AETNA INDEMNITY PLAN

This insurance plan option is available for employees who live outside of the network plan's service area.

- Individual coordinates his or her own health care.
- No PCP required.
- No referral required.
- Members can access any recognized physician or hospital for covered services.
- Employer may offer a Preferred Provider Benefits plan to in-area employees and the Indemnity plan to out-of-area employees.
- Deductibles and coinsurance apply.
- Annual and lifetime maximums may apply.
- No network providers.
- Members are responsible for paying provider directly and submitting claims for reimbursement.

HEALTH SAVINGS ACCOUNT (HSA)

No set-up or administrative fees

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.

MEMBER'S HSA PLAN

HSA ACCOUNT

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

TODAY
Use for qualified expenses with tax free dollars

FUTURE
Plan for future and retiree health-related costs

HIGH-DEDUCTIBLE HEALTH PLAN

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

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
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 – 50 Employees	$5- per month minimum
TRA	
Annual Fee	$350
Transit Monthly Fees	$4.25 per participant
Parking Monthly Fees	$3.15 per participant
COBRA	
Annual Fee 20 – 50 Employees	$50
Monthly Fee	$0.85 per employee

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. The fund is available to an employee for qualified expenses on the plan's effective date.

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

COBRA ADMINISTRATION

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

SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

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

Premium Only Plans (POP)

Employees can pay for their portion of the group health insurance expenses on a pretax basis.

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.

*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.

OPEN ACCESS® MANAGED CHOICE® (OAMC)

PLAN FEATURES	TX OAMC 500 – 09		TX OAMC 1000 – 09		TX OAMC 1500 – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	20%	40%	20%	40%	20%	40%
Calendar Year Deductible**						
Individual	$500	$1,000	$1,000	$2,000	$1,500	$3,000
Family	$1,500	$3,000	$3,000	$6,000	$4,500	$9,000
Calendar Year Out-Of-Pocket Maximum***						
Individual	$2,500	$5,000	$3,000	$6,000	$3,500	$7,000
Family	$7,500	$15,000	$9,000	$18,000	$10,500	$21,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Office Visits (Non-specialist)	$20 Deductible waived	40%	$25 Deductible waived	40%	$30 Deductible waived	40%
Office Visits (Specialist)	$40 Deductible waived	40%	$40 Deductible waived	40%	$45 Deductible waived	40%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures						
Outpatient Lab	$0 Deductible waived	40%	$0 Deductible waived	40%	$0 Deductible waived	40%
Outpatient X-rays / Testing (Facility)	$20 Deductible waived	40%	$25 Deductible waived	40%	$30 Deductible waived	40%
Complex Imaging	20%	40%	20%	40%	20%	40%
Outpatient Therapy						
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	20%	40%	20%	40%	20%	40%
Speech (20 visits per calendar year limit)	20%	40%	20%	40%	20%	40%
Inpatient Hospital Services	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%	20%	40%
Emergency Room (Copay waived if admitted)	20% after $150 Deductible waived	Paid as In-Network	20% after $150 Deductible waived	Paid as In-Network	20% after $150 Deductible waived	Paid as In-Network
Urgent Care	$50 Deductible waived	40%	$75 Deductible waived	40%	$75 Deductible waived	40%
Skilled Nursing Facility (30 days per calendar year limit)	20%	40%	20%	40%	20%	40%
Hospice Care						
Inpatient	20%	40%	20%	40%	20%	40%
Outpatient	20%	40%	20%	40%	20%	40%
Home Health Care (60 visits per calendar year limit)	20%	40%	20%	40%	20%	40%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	50%	50%	50%	50%	50%	50%
Prescription Drugs						
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15/$35/$50	Retail copay plus 30%	$15/$35/$50	Retail copay plus 30%	$15/$40/$60	Retail copay plus 30%
Pharmacy Deductible	N/A	N/A	N/A	N/A	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies	Applies	Applies	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

OPEN ACCESS® MANAGED CHOICE® (OAMC)

PLAN FEATURES	TX OAMC 2500 80% Value – 09		TX OAMC 5000 80% Value – 09		TX OAMC 1000 100% – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	20%	50%	20%	50%	0%	30%
Calendar Year Deductible**						
Individual	$2,500	$5,000	$5,000	$5,000	$1,000	$3,000
Family	$7,500	$15,000	$15,000	$15,000	$3,000	$9,000
Calendar Year Out-Of-Pocket Maximum***						
Individual	$5,000	$10,000	$5,000	$10,000	N/A	$5,000
Family	$15,000	$30,000	$15,000	$30,000	N/A	$15,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Office Visits (Non-specialist)	$30 Deductible waived	50%	$35 Deductible waived	50%	$30 Deductible waived	30%
Office Visits (Specialist)	$60 Deductible waived	50%	$70 Deductible waived	50%	$40 Deductible waived	30%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures						
Outpatient Lab	$30 Deductible waived	50%	$35 Deductible waived	50%	$0 Deductible waived	30%
Outpatient X-rays / Testing (Facility)	$60 Deductible waived	50%	$70 Deductible waived	50%	$30 Deductible waived	30%
Complex Imaging	50%	50%	50%	50%	0%	30%
Outpatient Therapy						
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	20%	50%	20%	50%	0%	30%
Speech (20 visits per calendar year limit)	20%	50%	20%	50%	0%	30%
Inpatient Hospital Services	20% Professional / 50% Facility	50%	20% Professional / 50% Facility	50%	0%	30%
Outpatient Surgery	20% Professional / 50% Facility	50%	20% Professional / 50% Facility	50%	0%	30%
Emergency Room (Copay waived if admitted)	20% Professional / 50% Facility after $200 copay Deductible waived	Paid as In-Network	20% Professional / 50% Facility after $250 copay Deductible waived	Paid as In-Network	$150 Deductible waived	Paid as In-Network
Urgent Care	$100 Deductible waived	50%	$125 Deductible waived	50%	$75 Deductible waived	30%
Skilled Nursing Facility (30 days per calendar year limit)	20% Professional / 50% Facility	50%	20% Professional / 50% Facility	50%	0%	30%
Hospice Care						
Inpatient	20% Professional / 50% Facility	50%	20% Professional / 50% Facility	50%	0%	30%
Outpatient	20%	50%	20%	50%	0%	30%
Home Health Care (60 visits per calendar year limit)	20%	50%	20%	50%	0%	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	50%	50%	50%	50%	0%	30%
Prescription Drugs						
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$20/$40/$70++	Retail copay plus 30%	$20/$40/$70++	Retail copay plus 30%	$15/$40/$60	Retail copay plus 30%
Pharmacy Deductible	N/A	N/A	N/A	N/A	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies	Applies	Applies	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

++Mandatory Generics policy applies.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

OPEN ACCESS® MANAGED CHOICE® (OAMC)

PLAN FEATURES	TX OAMC 2000 100% – 09		TX OAMC 2000 100% Value – 09		TX OAMC 3000 100% – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	0%	30%	0%	30%	0%	30%
Calendar Year Deductible**						
Individual	$2,000	$4,000	$2,000	$5,000	$3,000	$5,000
Family	$6,000	$12,000	$6,000	$15,000	$9,000	$15,000
Calendar Year Out-Of-Pocket Maximum***						
Individual	N/A	$6,000	N/A	$7,000	N/A	$7,000
Family	N/A	$18,000	N/A	$21,000	N/A	$21,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Office Visits (Non-specialist)	$30 Deductible waived	30%	$35 Deductible waived	30%	$30 Deductible waived	30%
Office Visits (Specialist)	$50 Deductible waived	30%	$60 Deductible waived	30%	$50 Deductible waived	30%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures						
Outpatient Lab	$0 Deductible waived	30%	$35 Deductible waived	30%	$0 Deductible waived	30%
Outpatient X-rays / Testing (Facility)	$30 Deductible waived	30%	$60 Deductible waived	30%	$30 Deductible waived	30%
Complex Imaging	0%	30%	0%	30%	0%	30%
Outpatient Therapy						
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	0%	30%	0%	30%	0%	30%
Speech (20 visits per calendar year limit)	0%	30%	0%	30%	0%	30%
Inpatient Hospital Services	0%	30%	0%	30%	0%	30%
Outpatient Surgery	0%	30%	0%	30%	0%	30%
Emergency Room (Copay waived if admitted)	$200 Deductible waived	Paid as In-Network	$250 Deductible waived	Paid as In-Network	$250 Deductible waived	Paid as In-Network
Urgent Care	$100 Deductible waived	30%	$100 Deductible waived	30%	$100 Deductible waived	30%
Skilled Nursing Facility (30 days per calendar year limit)	0%	30%	0%	30%	0%	30%
Hospice Care						
Inpatient	0%	30%	0%	30%	0%	30%
Outpatient	0%	30%	0%	30%	0%	30%
Home Health Care (60 visits per calendar year limit)	0%	30%	0%	30%	0%	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	0%	30%	0%	30%	0%	30%
Prescription Drugs						
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15/$40/$60	Retail copay plus 30%	$20/$40/$70++	Retail copay plus 30%	$15/$40/$60	Retail copay plus 30%
Pharmacy Deductible	N/A	N/A	N/A	N/A	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies	Applies	Applies	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

++Mandatory Generics policy applies.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

OPEN ACCESS® MANAGED CHOICE® (OAMC)

PLAN FEATURES	TX OAMC 5000 100% – 09		TX OAMC $10,000 Family – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	0%	30%	0%	30%
Calendar Year Deductible**				
Individual	$5,000	$6,000	$10,000	$20,000
Family	$15,000	$18,000	$10,000	$20,000
Calendar Year Out-Of-Pocket Maximum***				
Individual	N/A	$8,000	N/A	$20,000
Family	N/A	$24,000	N/A	$20,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Office Visits (Non-specialist)	$30 Deductible waived	30%	$25 Deductible waived	30%
Office Visits (Specialist)	$50 Deductible waived	30%	0%	30%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures				
Outpatient Lab	$0 Deductible waived	30%	0%	30%
Outpatient X-rays / Testing (Facility)	$30 Deductible waived	30%	0%	30%
Complex Imaging	0%	30%	0%	30%
Outpatient Therapy				
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	0%	30%	0%	30%
Speech (20 visits per calendar year limit)	0%	30%	0%	30%
Inpatient Hospital Services	0%	30%	0%	30%
Outpatient Surgery	0%	30%	0%	30%
Emergency Room (Copay waived if admitted)	$250 Deductible waived	Paid as In-Network	$250 Deductible waived	Paid as In-Network
Urgent Care	$100 Deductible waived	30%	0%	30%
Skilled Nursing Facility (30 days per calendar year limit)	0%	30%	0%	30%
Hospice Care				
Inpatient	0%	30%	0%	30%
Outpatient	0%	30%	0%	30%
Home Health Care (60 visits per calendar year limit)	0%	30%	0%	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	0%	30%	0%	30%
Prescription Drugs				
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15/$40/$60	Retail copay plus 30%	$15 copay for Generic meds. Member pays 100% for Brand	$15 copay plus 30% for Generic meds. Member pays 100% for Brand
Pharmacy Deductible	N/A	N/A	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

AETNA CHOICE® POS

PLAN FEATURES	TX CPOS 1500 100% – 09		TX CPOS 2000 80% Value – 09		TX CPOS 2500 100% – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Member Coinsurance	0%	30%	20%	50%	0%	30%
Calendar Year Deductible**						
Individual	$1,500	$3,000	$2,000	$4,000	$2,500	$5,000
Family	$4,500	$9,000	$6,000	$12,000	$7,500	$15,000
Out-Of-Pocket Maximum***						
Individual	$1,500	$6,000	$4,000	$8,000	$1,500	$10,000
Family	$4,500	$18,000	$12,000	$24,000	$4,500	$30,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Primary Physician (PCP) Office Visits	$35 Deductible waived	30%	$35 Deductible waived	50%	$35 Deductible waived	30%
Specialty Care Office Visit†**	$50 Deductible waived	30%	$70 Deductible waived	50%	$50 Deductible waived	30%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures						
Outpatient Lab	$0 Deductible waived	30%	$0 Deductible waived	50%	$0 Deductible waived	30%
Outpatient X-rays / Testing (Facility)	$35 Deductible waived	30%	$70 Deductible waived	50%	$35 Deductible waived	30%
Complex Imaging	0%	30%	20%	50%	0%	30%
Outpatient Therapy						
Physical & Occupational (20 visits per calendar year limit, combined)	0%	30%	20%	50%	0%	30%
Speech (20 visits per calendar year limit)	0%	30%	20%	50%	0%	30%
Inpatient Hospital Services	0%	30%	20%	50%	0%	30%
Outpatient Surgery	0%	30%	20%	50%	0%	30%
Emergency Room (Copay waived if admitted)	$200 Deductible waived	Paid as In-Network	20% after $250 copay Deductible waived	Paid as In-Network	$250 Deductible waived	Paid as In-Network
Urgent Care	$75 Deductible waived	30%	$100 Deductible waived	50%	$100 Deductible waived	30%
Skilled Nursing Facility (30 days per calendar year limit)	0%	30%	20%	50%	0%	30%
Hospice Care						
Inpatient **Outpatient**	0%	30%	20%	50%	20%	30%
Home Health Care (60 visits per calendar year limit)	0%	30%	20%	50%	20%	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	0%	30%	20%	50%	20%	30%
Prescription Drugs						
Pharmacy Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Pharmacy **Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies**	$15/$40/$60	N/A	$20/$40/$70††	N/A	$15/$40/$60	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Yes	N/A	Yes	N/A	Yes	N/A

Underwritten by Aetna Health Inc. and Aetna Health Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before other family members will be considered to have met the limit. In-network and out-of-network expenses accumulate separately and do not cross apply.

***Out-of-pocket max excludes deductible, pharmacy, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before other family members will be considered to have met the maximum.

†Referrals are not required for a member to access in-network, covered services. Member will pay the Primary Physician Office Visit cost-share when for covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

††Mandatory Generics policy applies.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

AETNA CHOICE® POS

PLAN FEATURES	TX CPOS 3000 80% Value – 09	
Network	In-Network	Out-of-Network*
Member Coinsurance	20%	50%
Calendar Year Deductible**		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Out-Of-Pocket Maximum***		
Individual	$4,000	$8,000
Family	$12,000	$24,000
Lifetime Maximum Benefit	$5,000,000	
Primary Physician (PCP) Office Visits	$35 Deductible waived	50%
Specialty Care Office Visit	$70 Deductible waived	50%
Preventive Services	$0 Deductible waived	30%
Diagnostic Procedures		
Outpatient Lab	$0 Deductible waived	50%
Outpatient X-rays / Testing (Facility)	$70 Deductible waived	50%
Complex Imaging	20%	50%
Outpatient Therapy		
Physical & Occupational (20 visits per calendar year limit, combined)	20%	50%
Speech (20 visits per calendar year limit)	20%	50%
Inpatient Hospital Services	20%	50%
Outpatient Surgery	20%	50%
Emergency Room (Copay waived if admitted)	20% after $250 copay Deductible waived	Paid as In-Network
Urgent Care	$100 Deductible waived	50%
Skilled Nursing Facility (30 days per calendar year limit)	20%	50%
Hospice Care		
Inpatient Outpatient	20%	50%
Home Health Care (60 visits per calendar year limit)	20%	50%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	20%	50%
Prescription Drugs		
Pharmacy Deductible	N/A	N/A
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$20/$40/$70††	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Yes	N/A

Underwritten by Aetna Health Inc. and Aetna Health Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before other family members will be considered to have met the limit. In-network and out-of-network expenses accumulate separately and do not cross apply.

***Out-of-pocket max excludes deductible, pharmacy, mental health, substance abuse and DME. All other covered expenses (In-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before other family members will be considered to have met the maximum.

†Referrals are not required for a member to access in-network, covered services. Member will pay the Primary Physician Office Visit cost-share when for covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

††Mandatory Generics policy applies.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

AETNA HEALTHFUND® (AHF) MANAGED CHOICE® OPEN ACCESS — HSA-COMPATIBLE PLANS

PLAN FEATURES	TX OAMC HSA 3000 100% – 09		TX OAMC HSA 4000 100% – 09		TX OAMC HSA 5000 100% – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	0%	30%	0%	30%	0%	30%
Calendar Year Deductible**						
Individual	$3,000	$6,000	$4,000	$8,000	$5,000	$8,000
Family	$6,000	$12,000	$8,000	$16,000	$10,000	$16,000
Out-Of-Pocket Maximum***						
Individual	$3,000	$12,000	$4,000	$16,000	$5,000	$16,000
Family	$6,000	$24,000	$8,000	$32,000	$10,000	$32,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Primary Care Physician (PCP)	0%	30%	0%	30%	0%	30%
Specialty Care	0%	30%	0%	30%	0%	30%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Outpatient Lab / X-rays / Testing (Facility)	0%	30%	0%	30%	0%	30%
Outpatient Therapy – Physical, Occupational or Spinal; (Limited to 20 visits per cal year combined)	0%	30%	0%	30%	0%	30%
Outpatient Therapy – Speech (Limited to 20 visits per cal year)	0%	30%	0%	30%	0%	30%
Inpatient Hospital Services	0%	30%	0%	30%	0%	30%
Outpatient Surgery	0%	30%	0%	30%	0%	30%
Emergency Room Copay/Coinsurance	0%	30%	0%	30%	0%	30%
Urgent Care Copay/Coinsurance	0%	30%	0%	30%	0%	30%
Skilled Nursing Facility (30 days per calendar year limit)	0%	30%	0%	30%	0%	30%
Hospice Care						
Inpatient	0%	30%	0%	30%	0%	30%
Outpatient	0%	30%	0%	30%	0%	30%
Home Health Care (60 visits per calendar year limit)	0%	30%	0%	30%	0%	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	0%	30%	0%	30%	0%	30%
Prescription Drugs†	0%	30%	0%	30%	0%	30%
Precertification and Step Therapy	N/A	N/A	N/A	N/A	N/A	N/A

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services except office visits for preventive services are subject to deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

***Out-of-pocket maximum includes deductible, member's share of coinsurance, copay (if applicable), and pharmacy expenses.

†Prescription Drug expenses are integrated with the medical plan (i.e., subject to plan deductible and applied toward the out-of-pocket max).

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

OPEN ACCESS® MANAGED CHOICE® (OAMC)

PLAN FEATURES	TX Basic OAMC 2500 – 09		TX Limited Benefit 50/50 – 09	
Network	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Plan Coinsurance	20%	50%	50%	50%
Calendar Year Deductible**				
Individual	$2,500	$4,000	$1,500	$3,000
Family	$7,500	$12,000	$4,500	$6,000
Calendar Year Out-Of-Pocket Maximum***				
Individual	$6,000	$10,000	$5,000	$10,000
Family	$18,000	$30,000	$15,000	$30,000
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Annual Benefit Maximum	N/A		$25,000 per member	
Office Visits (Non-specialist)	$35 - Deductible waived (3 visits per year, specialist & non-specialist combined at copay; additional visits subject to D&C)	50%	50%	50%
Office Visits (Specialist)	$35 - Deductible waived (3 visits per year, specialist & non-specialist combined at copay; additional visits subject to D&C)	50%	50%	50%
Preventive Services	$0 Deductible waived	30%	$0 Deductible waived	30%
Diagnostic Procedures				
Outpatient Lab	20% ($500 max benefit lab, X-ray & complex combined; Net & non-Net combined)	50%	50%	50%
Outpatient X-rays / Testing (Facility)	20% ($500 max benefit lab, X-ray & complex combined; Net & non-Net combined)	50%	50%	50%
Complex Imaging	20% ($500 max benefit lab, X-ray & complex combined; Net & non-Net combined)	50%	50%	50%
Outpatient Therapy				
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	20%	50%	50%	50%
Speech (20 visits per calendar year limit; in-network and out-of-network combined)	20%	50%	50%	50%
Inpatient Hospital Services	20%	50%	50%	50%
Outpatient Surgery	20%	50%	50%	50%
Emergency Room (Copay waived if admitted)	20%	Paid as In-Network	50%	Paid as In-Network
Urgent Care	20%	50%	50%	50%
Skilled Nursing Facility (30 days per calendar year limit)	20%	50%	50%	50%
Hospice Care				
Inpatient	20%	50%	50%	50%
Outpatient	20%	50%	50%	50%
Home Health Care (60 visits per calendar year limit)	20%	50%	50%	50%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	Not covered		50%	50%
Prescription Drugs				
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15 copay for Generic meds. Member pays 100% for Brand	$15 copay plus 30% for Generic meds. Member pays 100% for Brand	$15 copay for Generic meds. Member pays 100% for Brand	$15 copay plus 30% for Generic meds. Member pays 100% for Brand
Pharmacy Deductible	N/A	N/A	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

AETNA HMO PLUS QUALITY POINT-OF-SERVICE (QPOS®) NETWORK

PLAN FEATURES	TX HMO 40 Plus – 09	
Network	In-Network	Out-of-Network*
Member Coinsurance	N/A	30%
Calendar Year Deductible**		
Individual	N/A	$4,000
Family	N/A	$12,000
Out-Of-Pocket Maximum***		
Individual	$4,000	$5,000
Family	$12,000	$15,000
Lifetime Maximum Benefit	Unlimited	$2,000,000
Primary Physician Office Visits	$40	30%
Specialty Care Office Visit†	$50	30%
Preventive Services	$0	30%
Diagnostic Procedures		
Outpatient Lab	$0	30%
Outpatient X-rays / Testing (Facility)	$40	30%
Complex Imaging	$250	30%
Outpatient Therapy		
Physical & Occupational	$50	30%
Speech	$50	30%
Inpatient Hospital Services	$500 per day; 5 day max	30%
Outpatient Surgery	$300	30%
Emergency Room (Copay waived if admitted)	$250	Paid as In-Network
Urgent Care	$100	30%
Skilled Nursing Facility (30 days per calendar year limit)	$500 per day; 5 day max.	30%
Hospice Care		
Inpatient Outpatient	$500 per day; 5 day max.	30%
Home Health Care	$50	$50
Durable Medical Equipment ($2,500 per member per calendar year maximum)	50%	50%
Prescription Drugs		
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$20/$40/$70	Retail copay plus 30%
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Yes	Yes

Underwritten by Aetna Health Inc. and Aetna Health Insurance Company

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before other family members will be considered to have met the limit. In-network and out-of-network expenses accumulate separately and do not cross apply.

***Out-of-pocket max excludes deductible, pharmacy and DME. All other covered expenses (in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before other family members will be considered to have met the maximum.

†Primary Physician selection and referrals are required for a member to access in-network, covered services.

PREFERRED PROVIDER ORGANIZATION (PPO)

PLAN FEATURES	TX PPO 1000 – 09	
Network	In-Network	Out-of-Network*
Plan Coinsurance	20%	40%
Calendar Year Deductible**		
Individual	$1,000	$2,000
Family	$3,000	$6,000
Calendar Year Out-Of-Pocket Maximum***		
Individual	$3,000	$6,000
Family	$9,000	$18,000
Lifetime Maximum Benefit	$5,000,000	
Specialty Care Office Visit	$30 Deductible waived	40%
Preventive Services	$0 Deductible waived	30%
Specialty Care Office Visit	$40 Deductible waived	40%
Diagnostic Procedures		
Outpatient Lab	$0 Deductible waived	40%
Outpatient X-rays / Testing (Facility)	$30 Deductible waived	40%
Complex Imaging	20%	40%
Outpatient Therapy		
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	20%	40%
Speech (20 visits per calendar year limit; in-network and out-of-network combined)	20%	40%
Inpatient Hospital Services	20%	40%
Outpatient Surgery	20%	40%
Emergency Room (Copay waived if admitted)	20% after $150 Deductible waived	Paid as In-Network
Urgent Care	$75 Deductible waived	40%
Skilled Nursing Facility (30 days per calendar year limit)	20%	40%
Hospice Care		
Inpatient	20%	40%
Outpatient	20%	40%
Home Health Care (60 visits per calendar year limit)	20%	40%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	50%	50%
Prescription Drugs		
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15/$35/$50	Retail copay plus 30%
Pharmacy Deductible	N/A	N/A
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies	Applies

Plans are underwritten by Aetna Life Insurance Company.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as "Recognized Charges." In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider's billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses in-network and out-of-network) accumulate separately toward the out-of-pocket maximum and do not cross apply. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums.Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

TRADITIONAL CHOICE® — INDEMNITY

PLAN FEATURES	Indemnity
Plan Coinsurance	30%
Calendar Year Deductible**	
Individual	$1,000
Family	$3,000
Calendar Year Out-Of-Pocket Maximum***	
Individual	$3,000
Family	$9,000
Lifetime Maximum Benefit	$5,000,0000
Specialty Care Office Visit	30%
Office Visits (Specialist)	30%
Preventive Services	30%
Diagnostic Procedures	
Outpatient Lab	30%
Outpatient X-rays / Testing (Facility)	30%
Complex Imaging	40%
Outpatient Therapy	
Physical, Occupational and Spinal (20 visits per calendar year limit, combined)	30%
Speech (20 visits per calendar year limit; in-network and out-of-network combined)	30%
Inpatient Hospital Services	30%
Outpatient Surgery	30%
Emergency Room (Copay waived if admitted)	30%
Urgent Care	30%
Skilled Nursing Facility (30 days per calendar year limit)	30%
Hospice Care	
Inpatient	30%
Outpatient	30%
Home Health Care (30 visits per calendar year limit)	30%
Durable Medical Equipment ($2,500 per member per calendar year maximum)	50%
Prescription Drugs	
Pharmacy Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies	$15/$40/$60
Pharmacy Deductible	$100 Per member for brand
90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy	Applies

Plans are underwritten by Aetna Life Insurance Company.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out-of-pocket max excludes pharmacy, deductible and DME. All other covered expenses accumulate toward the out-of-pocket maximum. Three members must individually meet their out-of-pocket maximum before the family out-of-pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

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℠ (DMI) 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.

Participating Dental Network (PDN) plan (Options 3 – 7)

Members have the choice of using a dentist who participates in Aetna's network or choosing a licensed dentist who is not in the network. Participating dentists have agreed to offer members services at a negotiated rate and will not balance bill members.

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

DMI may not be available in all states.

PDN Max plan

The PDN Max plan uses the same PDN network. When members use out-of-network dentists, however, the service will be covered based on the PDN fee schedule, rather than the reasonable-and-customary charge. This means that the member will share in more of the costs and will be balance billed. This plan design enables your customer to offer members a quality plan with a significantly lower premium that encourages in-network usage.

Freedom-of-Choice plan design option

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

Dual Option plan*

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

Voluntary Dental option

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

*Dual Option does not apply to Voluntary Dental plans.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 – 50 Eligible Employees	**Option 1 DMO Access**	**Option 2**	**Option 3 Freedom-of-Choice —** Monthly selection between the DMO and the PDN Max Plan	
	Copay Plan 42	DMO Plan 100/90/60	DMO Plan 100/90/60	PDN Max Plan 100/70/40
Office Visit Copay	$10	$5	$5	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	None	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	No Charge	100%	100%	100%
Comprehensive oral exam	No Charge	100%	100%	100%
Problem-focused oral exam	No Charge	100%	100%	100%
X-rays				
Bitewing – single film	No Charge	100%	100%	100%
Complete series	No Charge	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	No Charge	100%	100%	100%
Child Cleaning	No Charge	100%	100%	100%
Sealants – per tooth	$10	100%	100%	100%
Fluoride application – with cleaning	No Charge	100%	100%	100%
Space maintainers	$100	100%	100%	100%
BASIC SERVICES				
Amalgam filling – 2 surfaces	$32	90%	90%	70%
Resin filling – 2 surfaces, anterior	$55	90%	90%	70%
Oral Surgery				
Extraction – exposed root or erupted tooth	$30	90%	90%	70%
Extraction of impacted tooth – soft tissue	$80	90%	90%	70%
***MAJOR SERVICES**				
Complete upper denture	$500	60%	60%	40%
Partial upper denture (resin base)	$513	60%	60%	40%
Crown – Porcelain with noble metal[1]	$488	60%	60%	40%
Pontic – Porcelain with noble metal[1]	$488	60%	60%	40%
Inlay – Metallic (3 or more surfaces)	$463	60%	60%	40%
Oral Surgery				
Removal of impacted tooth – partially bony	$175**	60%	60%	40%
ENDODONTIC SERVICES				
Bicuspid root canal therapy	$195	90%	90%	40%
Molar root canal therapy	$435**	60%	60%	40%
PERIODONTIC SERVICES				
Scaling & root planing – per quadrant	$65	90%	90%	40%
Osseous surgery – per quadrant	$445**	60%	60%	40%
***ORTHODONTIC SERVICES**	$2,300 copay	$2,300 copay	$2,300 copay	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1-3.

**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.

The copay amounts, including the Office Visit and Ortho Copays on the DMO in Plan Options 1, 2 & 3 are the member's responsibility.

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

Access to negotiated discounts; On the PDN plans in Plan Options 3-7, members are eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN 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 Plan Options 1-3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Option 6.

Plan Options 3, 4, & 7 PDN 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 in Plan Options 1 & 2 can be offered with any one of the plans in Plan Options 1, 4, 5-7 in a Dual Option package.

Orthodontic coverage is available only to groups with 10 or more eligibles and to 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. Aetna Dental Access Network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access network. Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 – 50 Eligible Employees	Option 4 PDN Max Plan 100/80/50	Option 5 PDN Plan 100/80/50	Option 6 PDN Plan 100/80/50	Option 7 PDN Max Plan 80/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,500	$2,000	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	80%
Comprehensive oral exam	100%	100%	100%	80%
Problem-focused oral exam	100%	100%	100%	80%
X-rays				
Bitewing – single film	100%	100%	100%	80%
Complete series	100%	100%	100%	80%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	80%
Child Cleaning	100%	100%	100%	80%
Sealants – per tooth	100%	100%	100%	80%
Fluoride application – with cleaning	100%	100%	100%	80%
Space maintainers	100%	100%	100%	80%
BASIC SERVICES				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – Porcelain with noble metal[1]	50%	50%	50%	50%
Pontic – Porcelain with noble metal[1]	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
ENDODONTIC SERVICES				
Bicuspid root canal therapy	50%	50%	80%	50%
Molar root canal therapy	50%	50%	80%	50%
PERIODONTIC SERVICES				
Scaling & root planing – per quadrant	50%	50%	80%	50%
Osseous surgery – per quadrant	50%	50%	80%	50%
***ORTHODONTIC SERVICES**	Not covered	50%	50%	Not covered
Orthodontic Lifetime Maximum	Does not apply	$1,000	$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 1-3.

**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.

The copay amounts, including the Office Visit and Ortho Copays on the DMO in Plan Options 1, 2 & 3 are the member's responsibility.

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

Access to negotiated discounts; On the PDN plans in Plan Options 3-7, members are eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN 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 Plan Options 1-3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Option 6.

Plan Options 3, 4, & 7 PDN 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 in Plan Options 1 & 2 can be offered with any one of the plans in Plan Options 1, 4, 5-7 in a Dual Option package.

Orthodontic coverage is available only to groups with 10 or more eligibles and to 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. Aetna Dental Access Network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access network. Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 – 50 Eligible Employees	**Voluntary Option 1 DMO Access**	**Voluntary Option 2**	**Voluntary Option 3 Freedom-of-Choice —** Monthly selection between the DMO and the PDN Max Plan	
	Copay Plan 42	DMO Plan 100/90/60	DMO Plan 100/90/60	PDN Max Plan 100/70/40
Office Visit Copay	$15	$10	$5	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	None	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	No Charge	100%	100%	100%
Comprehensive oral exam	No Charge	100%	100%	100%
Problem-focused oral exam	No Charge	100%	100%	100%
X-rays				
Bitewing – single film	No Charge	100%	100%	100%
Complete series	No Charge	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	No Charge	100%	100%	100%
Child Cleaning	No Charge	100%	100%	100%
Sealants – per tooth	$10	100%	100%	100%
Fluoride application – with cleaning	No Charge	100%	100%	100%
Space maintainers	$100	100%	100%	100%
BASIC SERVICES				
Amalgam filling – 2 surfaces	$32	90%	90%	70%
Resin filling – 2 surfaces, anterior	$55	90%	90%	70%
Oral Surgery				
Extraction – exposed root or erupted tooth	$30	90%	90%	70%
Extraction of impacted tooth – soft tissue	$80	90%	90%	70%
***MAJOR SERVICES**				
Complete upper denture	$500	60%	60%	40%
Partial upper denture (resin base)	$513	60%	60%	40%
Crown – Porcelain with noble metal[1]	$488	60%	60%	40%
Pontic – Porcelain with noble metal[1]	$488	60%	60%	40%
Inlay – Metallic (3 or more surfaces)	$463	60%	60%	40%
Oral Surgery				
Removal of impacted tooth – partially bony	$175**	60%	60%	40%
ENDODONTIC SERVICES				
Bicuspid root canal therapy	$195	90%	90%	40%
Molar root canal therapy	$435**	60%	60%	40%
PERIODONTIC SERVICES				
Scaling & root planing – per quadrant	$65	90%	90%	40%
Osseous surgery – per quadrant	$445**	60%	60%	40%
***ORTHODONTIC SERVICES**	$2,300 copay	$2,300 copay	$2,300 copay	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary Plan Options 1-3.

**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.

The copay amounts, including the Office Visit and Ortho Copays on the DMO in Voluntary Plan Options 1, 2 & 3 are the member's responsibility.

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

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

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 2 & 3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Voluntary Option 6.

Voluntary Plan Options 3 & 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Orthodontic coverage is available on the DMO in Voluntary Options 1 & 2 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 46.

AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 – 50 Eligible Employees	**Voluntary Option 4** PDN Plan 100/80/50	**Voluntary Option 5** PDN Plan 100/80/50	**Voluntary Option 6** PDN Plan 100/80/50	**Voluntary Option 7** PDN Max Plan 80/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	$1,500	$2,000	$2,000	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	80%
Comprehensive oral exam	100%	100%	100%	80%
Problem-focused oral exam	100%	100%	100%	80%
X-rays				
Bitewing – single film	100%	100%	100%	80%
Complete series	100%	100%	100%	80%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	80%
Child Cleaning	100%	100%	100%	80%
Sealants – per tooth	100%	100%	100%	80%
Fluoride application – with cleaning	100%	100%	100%	80%
Space maintainers	100%	100%	100%	80%
BASIC SERVICES				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – Porcelain with noble metal[1]	50%	50%	50%	50%
Pontic – Porcelain with noble metal[1]	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
ENDODONTIC SERVICES				
Bicuspid root canal therapy	50%	50%	80%	50%
Molar root canal therapy	50%	50%	80%	50%
PERIODONTIC SERVICES				
Scaling & root planing – per quadrant	50%	50%	80%	50%
Osseous surgery – per quadrant	50%	50%	80%	50%
***ORTHODONTIC SERVICES**	50%	50%	50%	Not covered
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 Voluntary Plan Options 1-3.

**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.

The copay amounts, including the Office Visit and Ortho Copays on the DMO in Voluntary Plan Options 1, 2 & 3 are the member's responsibility.

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

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

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 2 & 3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Voluntary Option 6.

Voluntary Plan Options 3 & 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Orthodontic coverage is available on the DMO in Voluntary Options 1 & 2 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 46.

OUT-OF-STATE PPO AETNA SMALL GROUP DENTAL PLANS

	Low Option No Ortho	Low Option Ortho	Medium Option No Ortho	Medium Option Ortho	High Option No Ortho	High Option Ortho
Dental Plan	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

*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 46.
For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.

OUT-OF-STATE PPO VOLUNTARY AETNA SMALL GROUP DENTAL PLANS

	Option 1 No Ortho	Option 1 Ortho
Dental Plan	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

*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 46.

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

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

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

LIFE INSURANCE

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

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

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

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

Giving you (and your employees) what you want

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

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

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

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

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

Our fresh approach to life

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

AD&D ULTRA®

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

Benefits include:

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

DISABILITY INSURANCE

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

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

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

INTEGRATED HEALTH AND DISABILITY

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

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

For a summary list of Limitations and Exclusions, refer to pages 44–47.

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 that 5 times the benefit amount of the lowest class
Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60
Age Reduction Schedule	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Guaranteed Issue	$20,000	10-25 employees $75,000 26-50 employees $100,000
Participation Requirements	100%	100% on non-contributory plans 75% on contributory plans
Contribution Requirements	100% Employer Contribution	Minimum 50% Employer Contribution
AD&D Ultra®		
AD&D Schedule	Matches Life Benefit	Matches Life Benefit
Additional Features	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	$5,000
Child Amount	Not Available	$2,000

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

PACKAGED LIFE AND DISABILITY PLAN OPTIONS

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

The above rates are valid for effective dates up to December 31, 2010 and are guaranteed for an assumed 12-month first-year policy period.

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, except those in an ineligible industry

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

PACKAGED DENTAL, LIFE & DISABILITY BENEFITS EFFECTIVE 1/1/2010

DENTAL	Low Option	Medium Option	High Option
MEMBER BENEFITS			
Office Visit Copay	$10	$10	$10
Annual Deductible per Member	None	None	None
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	No Charge	No Charge	No Charge
Comprehensive oral exam	No Charge	No Charge	No Charge
Problem-focused oral exam	No Charge	No Charge	No Charge
X-rays			
Bitewing – single film	No Charge	No Charge	No Charge
Complete series	No Charge	No Charge	No Charge
PREVENTIVE SERVICES			
Adult Cleaning	No Charge	No Charge	No Charge
Child Cleaning	No Charge	No Charge	No Charge
Sealants – per tooth	$10	$10	$10
Fluoride application – with cleaning	No Charge	No Charge	No Charge
Space maintainers	$100	$100	$100
BASIC SERVICES			
Amalgam filling – 2 surfaces	$32	$32	$32
Resin filling – 2 surfaces, anterior	$55	$55	$55
Oral Surgery			
Extraction – exposed root or erupted tooth	$30	$30	$30
Extraction of impacted tooth – soft tissue	$80	$80	$80
MAJOR SERVICES			
Complete upper denture	$500	$500	$500
Partial upper denture (resin base)	$513	$513	$513
Crown – Porcelain with noble metal[1]	$488	$488	$488
Pontic – Porcelain with noble metal[1]	$488	$488	$488
Inlay – Metallic (3 or more surfaces)	$463	$463	$463
Oral Surgery			
Removal of impacted tooth – partially bony	$175*	$175*	$175*
ENDODONTIC SERVICES			
Bicuspid root canal therapy	$195	$195	$195
Molar root canal therapy	$435*	$435*	$435*
PERIODONTIC SERVICES			
Scaling & root planing – per quadrant	$65	$65	$65
Osseous surgery – per quadrant	$445*	$445*	$445*
ORTHODONTIC SERVICES	$2,300 copay	$2,300 copay	$2,300 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

*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.

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.

Aetna Dental Access Network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access Network. Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

The copay amounts, including the Office Visit and Ortho Copays are the member's responsibility.

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

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

PACKAGED DENTAL, LIFE & DISABILITY PLAN OPTIONS (CONTINUED)

	Low Option		Medium Option		High Option	
BASIC LIFE	Per schedule		Per schedule		Per schedule	
Benefit	Flat $10,000		Flat $20,000		Flat $50,000	
Guaranteed Issue **2-9 Lives** **10-50 Lives**	 $10,000 $10,000		 $20,000 $20,000		 $20,000 $50,000	
Reduction Schedule	Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75		Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75		Employer's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	
Disability Provision	Premium Waiver 60		Premium Waiver 60		Premium Waiver 60	
Accelerated Death Benefit	Up to 75% of Face Amount		Up to 75% of Face Amount		Up to 75% of Face Amount	
Dependent Life	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	
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	
Definition of Disability	Own Occupation 20% earnings loss (80% earnings test)		Own Occupation 20% earnings loss (80% earnings test)		Own Occupation 20% earnings loss (80% earnings test)	
Benefit Duration	24 months of benefits		24 months of benefits		24 months of benefits	
Pre-Existing Condition Limitation	3/12		3/12		3/12	
Types of Disability	Occupational & Non-Occupational		Occupational & Non-Occupational		Occupational & Non-Occupational	
Mental Health / Substance Abuse	24 months of benefits		24 months of benefits		24 months of benefits	
RATES (per employee per month)	Single	Family	Single	Family	Single	Family
2-9 eligible employees	$22	$48	$29	$55	$41	$67
10-25 eligible employees	$21	$45	$28	$52	$40	$64
26-50 eligible employees	$20	$43	$27	$50	$39	$62

The above rates are valid for effective dates up to December 31, 2010 and are guaranteed for an assumed 12-month first-year policy period.
Life and Disability products are underwritten or administered by Aetna Life Insurance Company.

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

TEXAS UNDERWRITING GUIDELINES (FOR 4/1/08 EFFECTIVE DATES)

This list is meant to be informative and is not intended to be all inclusive. Other policies and guidelines may apply.

Carve outs	▪ Union Employees as a class, may be excluded by an employer as not being eligible for coverage. ▪ Management carve outs are not permitted.
Census Data	▪ Census date must be provided on all eligible (and COBRA/STATE continuation eligible) employees and include name, age/date of birth, date of hire, gender, dependent status and residence zip code. ▪ Retirees are not eligible.
COBRA/State Continuation Eligibility	▪ COBRA/State Continuation eligibles should be included and noted on the census. ▪ Family Health Statements must be provided on COBRA/State Continuation individual along with the rest of the group. ▪ Date COBRA/State Continuance coverage began and the length of eligibility will be required at time of enrollment. ▪ Employers with 20 or more employees (full and part-time) are eligible to offer COBRA coverage. ▪ Employers with less than 20 employees (full and part-time) are eligible to offer State Continuation.
Case Submission Dates	New groups with 2 to 50 eligibles must have all completed paperwork into Aetna Underwriting 1 business day prior to the requested effective date. If not received by this date, the effective date may be moved to the next month.
Common Ownership	▪ Single employer groups with multiple TINs may be considered as one group. ▪ One owner must have controlling interest of each separate business. ▪ A copy of most recent Quarterly Wage and Tax Statement or Payroll records must be provided. ▪ The two or more groups may have multiple Standard Industrial Classification Codes (SIC); however, rates will be based on the SIC code for the group with the majority of employees. ▪ The common ownership form must be completed
Dual Product Option	▪ A minimum of one person must enroll in each plan when a dual option is offered.
Triple Product Option	▪ A minimum of one person must enroll in each plan when a triple option is offered.
Effective Date	▪ The effective date will be the 1st or 15th of the month. ▪ Effective date requested by the employer may be up to 60 days in advance.

Employer Eligibility	▪ Medical plans can be offered to groups of 2 to 50 eligible employees ▪ Organizations must not be formed solely for the purpose of obtaining health coverage. ▪ Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage. ▪ A copy of the certificate of fictitious name should be provided. ▪ Submission of the most recent wage and tax statement. – Employees who have terminated or work part-time should be noted accordingly on the wage and tax statement. – Employees not listed on the wage and tax report should have the new hire form completed or payroll stub sent in with the request for coverage. ▪ If employee is a sole proprietor, partner or corporate officer, the Proof of Eligibility Form (see Producer World or contact Underwriting for this form) must be completed and submitted with the requested tax documentation requested on the form.
Employer Financial Condition	▪ A current carrier bill with billing summary will be required; group must be no more than one month in arrears on payments (i.e., current month only may not yet be paid). ▪ Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until 12 months after the date of termination.
Initial Premium Check	▪ The initial premium check is not a binder check and does not bind Aetna to provide coverage. ▪ If the request for coverage is denied due to business ineligibility, participation and/or contributions not met, or other permissible reasons, the check will be returned to the employer. ▪ An initial premium check equal to one-month's premium must accompany the application. ▪ Checks should be on company check stock.
Final Rates	Rating will be based on final enrollment.
Newly Formed Business	Must provide the following documentation for consideration: – Payroll records or letter from attorney or Certified Public Accountant listing the names of all employees and number of hours worked each week; and – Tax ID Number.
Plan Change Ancillary Additions	▪ Requests to add or change ancillary benefits must be requested by the desired effective date. ▪ The future renewal date of the ancillary products will be the same as the medical plan renewal date.
Probationary Period	▪ The employer decides whether or not to impose a probationary period. ▪ The probationary period must be consistently applied to all eligible employees. ▪ On-time entrant eligibility date will be the first day of the policy month (1st or 15th of the month) following the waiting period of 0, 30, 60, 90 days.
Producers	Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna Products.
Replacing Other Group Coverage	The employer should be told not to cancel any existing medical coverage until they have been notified of approval.

PRODUCT SPECIFICATIONS

Medical	
Product Availability	2 to 50 eligible employees. May be written standalone or with ancillary coverage as noted in the following columns.
Employer Contribution	The employer must contribute 50% of the employee only cost
Employee Eligibility	Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 30 hours and who have met any authorized waiting period requirements. Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. Employees who do not meet the definition of a permanent full-time employee will not be eligible (e.g., leased, part-time, temporary, seasonal or substitute employees; employees enrolled in the CHAMPUS, Medicare or Medicaid program; employees enrolled in a self-funded or self-insured health benefits plan).
Dependent Eligibility	Eligible dependents include an employee's spouse, common law, domestic partner, and unmarried dependent children up to the limiting age of 25. Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. Dependents must enroll in same benefit options as the employee.
Late Applications/Entrant	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 follows: Late applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and will be deferred to the next plan anniversary date of the group and must reapply for coverage 30 days prior to the group anniversary date.
Option Sales	Option sales not permitted
Medical Underwriting	2-50 lives
Participation	Groups with 2 to 50 eligible employees — 75% participation excluding valid waivers must enroll in Aetna's plan.
Retiree Coverage	Retiree coverage is not available to Retirees.
Out of State Employees	Please contact Underwriting for available options.
Ineligible Industries	All industries are eligible for medical coverage subject to underwriting guidelines.
Actively at Work	Waived
Dental	
Product Availability	2 eligible employees – Standard Dental available with Medical. – Voluntary — Not available. 3 to 50 eligible employees – Standard and Voluntary Plans available with or without Medical. Orthodontic coverage is available to dependent children only for groups with 10 or more eligible employees with a minimum of five enrolled for both Standard and Voluntary plans.
Employer Contribution	For Standard plans employers must contribute at least 25% of the total cost of the plan or 50% of the cost of employee only coverage. Coverage can be denied based on inadequate contributions. For Voluntary plans employer contribution of less than 50% of the cost of employee only coverage. Employee Pay All plans are permitted.
Employee Eligibility	Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 30 hours and who have met any authorized waiting period requirements. Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. Employees who do not meet the definition of a permanent full-time employee will not be eligible (e.g., leased, part-time, temporary, seasonal or substitute employees).
Dependent Eligibility	Eligible dependents include an employee's spouse, common law, domestic partner, and unmarried dependent children up to the limiting age of 25. Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. Dependents must enroll in same benefit options as the employee.

Late Applications/Entrant

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 follows:

- An employee or dependent that enrolls other than within 31 days of first becoming eligible is subject to the Late Entrant provision.
- Coverage limited to Preventive & Diagnostic services for first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).

Option Sales

- All dental plans must be offered on a full-replacement basis.
- No other employer sponsored dental plan.

Medical Underwriting

Not Applicable

Participation

- For non-contributory plans, 100% participation is required, excluding those with other qualifying dental coverage.
- Standard Dental
  - 2 to 3 eligible employees — 100% participation is required, excluding those with other qualifying existing dental coverage.
  - 4 to 50 eligible employees — 75% participation is required, excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental Plan
- 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.
- 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. Employees may select coverage for eligible dependents under the Dental plan even if they elected single coverage on the Medical plan or vice versa. Coverage can be denied based on inadequate participation.

Retiree Coverage

Retiree coverage is not available for Dental coverage.

Out of State Employees

- Out-of-State/Situs employees will be offered one of the specific out-of-state/situs dental PPO plans. Employees who fall out-side a dental PPO network area will default to a comparable Indemnity plan.

Ineligible Industries

The ineligible industry list applies only when Dental is sold stand-alone or packaged only with Group Insurance. This list does not apply when Dental is sold in combination with Medical.

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

Full-Time Hours	Full-time hour guideline will agree with the Medical guidelines
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
Coverage Waiting Period	For Major and Orthodontic Services must be an enrolled member of plan for 1 year before eligible (not applicable to DMO). ▪ The coverage waiting period is waived separately for Major or Orthodontics Services for employees who were covered by the group's immediately preceding Dental plan. ▪ To waive the waiting period for Orthodontic Services, the group's immediately preceding plan must have included orthodontic 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 Orthodontics coverage. Aetna plan has coverage for both Major and Orthodontics. The waiting period is waived for Major Services but not for Orthodontics Services.
Reinstatement	For Voluntary plans, members who were once enrolled then terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.
Product Packaging	▪ DMO can be sold as standalone and/or be packaged with any PDN option as Dual Option. ▪ PDN plans can be sold standalone or packaged with DMO as a Dual Option or Freedom-of-Choice. ▪ Freedom-of-Choice cannot be packaged with any other option. It must be the only sold plan.
Forms	The same enrollment applications and business eligibility documents as required for new business medical.
Life	
Product Availability	▪ 2 to 9 eligible employees — available only if packaged with Medical. ▪ 10 to 25 eligible employees — Standard life available either packaged with Medical or Dental. ▪ 26 to 50 eligible employees — Standard life available either packaged with medical or dental or on a standalone basis. ▪ 10 to 50 eligible employees — Packaged Life & Disability available either packaged with Medical or Dental or on a standalone basis. ▪ Conversion options are not available.
Employer Contribution	▪ 2 to 9 eligible employees — 100% of the total cost. ▪ 10 to 50 eligible — at least 50% of the total cost (excluding Optional Dependent Term).
Employee Eligibility	▪ Permanent full-time employees who work the minimum hours required for Medical coverage as mandated by the state are eligible for insurance on the effective date of the plan, provided they are actively at work on that date. ▪ New employees will be eligible after the completion of a period of continuous active service. ▪ Retirees are not eligible. ▪ 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.
Dependent Eligibility	▪ Dependent children are covered from 14 days up to age 19, or up to 25 if in school (subject to state laws). ▪ Incapacitated children can be covered beyond the standard age limit. ▪ Eligible dependents include an employee's spouse, domestic partner and unmarried children up to the limiting age of the plan. ▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. ▪ Dependent Life Insurance is available as a separate plan design. ▪ Dependents are not eligible for AD&D Ultra®.
Late Applications/Entrant	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 follows: An employee or dependent that enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee and may only enroll for coverage 30 days prior to the next plan anniversary date. The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).
Option Sales	Must be written on a full or primary replacement basis.
Medical Underwriting	▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested. ▪ Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit a completed enrollment form, which means they must complete an individual health statement and may have to submit medical evidence.
Participation	▪ For non-contributory plans, 100% participation is required. ▪ Employees may elect Life or Packaged Life/Disability insurance even if they do not elect Medical coverage, and the group must meet the required participation percentage. If not, then Life or Packaged Life/Disability will be declined for the group. Example: 9 employees, 3 waiving medical. All 9 must enroll for Life or Packaged Life/Disability. – 2 to 9 eligible 100% participation is required. – 10 to 50 eligible — 75% participation is required. – COBRA continuees are not eligible for Life. – Coverage can be denied based on in adequate participation.
Retiree Coverage	Retirees are not eligible for Life or Packaged Life/Disability Insurance coverage.

Out of State Employees

Ineligible Industries

- Basic Term Life: all industries are eligible.
- Packaged Life/Disability: the following industries are not eligible:

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

Actively at Work

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

Continuity of Coverage
(No Loss/No Gain)

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

Full-Time Hours

Full-time hour guideline will agree with the Medical guidelines

Contractual Underwriting

- Open enrollments are prohibited.
- Life is bundled with Medical at the employer level not the employee level. Therefore, a subscriber within a given group can waive Medical Underwriting coverage and still enroll for Life/AD&D.
- Life coverage can be offered to sole proprietorships, partnerships or corporations.
- Associations, Taft-Hartley groups, employee leasing firms and closed groups are not eligible for coverage and must be written individually.
- Must meet the qualifications of a small business. The same employer eligibility guidelines that apply to medical will apply to the life coverage.

Medical Underwriting

New Business Medical Evaluation

At new business time, any dependent enrolling for coverage are Guaranteed Issue and not subject to EOI.

Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts listed below will be required to submit a completed enrollment form (EOI), which means they must complete an individual health statement/questionnaire.

Case Size Basic Term Life Amount:

2 – 9 eligible employees	$20,000
10 – 25 eligible employees	$75,000
26 – 50 eligible employees	$100,000

Only those employees who have an unacceptable medical condition will be reduced to the Guaranteed Issue amount. The rest of the employees will be issued the higher amount if they medically qualify.

Evidence of Insurability (EOI)

Evidence of Insurability (evidence of good health) is required when one or more of the following conditions exist:

- Late Entrant — coverage is not requested within 31 days of eligibility for contributory coverage.
- Reinstatement or restoration of coverage is requested.
- New coverage is requested during the anniversary period.
- Coverage is requested outside of the employer's anniversary period due to qualifying life event (marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).
- Dependent coverage option was initially refused by employee but requested later. The dependent would be considered a late entrant and subject to EOI, and may be declined for medical reasons.

New Hires

- New hires wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit a completed enrollment form (EOI), which means they must complete a medical questionnaire.
- If the employee has an unacceptable medical condition; the employee will be reduced to the Guaranteed Issue amount.

Packaged Life Disability and Dental	
Product Availability	▪ 2 to 9 eligible employees — available only if packaged with Medical. ▪ 10 to 25 eligible employees — available only if packaged with either Medical or Dental. ▪ 26 to 50 eligible employees — available only if packaged with Medical or Dental or on a standalone basis. ▪ Product packaging rule is a group level requirement. ▪ Not available in New York, New Jersey, California, Rhode Island, Hawaii and Puerto Rico. ▪ Conversion options are not available.
Employer Contribution	▪ 2 to 9 eligible employees — 100% of the total cost. ▪ 10 to 50 eligible — at least 50% of the total cost (excluding Optional Dependent Term).
Employee Eligibility	▪ Permanent full-time employees who work the minimum hours required for Medical coverage as mandated by the state are eligible for insurance on the effective date of the plan, provided they are actively at work on that date. ▪ New employees will be eligible after the completion of a period of continuous active service. ▪ 1099 contractors, stockholders, partners or other outside consultants who are not active, permanent full-time employees are not eligible. Foreign nationals and expatriates are not eligible. ▪ Coverage must be extended to all employees meeting the above conditions, unless they belong to a class excluded as the result of conditions pertaining to their employment (e.g., union status or job class). ▪ Retirees are not eligible for STD coverage.
Dependent Eligibility	Same as medical
Late Applications/Entrant	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 follows: An employee or dependent that enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee and may only enroll for coverage 30 days prior to the next plan anniversary date. The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).
Option Sales	Must be written on a full or primary replacement basis.
Medical Underwriting	All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested and/or they are late entrants.
Participation	For contributory plans ▪ Groups with 2 to 9 employees — 100% participation is required. ▪ Groups with 10 to 50 employees — 75% of eligible must participate. For non-contributory plans ▪ 100% participation is required for non-contributory plans, where employer contributes 100% of the total cost. ▪ COBRA continuees are not eligible for Disability.
Retiree Coverage	Retirees are not eligible for STD coverage.

Out of State Employees

Ineligible Industries

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

Actively at Work

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

Continuity of Coverage
(No Loss/No Gain)

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

Full-Time Hours

Full-time hour guideline will agree with the Medical guidelines.

Guaranteed Issue No Medical Underwriting

Coverage is Guaranteed Issue and does not require an employee to answer any medical questions or submit to medical records or a medical exam unless:

- Reinstatement or restoration of coverage is requested, and/or
- Coverage is not requested within 31 days of eligibility for contributory coverage, and the employee is a late entrant.

Employer Eligibility

- The same employer eligibility guidelines that apply to medical apply to STD coverage. Underwriters may require IRS forms or other documents to demonstrate proof of business and employee eligibility.
- The employer must have Workers' Compensation coverage.
- 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.

LIMITATIONS AND EXCLUSIONS

MEDICAL

These plans do not cover all health care expenses and include exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

Aetna CPOS, HMO and HMO Plus, QPOS & HMO

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial)
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Aetna Open Access MC, Preferred Provider Benefits Plan (PPO) & Indemnity

- All medical or hospital services not specifically covered, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- 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
- Nonmedically necessary services or supplies
- Orthotics, as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special-duty nursing
- Those for or related to treatment of obesity or for diet or weight control

Pre-existing conditions exclusion provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 3 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 3-month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months from your first day of coverage, or if you were in a waiting period, from the day of your waiting period.

If you had prior creditable coverage within 63 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

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

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at using the number on the back of the member ID card if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

LIMITATIONS AND EXCLUSIONS

DENTAL

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

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

Specific service limitations

- DMO plans: Oral exams (4 per year)*
- PDN: 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)
  - Members who do not enroll within the first 31 days of becoming eligible may be subject to a late entrant penalty.
  - The waiting period may be waived in certain situations.

- All other limitations and exclusions in the plan documents.

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

Accidental Death and Personal Loss Coverage

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

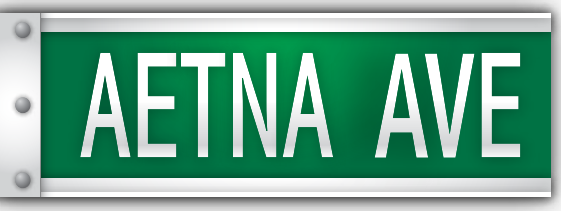
- A bodily or mental infirmity
- A disease, ptomaine or bacterial infection**
- Medical or surgical treatment**
- Suicide or attempted suicide (while sane or insane)
- An intentionally self-inflicted injury
- A war or any act of war (declared or not declared)
- Voluntary inhalation of poisonous gases
- 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 the 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 your committing or attempting to commit, a criminal act
- Is due to participation in an insurrection or rebellion
- Is due to war or any act of war (declared or not declared)

**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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