

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Pennsylvania 2–50 Plan guide



Like playing a symphony, the key to creating the right health plan is unlocking the right combination of cost and coverage

**Plans effective January 1, 2014
For businesses with 2–50 eligible employees**

www.aetna.com

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Unlocking the right health plan

Every company has its own particular needs, driven in part by the health of its employees, by its commitment to health and wellness and, of course, by its financial resources.

We believe creating the right health benefits and insurance plans means unlocking the right combination of these four options to meet a company's specific needs: **Benefits, Network, Cost sharing, Funding.**

Experience matters

Unlocking the right combination isn't a matter of chance. It's a matter of working with an experienced and knowledgeable guide. A guide like Aetna. We take the time to listen and learn about your needs, share knowledge and provide tools to help achieve the right balance of cost and coverage.

Our approach makes all the difference in the value you get from your plan, and in the satisfaction of your employees.

Today's health care environment demands a new set of solutions to meet new challenges. Together, we can unlock those solutions to create a healthy future for your company and your employees.

Unlock the Right Combination

We want to make unlocking the right benefits as easy as possible. So we've organized information in this easy-to-understand guide.

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Changes to your plan due to health care reform

Signed into law in March 2010, the Affordable Care Act is the most life-changing law passed since the passing of Medicare in the 1960s. The Affordable Care Act will shape new rules and guidance through 2014 and beyond. We are committed to following the new health care law and to helping you understand its impact.

We have outlined below key changes that may impact your health care benefits:

Essential health benefits package

As of January 1, 2014, Aetna plans must offer standard coverage known as “essential health benefits.” This includes all plans inside and outside of the health insurance exchanges. These benefits provide your employees with essential health benefits, and limit cost-sharing.

Here are the broad categories of essential benefits that will be included in your employees’ coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric dental
- Pediatric vision

Out-of-pocket (OOP) maximum mandate

Beginning in 2014, all cost sharing must apply toward the OOP maximum, including in-network medical, behavioral health and pharmacy cost-sharing. This does not include premiums, balance billing amounts of non-network providers or spending for non-covered services.

The out-of-pocket maximum must include:

- Copays
- Deductibles
- Coinsurance

Fees

These fees are included in your premium:

- Health Insurer Fee — Annual fee to offset premium subsidies and tax credit related expenses
- Transitional Reinsurance Program Contribution — Helps finance the cost of high-risk individuals in the individual market
- Patient-Centered Outcomes Research Fee (also known as the Comparative Effectiveness Fee) — Fee to fund clinical outcomes effectiveness research

Guaranteed issue

Guaranteed issue of health insurance coverage applies to individual, small group and large group markets. Guaranteed Issue is available for:

- Group Health Plans/Insurance Coverage (insured only)
- Individual Health Insurance Coverage (including medical conversion)
- Pharmacy (insured only)
- Behavioral Health (insured only)*

Please note that guaranteed issue is not available for:

- Self-funded plans
- Standalone/separate dental or vision
- Hospital Indemnity/Fixed Indemnity
- Medicare and Medicare Supplement
- Medicaid
- Retiree-only plans
- Grandfathered plans
- Association/MEWA plans

Rating rule changes

The rate review regulations are changing and we are making sure they stay affordable. We are working to protect you from rate increases without decreasing competition, reducing consumer choice of providers, or causing problems.

*Note: no standalone insured behavioral health.

Pediatric Dental/Vision

Pediatric dental and vision mandates are a separate essential health benefit category and are included with your medical benefits. We will cover those services in 2014 according to the benchmark plan coverage.

Pediatric Dental

Plan Name	Traditional HMO / HNO Only plans with no deductible	Traditional HMO / HNO Only / Indemnity plans with deductible	Consumer Directed - HMO HSA Compatible Plans	Consumer Directed - HMO HSA Compatible 6300 100% Plan	Traditional QPOS/HNO Option/ PPO plans with no in-network deductible	
	In Network	In Network	In Network	In Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	0%	0%, deductible waived	0% after deductible	0% after deductible	0%	30%, deductible waived
Dental Basic	30%	30% after deductible	30% after deductible	0% after deductible	30%	50% after deductible
Dental Major	50%	50% after deductible	50% after deductible	0% after deductible	50%	50% after deductible
Dental Ortho	50%	50% after deductible	50% after deductible	0% after deductible	50%	50% after deductible

Plan Name	Traditional QPOS/HNO Option/ PPO plans with in-network deductible		Consumer Directed — HNO Option and PPO HSA Compatible plans		Consumer Directed — HNO Option and PPO HSA Compatible 6300 100% plans	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Dental Check-Up (aka preventive/diagnostic)	0%, deductible waived	30%, deductible waived	0% after deductible	30% after deductible	0% after deductible	30% after deductible
Dental Basic	30% after deductible	50% after deductible	30% after deductible	50% after deductible	0% after deductible	50% after deductible
Dental Major	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible
Dental Ortho	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible

These plans do not cover all dental expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

Pediatric Vision

Plan Name	Traditional HMO/HNOnly plans with no deductible	Traditional HMO/HNOnly/ Indemnity plans with deductible	Consumer Directed — HMO HSA Compatible Plans	Consumer Directed — HMO HSA Compatible 6300 100% Plan	Traditional QPOS/HNOption/ PPO plans with no in-network deductible	
	In Network	In Network	In Network	In Network	In Network	Out of Network
Vision exam (one exam per 12 months)	0%	0%, deductible waived	0%, deductible waived	0%, deductible waived	0%	50% after deductible
Preferred eyeglass frames, prescription lenses or prescription contact lenses*	0%	0%, deductible waived	0% after deductible	0% after deductible	0%	50% after deductible
Non-Preferred eyeglass frames, prescription lenses or prescription contact lenses*	50%	50% after deductible	50% after deductible	0% after deductible	50%	50% after deductible

Plan Name	Traditional QPOS/HNOption/ PPO plans with in-network deductible		Consumer Directed — HNOption and PPO HSA Compatible plans		Consumer Directed — HNOption and PPO HSA Compatible 6300 100% plans	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Vision exam (one exam per 12 months)	0%, deductible waived	50% after deductible	0%, deductible waived	50% after deductible	0%, deductible waived	50% after deductible
Preferred eyeglass frames, prescription lenses or prescription contact lenses*	0%, deductible waived	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible
Non-Preferred eyeglass frames, prescription lenses or prescription contact lenses*	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible

* The pediatric vision plan will cover the following:

- One set of eyeglass frames per 12 months.
- One pair of prescription lenses per 12 months
- Prescription contact lenses maximum per 12 months: daily disposables (up to 3 month supply), extended wear disposable (up to 6 month supply) and nondisposable lenses (one set).
- Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months. Coverage does not include the office visit for the fitting of prescription contact lenses.

These plans do not cover all vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

Unlocking the right plan for your business

Our product portfolio includes a range of coverage and cost combinations. You'll find choices for different budgets and benefits strategies. And you'll see that we're more than medical. You can round out your benefits offering with dental as well as life and disability offerings.

Take a look at what's available.

Medical plans

- Traditional Plans
- Consumer-Directed Plans

Plan levels

Our health plans will now be assigned a metallic level. The level is based on how much of the total health care cost the plan pays, versus what members pay out of pocket. The levels are called bronze, silver, gold and platinum.

Health plan levels	Average amount the plan pays for covered services
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

You'll soon be seeing many changes in health insurance, thanks to health care reform. Many of them affect your business. And some of them might be confusing. Visit the health care reform section on www.aetna.com for more information. Or talk with your broker.

Tools to help your employees stay healthy, informed and productive

With Aetna health plans, your employees get online tools and helpful resources that let them make the most of their benefits. Our most popular tools include:

- **Secure member website.** Your employees get self-service tools, plus health plan and health information through their Aetna Navigator® website. Think of it as the key that unlocks the full value of their health benefits package. Encourage them to sign up at www.aetna.com.
- **Member Payment Estimator.** With an Aetna health plan, your employees can compare and estimate costs* for office visits, tests, surgeries and more. This means they can save money** — and avoid surprises. This online tool factors in their deductible, coinsurance and copays, plus contracted rates. They can see how much they have to pay and how much the plan will pay. They can log in to their Aetna Navigator member website to use the tool.
- **Online provider directory.** Finding doctors, specialists, hospitals and more in the Aetna network is easy with our DocFind® directory. It's available at www.aetna.com and the Aetna Navigator member website.
- **My Life Values.** Your employees get 24/7 online services and support for managing their everyday personal and work matters.

*Estimated costs not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that very point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted. Or, if the doctor or facility performs a different service at the time of your visit.

**In 2011, members who used Member Payment Estimator before receiving care saved an average of \$170 out of pocket on 34 common procedures, according to the Member Payment Estimator Study, Aetna Informatics and Product Development, August 2012.

Dental plans

- Dental Maintenance Organization or DMO® plan
- PPO
- PPO Max
- Freedom-of-Choice plan design

Dental plan extras

There's extra value built into our dental portfolio:

- **Dental-medical integration.** Our program encourages preventive dental care among employees who have diabetes or heart disease, or who are pregnant. This can lead to more of your employees taking steps to stay healthy.
- **Dental discounts.** Aetna ValuePassSM, a MasterCard® pre-paid card, is a flexible way to give employees access to our nationwide network of dental services at discounted rates. It guarantees savings that range from 15%–50% off the average retail cost of dental services.* Offer it alongside your current dental plan, as a voluntary plan with no employer contribution, or as a replacement for your current dental benefit, through defined contribution.

Life and disability plans

- Basic life
- Supplemental life
- AD&D Ultra®
- Supplemental AD&D Ultra®
- Dependent life
- Life and disability plans

Life & Disability Plan Extras

- **Aetna Life EssentialsSM.** Through our program, your employees get access to expert advice on legal and financial matters — at no added cost. Plus, they get discounts on health products and services, like fitness and vision care.**
- **Funeral planning and concierge service.** Through our partnership with Everest, we offer our life members pre-planning and at-need services.
- **Aetna Return to Work SolutionsSM Program.** Our return to work solutions provide customers with the support and resources they need to help get valued employees back to work safely and as soon as possible.

*Savings are based on average retail charges in the geographic area and Aetna's negotiated rates. Actual retail charges and discounts provided by Aetna ValuePass participating providers will vary.

**These services are discount programs, not insurance.

The Aetna ValuePassSM program (the “Program”) is NOT insurance. The Program provides cardholders with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company (“Aetna”), 151 Farmington Avenue, Hartford, CT 06156, **1-888-215-6578**, with dental providers (the “Aetna ValuePass Participating Providers”) in the Aetna Dental Access(R) network. Aetna is the Discount Medical Plan Organization. Your Card may be used at any dental provider, but you will only receive discounted fees at Aetna ValuePass Participating Providers. The range of discounts provided under the Program will vary depending on the type of Aetna ValuePass Participating Provider and type of services received. The Card provides payments directly to the providers accepting payment using the funds on your Card. In order to receive a discount, you must use the Card to pay for services or products furnished by the Aetna ValuePass Participating Providers.

www.aetnavaluepass.com.

Together, we'll unlock the right combination of benefits, network, cost-sharing and funding options for you and your employees.

About our benefits

Choose from numerous, integrated benefits options that can lead to improved employee engagement and health, while helping you manage your costs. This includes medical, pharmacy, dental, life, disability and vision. Plus, online tools that help employees use their benefits wisely and get help when they need it.

About our network

We have many full-network options to lower employer costs while still providing employees with access to quality care. Our doctor networks prioritize quality and efficiency to improve the health care experience and make it easy for individuals to get the care they need.

About our cost sharing

Some of our cost sharing arrangements encourage employees to become more involved in their own health care and become better health care consumers. Employees with these plans receive more preventive care, have lower overall costs and use online tools more frequently.

About our funding options

We can show you how a combined network, cost sharing and benefits approach can help you manage your premium to meet your budget. We also offer a range of funding options—from traditional fully insured to enhanced self-insured solutions—that provide different levels of cost, plan control and information access.

Cost-sharing and premiums for every budget

Your focus is on lower costs. Increasingly, that means greater levels of employee cost sharing. With Aetna in your corner, you can map out a strategy based on your employee base and price point. And you can choose from the full spectrum of health plan types:

- Our fully-insured portfolio, traditionally a mainstay for small businesses, provides plans with a range of robust coverage options.
- Emerging self-funded options for small businesses may help you manage costs while offering the needed administrative support.
- Our defined contribution offering combines an attractive benefits package with more predictable costs. As well as motivation for your employees to get more involved in their health care.
- Our consumer-directed health plans have long offered fully featured coverage, along with lower premiums and higher deductibles. Our research has found that members with Aetna HealthFund® plans have lower overall health care costs, receive more preventive care and use online tools more frequently than members with traditional plans.

We can help you unlock What's Your Healthy?SM

Unlock health and wellness

Having a happier, healthier workforce is important to you. So is cost management. We've found that helping your employees get more involved in managing their health and well-being is a great way to meet these goals. Talk to your broker or Aetna representative to learn more about our programs.

Health assessment and screening incentive*

Members can earn \$50 in just a few simple steps. If the employee's spouse is covered under the plan, he or she is also eligible for the same incentive. So a family could earn up to \$100 incentive each year. Here's how:

- Complete or update their Snapshot[®] health assessment on Simple Steps To A Healthier Life[®], and
- Complete a biometric screening

Wellness programs can make health and fitness part of everyday living

- Women's health and preventive health reminders
- Simple Steps To A Healthier Life[®] program
- Informed Health[®] Line
- Healthy Lifestyles coaching
- 24-hour nurse line
- Aetna discount programs
- Personal health record

Women's preventive health benefits

These services are generally covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Preferred generic contraceptives and certain preferred brand contraceptives are covered without member copayment. Certain religious organizations or religious employers may be exempt from offering contraceptive services

We make things easy for you

Health plan management and administration is our specialty, which makes it easier for you to manage health insurance benefits with:

- **eEnrollment.** Handle enrollments, terminations and other changes online, with less paperwork and greater efficiency.
- **eBilling.** Save time and simplify reconciliation and payment, anytime, anywhere, with our secure system. It lets you get, view and pay all your medical and dental bills online.

*Incentive rewards will be offered in the form of a gift card. This program is included at no additional cost on all plans.

Aetna Medical Overview

Medical coverage can be a deal-breaker in recruiting and keeping talented employees. Our medical plan portfolio was designed with the needs of businesses like yours in mind. You'll find flexible options, from traditional indemnity to consumer-directed plans. You can choose the plan design and benefits level that fits your budget and achieve the right combination of cost and coverage for your business.

Medical Overview

At Aetna, we are committed to putting the member at the center of everything we do. You can count on us to provide health plans that help simplify decision making and plan administration so you can focus on the health of your business.

Pennsylvania provider network*

HMO, Health Network Only, QPOS, Health Network Option & PPO Plans

Adams	Clarion	Lackawanna	Pike
Allegheny	Clinton	Lancaster	Schuylkill
Armstrong	Columbia	Lawrence	Snyder
Beaver	Cumberland	Lebanon	Somerset
Bedford	Dauphin	Lehigh	Sullivan
Berks	Delaware	Luzerne	Susquehanna
Blair	Erie	Lycoming	Venango
Bradford	Fayette	Mercer	Washington
Bucks	Franklin	Monroe	Wayne
Butler	Fulton	Montgomery	Westmoreland
Cambria	Greene	Northampton	Wyoming
Carbon	Indiana	Perry	York
Chester	Jefferson	Philadelphia	

PPO Plans Only

Cameron	McKean
Centre	Mifflin
Clearfield	Montour
Crawford	Potter
Elk	Tioga
Forest	Union
Huntingdon	Warren
Juniata	

*Network subject to change.

Product information

Plan Name	Product Description	PCP Required	Referrals Required	Network
HMO	A health maintenance organization (HMO) uses a network of participating providers. Each family member selects a primary care physician (PCP) participating in the Aetna network. The PCP provides routine and preventive care and helps coordinate the member's total health care. The PCP refers members to participating specialists and facilities for medically necessary specialty care. Only services provided or referred by the PCP are covered, except for emergency, urgently needed care or direct-access benefits, unless approved by the HMO in advance of receiving services.	Yes	Yes	HMO
Health Network Only (HNOOnly)	A health maintenance organization (HMO) uses a network of participating providers. Each family member may select a primary care physician (PCP) participating in the Aetna network to provide routine and preventive care and help coordinate the member's total health care. Members never need a referral when visiting a participating specialist for covered services. Only services rendered by a participating provider are covered, except for emergency or urgently needed care.	Optional	No	Aetna Health Network Only SM (Open Access)
QPOS[®]	QPOS (Quality Point-of-Service [®]) is a two-tiered product that allows members to access care in one of two ways: 1. PCP referred in network, 2. Self-referred, in or out of network Members have lower out-of-pocket costs when they use the HMO (referred) tier of the plan and follow the PCP referral process. Member cost sharing increases if members decide to self-refer in or out of network.	Yes	Yes for PCP-referred care. No for self-referred care.	QPOS [®]
Health Network Option (HNOOption)	Health Network Option (HNOOption) is a two-tiered product that allows members to access care in or out of network. Members have lower out-of-pocket costs when they use the in-network tier of the plan. Member cost sharing increases if members decide to go out of network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care.	Optional	No	Aetna Health Network Option SM (Open Access)
PPO	PPO plan members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either participating providers at lower out-of-pocket costs, or nonparticipating providers at higher out-of-pocket costs.	No	No	Open Choice [®] PPO
Indemnity	PPO plan members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either participating providers at lower out-of-pocket costs, or nonparticipating providers at higher out-of-pocket costs.	No	No	N/A

Aetna high-deductible HSA-compatible HMO / Health Network Option (Open Access)/PPO plans

Aetna high-deductible HSA-compatible HMO, health network option (open access) and PPO health plans are compatible with a health savings account (HSA). HSA-compatible plans provide integrated medical and pharmacy benefits.

HSAs 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 help cover their future medical and dental expenses. HSAs 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.

Note: Employers and employees should consult with their tax advisor to determine eligibility requirements and tax advantages for participation in the HSA plan.

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 will not be subject to the deductible
- You pay 100 percent until deductible is met, then only pay a share of the cost
- Meet out-of-pocket maximum, then plan pays 100 percent

Health Reimbursement Arrangement (HRA)

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

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

COBRA administration

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

Section 125 cafeteria plans and Section 132 Transit Reimbursement Accounts

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

Premium-Only Plans (POP)

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

Flexible Savings Account (FSA)

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

Transit Reimbursement Account (TRA)

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

Group situs

Medical and dental benefits and rates are based on the group's headquarters location, subject to applicable state laws. Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA and VA (the situs region) will receive the same rates and benefits as the headquarters location.

Multi-state solution

We offer a multi-state solution to make it easier for businesses like yours to do business with us. We believe it brings more consistency across medical benefits offerings to employers with employees in multiple locations.

Employers based in Pennsylvania can offer PA PPO plans to their employees who live and work outside of the “situs” region. The situs region comprises the following eight states – PA, NJ, DE, MD, DC, VA, NY and CT.

The rates and benefits will match those offered in Pennsylvania. If the out-of-situs employee lives in a non-network area, the employee will be enrolled in an indemnity plan. Plan sponsors will need to continue to meet underwriting guidelines, subject to all applicable state laws.

In all instances, extraterritorial benefits that may apply on any of the out-of-situs employees will be implemented where required.

Administrative Fees

Fee description	Fee	
Premium Only Plan (POP)		
Initial set-up*	\$190	
Monthly fees	\$125	
Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA)**		
	Initial set-up	Renewal fee
2–25 Employees	\$360	\$235
Monthly Fees†	\$5.45 per participant	
Additional set-up fee For “stacked” plans (those electing an Aetna HRA and FSA simultaneously)	\$150	
Participation fee for “stacked” participants	\$10.45 per participant	
Minimum fees		
0–25 Employees	\$25 per month minimum	
26–50 Employees	\$50 per month minimum	
COBRA Services		
Annual fee		
20–50 Employees	\$165	
Per employee per month		
20–50 Employees	\$0.95	
Initial notice fee	\$3.00 per notice (includes notices at time of implementation and during ongoing administration)	
Minimum fees		
20–50 Employees	\$25 per month minimum	
Transit Reimbursement Account (TRA)		
Annual fee	\$350	
Transit monthly fees	\$4.25 per participant	
Parking monthly fees	\$3.15 per participant	

*Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for \$100 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. For FSA, the debit card is available for an additional \$1 per participant per month. Mailing reimbursement checks direct to employee homes is an additional \$1 per participant per month.

Aetna HRAs are subject to employer-defined use and forfeiture rules. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information subject to change.

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

Traditional – HMO and HNOly Plans

Plan Name Referral Plan Open Access Plan	PA Gold HMO 500D \$25 PA Gold HNOly 500D \$25	PA Gold HMO 600D \$35 PA Gold HNOly 600D \$35	PA Gold HMO 600D \$45 PA Gold HNOly 600D \$45	PA Gold HMO 1000 100% PA Gold HNOly 1000 100%
Member benefits	Participating Providers	Participating Providers	Participating Providers	Participating Providers
Plan Year Deductible²	\$0 Individual / \$0 Family	\$0 Individual / \$0 Family	\$0 Individual / \$0 Family	\$1,000 Individual / \$2,000 Family
Plan Year Out-of-Pocket Limit	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses	Non-covered expenses	Non-covered expenses	Non-covered expenses
Primary Care Physician Office Visit	\$25 copay	\$35 copay	\$45 copay	\$25 copay, deductible waived
Specialist Office Visit	\$50 copay	\$60 copay	\$65 copay	\$50 copay, deductible waived
Walk-In Clinic Visit	\$25 copay	\$35 copay	\$45 copay	\$25 copay, deductible waived
Chiropractic Services (20 visits per plan year)	25%	25%	25%	25%, deductible waived
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	\$0 copay	\$0 copay	\$0 copay	\$0 copay, deductible waived
Diagnostic Testing: Lab	\$15 copay	\$15 copay	\$15 copay	\$10 copay, deductible waived
Diagnostic Testing: X-ray	\$50 copay	\$60 copay	\$65 copay	\$50 copay, deductible waived
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$250 copay	\$300 copay	\$350 copay	\$300 copay, deductible waived
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	\$10/\$50/\$125	\$10/\$50/\$125	\$10/\$50/\$125
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000
Outpatient Surgery	\$500 copay	\$600 copay	\$600 copay	\$0 copay after deductible
Emergency room (Copay is waived if admitted.)	\$250 copay	\$300 copay	\$350 copay	\$300 copay, deductible waived
Urgent care	\$75 copay	\$75 copay	\$75 copay	\$75 copay, deductible waived
Inpatient hospital	\$500 copay per day, 5 day copay max per admission	\$600 copay per day, 5 day copay max per admission	\$600 copay per day, 5 day copay max per admission	\$0 copay after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	\$50 copay	\$60 copay	\$65 copay	\$50 copay, deductible waived

refer to pages 28–29 for important plan provisions.

Traditional – HMO and HNOly Plans

Plan Name Referral Plan Open Access Plan	PA Silver HMO 2000 100% PA Silver HNOly 2000 100%	PA Silver HMO 1000 60% PA Silver HNOly 1000 60%	PA Silver HMO 1500 50% PA Silver HNOly 1500 50%	PA Silver HMO 2000 50% PA Silver HNOly 2000 50%
Member benefits	Participating Providers	Participating Providers	Participating Providers	Participating Providers
Plan Year Deductible²	\$2,000 Individual / \$4,000 Family	\$1,000 Individual / \$2,000 Family	\$1,500 Individual / \$3,000 Family	\$2,000 Individual / \$4,000 Family
Plan Year Out-of-Pocket Limit	\$6,350 Individual / \$12,700 Family	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family	\$5,000 Individual / \$10,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses	Non-covered expenses	Non-covered expenses	Non-covered expenses
Primary Care Physician Office Visit	\$45 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Specialist Office Visit	\$75 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Walk-In Clinic Visit	\$45 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year)	25%, deductible waived	25% after deductible	25% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and Frequency schedules may apply.)	\$0 copay, deductible waived	0%, deductible waived	0%, deductible waived	0%, deductible waived
Diagnostic Testing: Lab	\$25 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Diagnostic Testing: X-ray	\$75 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$350 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	\$10/\$50/\$125	\$10/\$50/\$125	\$10/\$50/\$125
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000
Outpatient Surgery	\$0 copay after deductible	40% after deductible	50% after deductible	50% after deductible
Emergency room (Copay is waived if admitted.)	\$350 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Urgent care	\$75 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible
Inpatient hospital	\$0 copay after deductible	40% after deductible	50% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	\$75 copay, deductible waived	40% after deductible	50% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Consumer-Directed – HMO HSA-Compatible Plans

Plan Name	PA Silver HMO 2000 100% HSA	PA Silver HMO 2000 90% HSA	PA Bronze HMO 3000 HSA	PA Bronze HMO 4500 100% HSA
Member Benefits	Participating Providers	Participating Providers	Participating Providers	Participating Providers
Plan Year Deductible²	\$2,000 Individual / \$4,000 Family	\$2,000 Individual / \$4,000 Family	\$3,000 Individual / \$6,000 Family	\$4,500 Individual / \$9,000 Family
Plan Year Out-of-Pocket Limit	\$6,350 Individual / \$12,700 Family	\$6,350 Individual / \$12,700 Family	\$6,350 Individual / \$12,700 Family	\$6,350 Individual / \$12,700 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses	Non-covered expenses	Non-covered expenses	Non-covered expenses
Primary Care Physician Office Visit	0% after deductible	10% after deductible	\$40 copay after deductible	0% after deductible
Specialist Office Visit	0% after deductible	10% after deductible	\$60 copay after deductible	0% after deductible
Walk-In Clinic Visit	0% after deductible	10% after deductible	\$40 copay after deductible	0% after deductible
Chiropractic Services (20 visits per plan year)	0% after deductible	10% after deductible	25% after deductible	0% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	0%, deductible waived	0%, deductible waived	0%, deductible waived	0%, deductible waived
Diagnostic Testing: Lab	0% after deductible	10% after deductible	\$15 copay after deductible	0% after deductible
Diagnostic Testing: X-ray	0% after deductible	10% after deductible	\$60 copay after deductible	0% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	0% after deductible	10% after deductible	\$300 copay after deductible	0% after deductible
Prescription Drug Deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125 after deductible	\$10/\$50/\$125 after deductible	\$10/\$50/\$125 after deductible	\$10/\$50/\$125 after deductible
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible
Outpatient Surgery	0% after deductible	10% after deductible	\$500 copay after deductible	0% after deductible
Emergency room (Copay is waived if admitted.)	0% after deductible	10% after deductible	\$300 copay after deductible	0% after deductible
Urgent care	0% after deductible	10% after deductible	\$75 copay after deductible	0% after deductible
Inpatient hospital	0% after deductible	10% after deductible	\$500 copay per day, 5 day copay max per admission, after deductible	0% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	0% after deductible	10% after deductible	\$60 copay after deductible	0% after deductible

refer to pages 28–29 for important plan provisions.

Consumer-Directed – HMO HSA-Compatible Plans

Plan Name	PA Bronze HMO 6300 100% HSA
Member Benefits	Participating Providers
Plan Year Deductible²	\$6,300 Individual / \$12,600 Family
Plan Year Out-of-Pocket Limit	\$6,300 Individual / \$12,600 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses
Primary Care Physician Office Visit	0% after deductible
Specialist Office Visit	0% after deductible
Walk-In Clinic Visit	0% after deductible
Chiropractic Services (20 visits per plan year)	0% after deductible
Preventive Care/Screenings/Immunizations (Age and Frequency schedules may apply.)	0%, deductible waived
Diagnostic Testing: Lab	0% after deductible
Diagnostic Testing: X-ray	0% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	0% after deductible
Prescription Drug Deductible	Integrated with medical deductible
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	0% after deductible
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	0% after deductible
Outpatient Surgery	0% after deductible
Emergency room	0% after deductible
Urgent care	0% after deductible
Inpatient hospital	0% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	0% after deductible

refer to pages 28–29 for important plan provisions.

Traditional – QPOS, HNOption and PPO Plans

Plan Name Referral Plan Open Access Plans	PA Gold QPOS 500D \$25 PA Gold HNOption 500D \$25 PA Gold PPO 500D \$25		PA Gold QPOS 600D \$35 PA Gold HNOption 600D \$35 PA Gold PPO 600D \$35	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$0 Individual / \$0 Family	\$5,000 Individual / \$10,000 Family	\$0 Individual / \$0 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	\$25 copay	50% after deductible	\$35 copay	50% after deductible
Specialist Office Visit	\$50 copay	50% after deductible	\$60 copay	50% after deductible
Walk-In Clinic Visit	\$25 copay	50% after deductible	\$35 copay	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	25%	25% after deductible	25%	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	\$0 copay	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	\$0 copay	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	\$15 copay	50% after deductible	\$15 copay	50% after deductible
Diagnostic Testing: X-ray	\$50 copay	50% after deductible	\$60 copay	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$250 copay	50% after deductible	\$300 copay	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered
Outpatient Surgery	\$500 copay	50% after deductible	\$600 copay	50% after deductible
Emergency room (Copay is waived if admitted.)		\$250 copay		\$300 copay
Urgent care	\$75 copay	50% after deductible	\$75 copay	50% after deductible
Inpatient hospital	\$500 copay per day, 5 day copay max per admission	50% after deductible	\$600 copay per day, 5 day copay max per admission	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	\$50 copay	50% after deductible	\$60 copay	50% after deductible

refer to pages 28–29 for important plan provisions.

Traditional – QPOS, HNOption and PPO Plans

Plan Name Referral Plan Open Access Plans	PA Gold QPOS 600D \$45 PA Gold HNOption 600D \$45 PA Gold PPO 600D \$45		PA Gold QPOS 1000 100% PA Gold HNOption 1000 100% PA Gold PPO 1000 100%	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$0 Individual / \$0 Family	\$5,000 Individual / \$10,000 Family	\$1,000 Individual / \$2,000 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	\$45 copay	50% after deductible	\$25 copay, deductible waived	50% after deductible
Specialist Office Visit	\$65 copay	50% after deductible	\$50 copay, deductible waived	50% after deductible
Walk-In Clinic Visit	\$45 copay	50% after deductible	\$25 copay, deductible waived	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	25%	25% after deductible	25%, deductible waived	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	\$0 copay	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	\$0 copay, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	\$15 copay	50% after deductible	\$10 copay, deductible waived	50% after deductible
Diagnostic Testing: X-ray	\$65 copay	50% after deductible	\$50 copay, deductible waived	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$350 copay	50% after deductible	\$300 copay, deductible waived	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered
Outpatient Surgery	\$600 copay	50% after deductible	\$0 copay after deductible	50% after deductible
Emergency room (Copay is waived if admitted.)	\$350 copay		\$300 copay, deductible waived	
Urgent care	\$75 copay	50% after deductible	\$75 copay, deductible waived	50% after deductible
Inpatient hospital	\$600 copay per day, 5 day copay max per admission	50% after deductible	\$0 copay after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	\$65 copay	50% after deductible	\$50 copay, deductible waived	50% after deductible

refer to pages 28–29 for important plan provisions.

Traditional – QPOS, HNOption and PPO Plans

Plan Name Referral Plan Open Access Plans	PA Silver QPOS 2000 100% PA Silver HNOption 2000 100% PA Silver PPO 2000 100%		PA Silver QPOS 1000 60% PA Silver HNOption 1000 60% PA Silver PPO 1000 60%	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$2,000 Individual / \$4,000 Family	\$5,000 Individual / \$10,000 Family	\$1,000 Individual / \$2,000 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$6,350 Individual / \$12,700 Family	\$10,000 Individual / \$20,000 Family	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	\$45 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Specialist Office Visit	\$75 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Walk-In Clinic Visit	\$45 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	25%, deductible waived	25% after deductible	25% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	\$0 copay, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	\$25 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Diagnostic Testing: X-ray	\$75 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$350 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered
Outpatient Surgery	\$0 copay after deductible	50% after deductible	40% after deductible	50% after deductible
Emergency room (Copay is waived if admitted.)	\$350 copay, deductible waived		40% after deductible	
Urgent care	\$75 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible
Inpatient hospital	\$0 copay after deductible	50% after deductible	40% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	\$75 copay, deductible waived	50% after deductible	40% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Traditional – QPOS, HNOption and PPO Plans

Plan Name Referral Plan Open Access Plans	PA Silver QPOS 1500 50% PA Silver HNOption 1500 50% PA Silver PPO 1500 50%		PA Silver QPOS 2000 50% PA Silver HNOption 2000 50% PA Silver PPO 2000 50%	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$1,500 Individual / \$3,000 Family	\$5,000 Individual / \$10,000 Family	\$2,000 Individual / \$4,000 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Specialist Office Visit	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Walk-In Clinic Visit	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	25% after deductible	25% after deductible	25% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Diagnostic Testing: X-ray	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%	\$10/\$50/\$125	QPOS/HNOption: Not Covered PPO: \$10/\$50/\$125 + 30%
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered	Preferred: 50% up to \$500; Non-Preferred: 50% up to \$1,000	Not Covered
Outpatient Surgery	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Emergency room	50% after deductible		50% after deductible	
Urgent care	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient hospital	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Consumer-Directed – HNOption / PPO HSA-Compatible Plans

Plan Name HNOption Plan PPO Plan	PA Silver HNOption 2000 100% HSA PA Silver PPO 2000 100% HSA		PA Silver HNOption 2000 90% HSA PA Silver PPO 2000 90% HSA	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$2,000 Individual / \$4,000 Family	\$5,000 Individual / \$10,000 Family	\$2,000 Individual / \$4,000 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$6,350 Individual / \$12,700 Family	\$10,000 Individual / \$20,000 Family	\$6,350 Individual / \$12,700 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Specialist Office Visit	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Walk-In Clinic Visit	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	0% after deductible	25% after deductible	10% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Diagnostic Testing: X-ray	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Prescription Drug Deductible	Integrated with medical deductible	Refer to Prescription Drugs	Integrated with medical deductible	Refer to Prescription Drugs
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125 after deductible	HNOption: Not Covered PPO: \$10/\$50/\$125 + 30% after deductible	\$10/\$50/\$125 after deductible	HNOption: Not Covered PPO: \$10/\$50/\$125 + 30% after deductible
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Not Covered	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Not Covered
Outpatient Surgery	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Emergency room	0% after deductible		10% after deductible	
Urgent care	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Inpatient hospital	0% after deductible	50% after deductible	10% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	0% after deductible	50% after deductible	10% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Consumer-Directed – HNOption / PPO HSA-Compatible Plans

Plan Name HNOption Plan PPO Plan	PA Bronze HNOption 3000 HSA PA Bronze PPO 3000 HSA		PA Bronze HNOption 4500 100% HSA PA Bronze PPO 4500 100% HSA	
Member Benefits	Participating Providers	Non-Participating Providers ¹	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$3,000 Individual / \$6,000 Family	\$5,000 Individual / \$10,000 Family	\$4,500 Individual / \$9,000 Family	\$5,000 Individual / \$10,000 Family
Plan Year Out-of-Pocket Limit	\$6,350 Individual / \$12,700 Family	\$10,000 Individual / \$20,000 Family	\$6,350 Individual / \$12,700 Family	\$10,000 Individual / \$20,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.		Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	\$40 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Specialist Office Visit	\$60 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Walk-In Clinic Visit	\$40 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	25% after deductible	25% after deductible	0% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	\$15 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Diagnostic Testing: X-ray	\$60 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	\$300 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Prescription Drug Deductible	Integrated with medical deductible	Refer to Prescription Drugs	Integrated with medical deductible	Refer to Prescription Drugs
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	\$10/\$50/\$125 after deductible	HNOption: Not Covered PPO: \$10/\$50/\$125 + 30% after deductible	\$10/\$50/\$125 after deductible	HNOption: Not Covered PPO: \$10/\$50/\$125 + 30% after deductible
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Not Covered	Preferred: 50% up to \$500 after deductible; Non-Preferred: 50% up to \$1,000 after deductible	Not Covered
Outpatient Surgery	\$500 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Emergency room (Copay is waived if admitted.)	\$300 copay after deductible		0% after deductible	
Urgent care	\$75 copay after deductible	50% after deductible	0% after deductible	50% after deductible
Inpatient hospital	\$500 copay per day, 5 day copay max per admission, after deductible	50% after deductible	0% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	\$60 copay after deductible	50% after deductible	0% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Consumer-Directed – HNOption / PPO HSA-Compatible Plans

Plan Name HNOption Plan PPO Plan

PA Bronze HNOption 6300 100% HSA PA Bronze PPO 6300 100% HSA

Member Benefits	Participating Providers	Non-Participating Providers ¹
Plan Year Deductible²	\$6,300 Individual / \$12,600 Family	\$10,000 Individual / \$20,000 Family
Plan Year Out-of-Pocket Limit	\$6,300 Individual / \$12,600 Family	\$20,000 Individual / \$40,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.	
Primary Care Physician Office Visit	0% after deductible	50% after deductible
Specialist Office Visit	0% after deductible	50% after deductible
Walk-In Clinic Visit	0% after deductible	50% after deductible
Chiropractic Services (20 visits per plan year. Participating and Non-Participating combined.)	0% after deductible	25% after deductible
Preventive Care/Screenings/Immunizations (Age and Frequency schedules may apply.)	0%, deductible waived	50% after deductible (Deductible waived for child immunizations and routine gyn exam)
Diagnostic Testing: Lab	0% after deductible	50% after deductible
Diagnostic Testing: X-ray	0% after deductible	50% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	0% after deductible	50% after deductible
Prescription Drug Deductible	Integrated with medical deductible	Refer to Prescription Drugs
Prescription Drugs (up to 30-day supply) ⁴ : Preferred generic drugs / Preferred brand drugs / Non-preferred generic and brand drugs. Two-times the 30-day supply cost-sharing for up to 90-day supply.	0% after deductible	HNOption: Not Covered PPO: 30% after deductible
Aetna Specialty CareRxSM Drugs⁴ (up to 30-day supply for self-injectable, infused and oral specialty drugs, excludes insulin)	0% after deductible	Not Covered
Outpatient Surgery	0% after deductible	50% after deductible
Emergency room	0% after deductible	
Urgent care	0% after deductible	50% after deductible
Inpatient hospital	0% after deductible	50% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Participating and Non-Participating combined.)	0% after deductible	50% after deductible

refer to pages 28–29 for important plan provisions.

Traditional – Indemnity Plan

Plan Name	PA Silver Indemnity 2000 80%
Member Benefits	Non-Participating Providers ¹
Plan Year Deductible²	\$2,000 Individual / \$4,000 Family
Plan Year Out-of-Pocket Limit	\$6,000 Individual / \$12,000 Family
Deductible and Out-of-Pocket Limit Accumulation³	Non-Embedded
Not Included In Out-of-Pocket Limit	Non-covered expenses, balance-billed charges and failure to precertify penalties.
Primary Care Physician Office Visit	20% after deductible
Specialist Office Visit	20% after deductible
Walk-In Clinic Visit	20% after deductible
Chiropractic Services (20 visits per plan year)	20% after deductible
Preventive Care/Screenings/Immunizations (Age and frequency schedules may apply.)	0%, deductible waived
Diagnostic Testing: Lab	20% after deductible
Diagnostic Testing: X-ray	20% after deductible
Imaging (MRA/MRS, MRI, PET and CAT scans)	20% after deductible
Prescription Drug Deductible	Integrated with medical deductible
Prescription Drugs	20% after deductible
Aetna Specialty CareRxSM Drugs	20% after deductible
Outpatient Surgery	20% after deductible
Emergency room	20% after deductible
Urgent care	20% after deductible
Inpatient hospital	20% after deductible
Rehabilitation services (PT/OT/ST) (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	20% after deductible

Important plan provisions

¹QPOS, HNOption and PPO Plans:

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

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

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

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

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

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

¹Indemnity Plan:

Payment for care is determined based upon the lowest of: the provider’s usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as “reasonable” or “recognized” charges.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify or obtain prior approval for certain services.

Note: For a summary list of Limitations and Exclusions, refer to page 66. Please refer to Aetna’s Producer World® web site at www.aetna.com for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna Sales Representative.

²Deductible credit and deductible carryover do not apply.

³The individual deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible can be met by a combination of family members or by any single individual within the family. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the plan year. For plans with in and out of network benefits, all covered expenses accumulate separately toward the in-network and out-of-network deductibles.

³The individual out-of-pocket limit can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family out-of-pocket limit is met, all family members will be considered as having met their out-of-pocket limit for the remainder of the plan year. All amounts paid as deductible, copayment and coinsurance for covered medical services and supplies and prescription drugs apply toward the out-of-pocket limit. For plans with in and out of network benefits, all covered expenses accumulate separately toward the in-network and out-of-network out-of-pocket limits.

⁴RX Plan Provisions:

- Preferred generic contraceptives and certain preferred brand contraceptives are covered without member copayment. Certain religious organizations or religious employers may be exempt from offering contraceptive services.
- Contraceptives and diabetic supplies included.
- If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable copayment.
- Transition of coverage for prior authorizations and step therapy helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization and step-therapy requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization and step-therapy edits will apply to all drugs requiring prior authorization and step therapy as listed in the formulary guide. Members, who have claims paid for a drug requiring prior authorization and step therapy during the transition of coverage period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization or approval for a medical exception for this drug.

Aetna Dental Plans

Dental coverage is sure to put a smile on an employee's face. Our affordable plan design options make it possible for you to add this valuable benefit to your package.

Dental Overview

The Mouth MattersSM

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

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

The Dental Maintenance Organization (DMO)[®]

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

Preferred Provider Organization (PPO) plan

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

PPO Max plan

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

Freedom-of-Choice plan design option

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

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.

Aetna Dental Preventive CareSM plan

The Aetna Dental preventive Care plan is a lower cost dental plan that covers preventive and diagnostic procedures. Members pay nothing for these services when visiting an Aetna PPO dentist.

¹MayoClinic.com. "Oral health: A window to your overall health." www.mayoclinic.com/health/dental/DE00001 [article online]. February 5, 2011. Accessed August 2013.

*DMI may not be available in all states.

Small Group Dental Plans 2–9

	Option 1 Aetna Dental Preventive CareSM	Option 2	Option 3 Freedom-of-Choice Monthly selection between the DMO and PPO Max	
Member Benefits	PPO Max Plan – Aetna Dental Preventive Care	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/40
Office Visit Copay	N/A	\$5	\$5	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	None	None	\$50; 3X family maximum
Annual Maximum Benefit	None	None	None	\$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	Not covered	80%	90%	70%
Resin filling – 2 surfaces, anterior	Not covered	80%	90%	70%
Oral Surgery				
Extraction – exposed root or erupted tooth	Not covered	80%	90%	70%
Extraction of impacted tooth – soft tissue	Not covered	80%	90%	70%
Major Services*				
Complete upper denture	Not covered	50%	60%	40%
Partial upper denture (resin base)	Not covered	50%	60%	40%
Crown – Porcelain with noble metal	Not covered	50%	60%	40%
Pontic – Porcelain with noble metal	Not covered	50%	60%	40%
Inlay – Metallic (3 or more surfaces)	Not covered	50%	60%	40%
Oral Surgery				
Removal of impacted tooth – partially bony	Not covered	50%	60%	40%
Endodontic Services				
Bicuspid root canal therapy	Not covered	80%	90%	40%
Molar root canal therapy	Not covered	50%	60%	40%
Periodontic Services				
Scaling & root planing – per quadrant	Not covered	80%	90%	40%
Osseous surgery – per quadrant	Not covered	50%	60%	40%
Orthodontic Services				
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 41 for footnotes.

Small Group Dental Plans 2–9

	Option 4	Option 5 Active PPO High-Option Plan	Option 5 Nonpreferred Plan	Option 6
Member Benefits	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Nonpreferred Plan 80/60/40	PPO 1500 Plan 100/80/50
Office Visit Copay	None	None	None	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
Annual Maximum Benefit	\$1,500	\$1,500	\$1,000	\$1,500
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing – single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
Preventive Services				
Adult cleaning	100%	100%	80%	100%
Child cleaning	100%	100%	80%	100%
Sealants – per tooth	100%	100%	80%	100%
Fluoride application – with cleaning	100%	100%	80%	100%
Space maintainers	100%	100%	80%	100%
Basic Services				
Amalgam filling – 2 surfaces	80%	80%	60%	80%
Resin filling – 2 surfaces, anterior	80%	80%	60%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth – soft tissue	80%	80%	60%	80%
Major Services*				
Complete upper denture	50%	50%	40%	50%
Partial upper denture (resin base)	50%	50%	40%	50%
Crown – Porcelain with noble metal	50%	50%	40%	50%
Pontic – Porcelain with noble metal	50%	50%	40%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	40%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	80%	60%	50%
Molar root canal therapy	50%	50%	40%	50%
Periodontic Services				
Scaling & root planing – per quadrant	50%	80%	60%	50%
Osseous surgery – per quadrant	50%	50%	40%	50%
Orthodontic Services				
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 41 for footnotes.

Small Group Voluntary Dental Plans 3–9

	Voluntary Option 1 Aetna Dental Preventive Care	Voluntary Option 2
Member Benefits	PPO Max Plan – Aetna Dental Preventive Care	DMO Plan 100/80/50
Office Visit Copay	N/A	\$10
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	None
Annual Maximum Benefit	None	None
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	Not covered	80%
Resin filling – 2 surfaces, anterior	Not covered	80%
Oral Surgery		
Extraction – exposed root or erupted tooth	Not covered	80%
Extraction of impacted tooth – soft tissue	Not covered	80%
Major Services*		
Complete upper denture	Not covered	50%
Partial upper denture (resin base)	Not covered	50%
Crown – Porcelain with noble metal	Not covered	50%
Pontic – Porcelain with noble metal	Not covered	50%
Inlay – Metallic (3 or more surfaces)	Not covered	50%
Oral Surgery		
Removal of impacted tooth – partially bony	Not covered	50%
Endodontic Services		
Bicuspid root canal therapy	Not covered	80%
Molar root canal therapy	Not covered	50%
Periodontic Services		
Scaling & root planing – per quadrant	Not covered	80%
Osseous surgery – per quadrant	Not covered	50%
Orthodontic Services		
Orthodontic lifetime maximum	Does not apply	Does not apply

Refer to page 41 for footnotes.

Small Group Voluntary Dental Plans 3–9

	Voluntary Option 3 Freedom-of-Choice – Monthly selection between the DMO and PPO Max		Voluntary Option 4
Member Benefits	DMO Plan 100/90/60	PPO Max Plan 100/70/40	PPO Max Plan 100/80/50
Office Visit Copay	\$10	N/A	N/A
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	\$75; 3X family maximum	\$75; 3X family maximum
Annual Maximum Benefit	None	\$1,000	\$1,500
Diagnostic Services			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Problem-focused oral exam	100%	100%	100%
X-rays			
Bitewing – single film	100%	100%	100%
Complete series	100%	100%	100%
Preventive Services			
Adult cleaning	100%	100%	100%
Child cleaning	100%	100%	100%
Sealants – per tooth	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%
Space maintainers	100%	100%	100%
Basic Services			
Amalgam filling – 2 surfaces	90%	70%	80%
Resin filling – 2 surfaces, anterior	90%	70%	80%
Oral Surgery			
Extraction – exposed root or erupted tooth	90%	70%	80%
Extraction of impacted tooth – soft tissue	90%	70%	80%
Major Services*			
Complete upper denture	60%	40%	50%
Partial upper denture (resin base)	60%	40%	50%
Crown – Porcelain with noble metal	60%	40%	50%
Pontic – Porcelain with noble metal	60%	40%	50%
Inlay – Metallic (3 or more surfaces)	60%	40%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	60%	40%	50%
Endodontic Services			
Bicuspid root canal therapy	90%	40%	50%
Molar root canal therapy	60%	40%	50%
Periodontic Services			
Scaling & root planing – per quadrant	90%	40%	50%
Osseous surgery – per quadrant	60%	40%	50%
Orthodontic Services			
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply

Refer to page 41 for footnotes.

Aetna 10 – 50 Dental Plans

	Option 1A DMO Fixed Copay 42	Option 2A DMO Coinsurance	Option 3A DMO 100/100/60	Option 4A DMO Fixed Copay 56
Member Benefits	Plan code 42	DMO Plan 100/80/50	DMO Plan 100/100/60	Plan code 56
Office Visit Copay	\$5	\$5	\$5	\$5
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	None	None	None
Annual Maximum Benefit	None	None	None	None
Diagnostic Services				
Oral Exams				
Periodic oral exam	No charge	100%	100%	No charge
Comprehensive oral exam	No charge	100%	100%	No charge
Problem-focused oral exam	No charge	100%	100%	No charge
X-rays				
Bitewing – single film	No charge	100%	100%	No charge
Complete series	No charge	100%	100%	No charge
Preventive Services				
Adult cleaning	No charge	100%	100%	No charge
Child cleaning	No charge	100%	100%	No charge
Sealants – per tooth	\$10	100%	100%	No charge
Fluoride application – with cleaning	No charge	100%	100%	No charge
Space maintainers	\$100	100%	100%	No charge
Basic Services				
Amalgam filling – 2 surfaces	\$32	80%	100%	No charge
Resin filling – 2 surfaces, anterior	\$55	80%	100%	No charge
Endodontic Services				
Bicuspid root canal therapy	\$195	80%	100%	No charge
Periodontic Services				
Scaling & root planing – per quadrant	\$65	80%	100%	\$25
Oral Surgery				
Extraction – exposed root or erupted tooth	\$30	80%	100%	No charge
Extraction of impacted tooth – soft tissue	\$80	80%	100%	No charge
Major Services*				
Complete upper denture	\$500	50%	60%	\$185
Partial upper denture (resin base)	\$513	50%	60%	\$185
Crown – Porcelain with noble metal1	\$488	50%	60%	\$150
Pontic – Porcelain with noble metal1	\$488	50%	60%	\$150
Inlay – Metallic (3 or more surfaces)	\$463	50%	60%	\$150
Oral Surgery				
Removal of impacted tooth – partially bony	175**	50%	60%	\$45
Endodontic Services				
Molar root canal therapy	435**	50%	60%	\$125
Periodontic Services				
Osseous surgery – per quadrant	\$445**	50%	60%	\$140
Orthodontic Services* (Optional)	\$2,300 copay	\$2,300 copay	\$2,300 copay	\$2,300 copay
Orthodontic lifetime maximum	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 42 for footnotes.

Aetna 10 – 50 Dental Plans

	Option 5A Freedom-of-Choice – PPO Max Low - Monthly selection between the DMO and PPO Max		Option 6A Freedom-of-Choice – PPO Max High - Monthly selection between the DMO and PPO Max	
Member Benefits	DMO Plan 100/90/60	PPO Max Plan 100/70/40	DMO Plan 100/100/60	PPO Max Plan 100/80/50
Office Visit Copay	\$5	None	\$5	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	None	\$50; 3X family maximum
Annual Maximum Benefit	None	\$1,000	None	\$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	90%	70%	100%	80%
Resin filling – 2 surfaces, anterior	90%	70%	100%	80%
Endodontic Services				
Bicuspid root canal therapy	90%	70%	100%	80%
Periodontic Services				
Scaling & root planing – per quadrant	90%	70%	100%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	90%	70%	100%	80%
Extraction of impacted tooth – soft tissue	90%	70%	100%	80%
Major Services*				
Complete upper denture	60%	40%	60%	50%
Partial upper denture (resin base)	60%	40%	60%	50%
Crown – Porcelain with noble metal1	60%	40%	60%	50%
Pontic – Porcelain with noble metal1	60%	40%	60%	50%
Inlay – Metallic (3 or more surfaces)	60%	40%	60%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	60%	40%	60%	50%
Endodontic Services				
Molar root canal therapy	60%	40%	60%	50%
Periodontic Services				
Osseous surgery – per quadrant	60%	40%	60%	50%
Orthodontic Services* (Optional)	\$2,300 copay	40%	\$2,300 copay	\$1,000
Orthodontic lifetime maximum	Does not apply	\$1,000	Does not apply	\$1,000

Refer to page 42 for footnotes.

Aetna 10 – 50 Dental Plans

	Option 7A Freedom-of-Choice – PPO 1000 80th - Monthly selection between the DMO and PPO		Option 8A Freedom-of-Choice – PPO 1500 90th - Monthly selection between the DMO and PPO	
Member Benefits	Plan code 56	PPO Plan 100/80/50	DMO Plan 100/100/60	PPO Plan 100/80/50
Office Visit Copay	\$5	None	\$5	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	None	\$50; 3X family maximum
Annual Maximum Benefit	None	\$1,000	None	\$1,500
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	No charge	100%	100%	100%
Fluoride application – with cleaning	No charge	100%	100%	100%
Space maintainers	No charge	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	No charge	80%	100%	80%
Resin filling – 2 surfaces, anterior	No charge	80%	100%	80%
Endodontic Services				
Bicuspid root canal therapy	No charge	80%	100%	80%
Periodontic Services				
Scaling & root planing – per quadrant	\$25	80%	100%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	No charge	80%	100%	80%
Extraction of impacted tooth – soft tissue	No charge	80%	100%	80%
Major Services*				
Complete upper denture	\$185	50%	60%	50%
Partial upper denture (resin base)	\$185	50%	60%	50%
Crown – Porcelain with noble metal1	\$150	50%	60%	50%
Pontic – Porcelain with noble metal1	\$150	50%	60%	50%
Inlay – Metallic (3 or more surfaces)	\$150	50%	60%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	\$45	50%	60%	80%
Endodontic Services				
Molar root canal therapy	\$125	50%	60%	80%
Periodontic Services				
Osseous surgery – per quadrant	\$140	50%	60%	80%
Orthodontic Services* (Optional)	\$2,300 copay	50%	\$2,300 copay	50%
Orthodontic lifetime maximum	Does not apply	\$1,000	Does not apply	\$1,000

Refer to page 42 for footnotes.

Aetna 10 – 50 Dental Plans

	Option 9A Freedom-of-Choice – PPO 2000 80th – Monthly selection between the DMO and PPO		Option 10A PPO Max 1000	Option 11A PPO Max 1500
Member Benefits	DMO Plan 100/100/60	PPO Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	\$5	None	None	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
Annual Maximum Benefit	None	\$2,000	\$1,000	\$1,500
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	100%	80%	80%	80%
Resin filling – 2 surfaces, anterior	100%	80%	80%	80%
Endodontic Services				
Bicuspid root canal therapy	100%	80%	80%	80%
Periodontic Services				
Scaling & root planing – per quadrant	100%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	100%	80%	80%	80%
Extraction of impacted tooth – soft tissue	100%	80%	80%	80%
Major Services*				
Complete upper denture	60%	50%	50%	50%
Partial upper denture (resin base)	60%	50%	50%	50%
Crown – Porcelain with noble metal1	60%	50%	50%	50%
Pontic – Porcelain with noble metal1	60%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	60%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	60%	80%	80%	80%
Endodontic Services				
Molar root canal therapy	60%	80%	80%	80%
Periodontic Services				
Osseous surgery – per quadrant	60%	80%	80%	80%
Orthodontic Services* (Optional)				
Orthodontic lifetime maximum	Does not apply	\$1,000	\$1,000	\$1,000

Refer to page 42 for footnotes.

Aetna 10 – 50 Dental Plans

	Option 12A PPO 1000 90th	Option 13A PPO 2000 80th	Option 14A PPO 1500 90th
Member Benefits	PPO 1000 Plan 100/80/50	PPO 2000 Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	None	None	None
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
Annual Maximum Benefit	\$1,000	\$2,000	\$1,500
Diagnostic Services			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Problem-focused oral exam	100%	100%	100%
X-rays			
Bitewing – single film	100%	100%	100%
Complete series	100%	100%	100%
Preventive Services			
Adult cleaning	100%	100%	100%
Child cleaning	100%	100%	100%
Sealants – per tooth	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%
Space maintainers	100%	100%	100%
Basic Services			
Amalgam filling – 2 surfaces	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%
Endodontic Services			
Bicuspid root canal therapy	80%	80%	80%
Periodontic Services			
Scaling & root planing – per quadrant	80%	80%	80%
Oral Surgery			
Extraction – exposed root or erupted tooth	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%
Major Services*			
Complete upper denture	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%
Crown – Porcelain with noble metal1	50%	50%	50%
Pontic – Porcelain with noble metal1	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	80%	80%	80%
Endodontic Services			
Molar root canal therapy	80%	80%	80%
Periodontic Services			
Osseous surgery – per quadrant	80%	80%	80%
Orthodontic Services* (Optional)			
Orthodontic lifetime maximum	\$1,000	\$1,500	\$1,000

Refer to page 42 for footnotes.

Dental plans for 2–50

Footnotes

Aetna Small Group Dental Plans 2–9

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in plan options 2 and 3 and the Preventive Care Plan in plan option 1.

The DMO in plan option 2 can be offered with any of the PPO plans in plan options 4–6 in a Dual Option package.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 2, 3 and the PPO in plan option 5.

Plan options 1, 3 and 4; PPO Max nonpreferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

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 67.

Aetna Small Group Voluntary Dental Plans 3–9

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in voluntary plan options 2 and 3 and the Preventive Care Plan in voluntary plan option 1.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in voluntary plan options 2 and 3.

Voluntary plan options 1, 3 and 4; PPO Max nonpreferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

All voluntary plans require a minimum of 3 to enroll.

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.

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

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 67.

Aetna 10–50 Dental Plans

*Coverage waiting period applies to voluntary PPO and PPO Max plans in plan options 5A–14A: 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 voluntary DMO in plan options 1A–9A, and all standard plans.

**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.

¹There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures in DMO Options 1A, 4A and 7A.

Fixed dollar amounts on the DMO in plan options 1A–9A, including office visit and orthodontic copays, are the member's responsibility.

The DMO in plan options 1A–4A can be offered with any of the PPO plans in plan options 10A–14A in a dual option package.

Plan options 5A, 6A, 10A and 11A; PPO Max nonpreferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on the PPO in plan Options 7A, 9A and 13A to the prevailing fees at the 80th percentile and the 90th percentile in plan options 8A, 12A and 14A.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 1A–9A. Most all oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan options 5A, 6A, and 7A. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan options 8A, 9A–14A. General anesthesia is covered as basic services on the PPO in plan options 5A–14A.

Alternate benefits will not be applied to posterior resin fillings on the PPO in plan options 5A–14A.

Coverage for Implants is included as a major service on the PPO in plan option 9A and 13A.

Orthodontic coverage is available for dependent children only.

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

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

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 on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 67.

Aetna Life & Disability

With Aetna as your insurer, you can round out employee benefits package with even more coverage. Our group life and disability is an affordable way to offer your employees — and their families — the extra financial protection of life insurance and disability benefits.

Life & Disability

Overview

For groups of 2 to 50, Aetna Life Insurance Company (Aetna) 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 benefits payout to include useful enhancements through the **Aetna Life EssentialsSM** program.

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

Giving you (and your employees) what you want

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

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

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

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

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

Our fresh approach to life

With **Aetna Life EssentialsSM**, your employees have access to programs during their active lives to help promote healthy, fulfilling lifestyles. In addition, Aetna Life EssentialsSM 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 term life plans and in our packaged life and disability plans. It provides employees and their families with the same coverage as a typical accidental death and personal loss plan — and then some. This includes extra benefits at no additional cost to you, such as coverage for education or child-care expenses that make this protection even more valuable.

Covered losses include:

- Death
- Loss of arm or leg
- Loss of sight
- Loss of speech
- Loss of hearing
- Third-degree burns
- Paralysis
- Coma
- Total disability
- Exposure and disappearance

Extra benefits for the following:

- Passenger restraint use and airbag deployment*
- Education assistance for dependent child and/or spouse*
- Child care*
- Repatriation of mortal remains*

Disability insurance

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

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

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

Integrated health and disability

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

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

For a summary list of Limitations and Exclusions, refer to pages refer to pages 67–68.

Term Life Plan Options

	2–9 Employees	10–50 Employees
Basic Life Schedule	Flat \$10,000, \$15,000, \$20,000, \$50,000	Flat \$10,000, \$15,000, \$20,000, \$50,000, \$75,000, \$100,000, \$125,000
Class Schedules	Not available	Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class
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 noncontributory plans; 75% on contributory plans
Contribution Requirements	100% employer contribution	Minimum 50% employer contribution
AD&D Ultra		
AD&D Ultra Schedule	Matches life benefit	Matches life benefit
AD&D Ultra Extra Benefits	Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains	Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains
Optional Dependent Term Life		
Spouse Amount	Not available	\$5,000
Child Amount	Not available	\$2,000

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

Packaged Life and Disability Plan Options

	Low Option	Medium Option	High Option
Benefit	Flat \$10,000	Flat \$20,000	Flat \$50,000
Guaranteed issue			
2–9 Lives	\$10,000	\$20,000	\$20,000
10–50 Lives	\$10,000	\$20,000	\$50,000
Reduction Schedule	Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Disability 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 Schedule	Matches basic life benefit	Matches basic life benefit	Matches basic life benefit
AD&D Ultra Extra Benefits	Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains		
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	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions
Waiver of Premium	Included	Included	Included
Other Plan Provisions			
Eligibility	Active full-time employees	Active full-time employees	Active full-time employees
Rate Guarantee	1 year	1 year	1 year
Rates PEPM	\$8.00	\$15.00	\$27.00

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

Underwriting guidelines

In business, nothing is more critical to success than the health and well-being of employees.

Underwriting Guidelines

For businesses with 50 or fewer eligible employees

In business, nothing is more critical to success than the health and well-being of employees.

This material is for informational purposes only and is not intended to be all inclusive.

Other policies and guidelines may apply.

Note: State and Federal Legislation/Regulations, including Small Group Reform, HIPAA, and ACA, take precedence over any and all underwriting rules. Exceptions to underwriting rules require approval of the Regional Underwriting Manager except where Head Underwriter approval is indicated. This information is the property of Aetna and its affiliates (“Aetna”), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing. All underwriting guidelines above are subject to change without notice.

Case Submission Dates

- Groups must have all completed paperwork into Aetna Underwriting the 25th of the prior month for 1st of the month effective dates; 10th of the month for 15th of the month effective dates.
- Any cases received after the cut-off date will be considered on an exception basis only, as approved by the Underwriting Unit manager.
- If not approved, the effective date will be moved to the next available effective date, with potential rate impact.

COBRA/State Enrollees

- COBRA Applies to: Group health plans sponsored by employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.
 - Employers with less than 20 employees (full and part-time) are eligible to offer State Continuation.
 - COBRA Counting:
 - Include: full-time, part-time, seasonal, temporary, union, owners, partners, officers
 - Exclude: self-employed persons, independent contractors (1099), directors
 - Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.
 - Because COBRA is directed at employers, the decision to comply with COBRA should be made by the employer. In situations where it may appear the employer is not subject to COBRA, for example a three life group requesting COBRA, we will ask the employer to “validate” the number of employees in the prior calendar year in order to determine the number of employees for COBRA purposes.
 - Life, disability and/or voluntary dental: COBRA/state continuation enrollees are not eligible.
 - Eligible enrollees are required to be included on the census.
 - The qualifying event, length, start date and end date must be provided.
 - Note: COBRA/state continuation enrollees are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined according to the law applicable to the group, COBRA/state continuation enrollees can be included for coverage subject to normal underwriting guidelines.
-

Dependent Eligibility

Eligible dependents include:

- Spouse of employee. If both employee and spouse/partner work for the same company they may enroll together or separately, with the exception of two life groups, in which case the spouse must enroll separately.
- A domestic partner may be covered as an eligible dependent if the employer elects this designation at contract effective or renewal date.
- Children
 - Medical and dental - children are eligible as defined in plan documents in accordance with applicable state and federal laws, up to age 26, regardless of financial dependency, employment, eligibility of other coverage, student status, marital status, tax dependency or residency. This requirement applies to natural and adopted children, stepchildren and children subject to legal guardianship.
 - At the request of the employer at contract effective or renewal date, medical coverage for dependent children may be extended to age 30 and must meet all of the following:
 - Need not be a full-time student.
 - Is not married.
 - Has no dependents.
 - Is a resident of this commonwealth or is enrolled as a full-time student at an institution of higher education.
 - Is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program.
 - Children can only be covered under one parent's plan when both parents work for the same company.
 - Grandchildren are eligible if court ordered. A copy of the court papers must be submitted.
 - Incapacitated child: Attainment of limiting age will not terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance. Proof of incapacity and dependency shall be furnished to Aetna by the employee or the member within 31 days of the child's attainment of the limiting age and subsequently as may be required by Aetna, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
 - Dependent Life – eligible from 14 days up to their 19th birthday or to their 23rd birthday, if in school on a regular basis and dependent solely on the employee for support.

Other eligibility rules

- Individuals cannot be covered as an employee and dependent under the same plan.
- AD&D and Disability - dependents are not eligible.
- Employee must elect Life to purchase Dependent Life.

Effective Date

- The effective date must be the 1st or the 15th of the month.
- The effective date requested by the employer must be within 60 days of the submission date.

Electronic Funds Transfer/ACH

- The first month's premium for new business can be processed via an electronic funds transfer/ACH.
- Once the group is issued, customers can pay their monthly premiums online or by calling an automated phone number, **1-866-350-7644**, using their checking account and routing number. There is no extra charge for this service.

Employee Eligibility

- Eligible employees are those employees and active owners who are permanent and work on a full-time basis, as defined by the employer, and who meet any authorized waiting period requirements. Our minimum acceptable hours per week is 25.
- This includes a sole proprietor or partner of a partnership, if included as an employee in the health benefits plan of employer.
- 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. See Excluded class/Carve out under Product Specification section.
- Employees/individuals not eligible for coverage include 1099 contractors, temporary, seasonal, substitute or uncompensated employees, employees making less than equivalent minimum wage, volunteers, retirees, inactive owners, shareholders, officers or managing members who are not active, investors, or silent partners.

Retirees

- Early retiree coverage is not available.
- Coverage is available for Medicare-eligible retirees and/or active Medicare-eligibles in accordance with the small group Medicare underwriting guidelines.
- Medicare-eligible retirees who are enrolled in an Aetna Medicare plan are eligible to enroll in standard dental plans in accordance with the dental underwriting guidelines.
- Retirees are not eligible for life, disability or voluntary dental coverage.

Employer Eligibility

- An employer who employed at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code shall be treated as one employer.
- Groups that do not meet the above definition of a small employer are not eligible for coverage.
- Medical plans can be offered to sole proprietorships, partnerships or corporations.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Associations, Taft Hartley groups, professional employer organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible.
- Dental and disability have ineligible industries listed under the Product Specification section.
- The dental ineligible industry list does not apply when dental is sold in combination with medical.

Initial Premium

- Submit a “copy” of the initial premium check payable to Aetna Inc. or complete the ACH/EFT form (Aetna form).
- If the EFT method is selected, we will withdraw the first initial premium from the checking account when the group is approved. This is a one-time authorization for the first month’s premium only. If you supply a copy of the check, once coverage is approved, you will be advised where to mail the 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 withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium payment will not be processed.
- If the initial premium is returned for nonsufficient funds, the standard termination process will be followed.
- If the plan sponsor is currently with Aetna and adding a medical product, no premium check is required.

Licensed, Appointed Producers

- Only appropriately licensed agents/producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna products.
- License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted.

Medicare (MSP) for CMS Reporting

- Each year, all carriers must report to CMS (Centers for Medicare and Medicaid Services) the number of Medicare Secondary Payer (MSP) groups and the number of employees based on the number of employees provided by the employer.
- Medicare secondary – 20 or more employees: Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the Aetna plan would pay primary to Medicare for active employees and would pay first when there are 20 or more total employees (full and part-time) for 20 or more weeks during this calendar year or prior calendar year.
- Both full and part-time employees are counted based on the number the employer employed for at least 20 or more calendar weeks during the current or prior calendar year.
 - Include: full-time, part-time, seasonal, temporary, union, owners, partners, officers
 - Exclude: self-employed persons, independent contractors (1099), directors, leased employees

Multi-Option Plans

- Groups may offer up five medical plans, provided the five plans have different medical features.
- A minimum of one person must enroll in each plan when multiple options are offered.

Municipalities and Townships

- A township is generally a small unit that has the status and powers of local government.
- A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town or village. A municipality is typically governed by a mayor and city council, or municipal council.
- Underwriting requirements:
 - Quarterly Wage and Tax Statement (QWTS)
 - W2 – Elected or appointed officials and trustees “may” be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS; rather, they may be paid via W2. In that case, obtain a copy of their prior year W2.
 - If elected officials are to be covered, provide a copy of the charter or contract indicating which classes or employees are to be covered, the minimum hours required to work per week to be eligible for coverage, and confirmation that coverage will be offered to all employees meeting the minimum number of required hours and that minimum participation will be maintained.

Newly Formed Business (in operation less than 3 months)

The following documentation must be provided for consideration:

- **Sole Proprietor**
 - A copy of the Business License (not a professional license).
- **Partnership or Limited Liability Partnership**
 - A copy of the Partnership Agreement.
- **Limited Liability Company**
 - A copy of the Articles of Organization and the Operating Agreement to include the signature page(s) of all officers.
- **Corporation**
 - A copy of the Articles of Incorporation that includes the signature page(s) of all officers (must be followed up with a copy of the statement of information within 30 days of filing with the state)

Each newly formed business must also provide:

- Proof of employer identification number/federal tax identification number; and
- Quarterly Wage and Tax Statement. If not available, when will one be filed; and
- The most recent two consecutive weeks of payroll records which includes hours worked, taxes withheld, check number and wages earned; or
- A letter from the group or a CPA with the following information:
 - A list of all employees, to include owners, partners, officers (full time and part time)
 - Number of hours worked by each employee
 - Weekly salary for each employee
 - Date of hire for each employee
 - Whether payroll records have been established
- Groups that are not subject to guaranteed issue may be declined.

PEO (professional employer organization)

- As long as the PEO provides payroll specific for the group and we can determine it is a small group, even though the group may be reported under the PEO tax ID number, the group may be considered subject to underwriting approval.

Prior Aetna Coverage

- Groups that terminate for nonpayment must pay all premiums owed before a new plan will be issued.

Rating Information

- Illustrative quotes should be processed via the quoting tools in Producer World.
- All quotes are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in census.
- If any of the information we receive is determined to be incomplete or incorrect, we reserve the right to adjust rates.

Replacing Other Group Coverage

- Current carrier bill with billing summary and employee roster is required.
- For dental, also provide a copy of the benefit summary to verify major and orthodontia benefits.
- The employer should be told not to cancel any existing medical coverage until it has been notified of approval from the Aetna Underwriting Unit.

Signature Dates

- The Aetna Employer Application and all employee applications must be signed and dated before and within 90 days of the requested effective date.
- All employee applications must be completed by the employee himself/herself.

Spin-Off Groups
(current Aetna
customers leaving
an Aetna group only)

We will consider the group with the following:

- A letter from the group or broker indicating the group is enrolling as a spin-off. Letter needs to include the name of the group they are spinning off from and the name of the new spin-off group.
- Ownership documents showing that the spin-off company is a newly formed separate entity.
- A minimum of 2 weeks payroll. If the group that is spinning off has been in business longer than 2 weeks, payroll will be required for the amount of time in business up to a maximum of 6 consecutive weeks.

**Tax Information/
Documents**

- Groups with 2 to 20 eligible employees OR groups with 21+ eligible employees WITHOUT prior GROUP coverage
 - Provide a copy of the most recent Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc., of all employees of the employer group.
 - Newly hired employees should be written in on the Quarterly Wage & Tax Statement.
 - Employees who have terminated or work part-time must be noted accordingly on the QWTS.
 - Reconciled QWTS must be signed and dated by the employer.
 - Any handwritten comments added to the QWTS must be signed and dated by the employer. This may be requested at the discretion of the underwriter.
- Groups with 21 to 50 eligible employees WITH prior GROUP coverage
 - A QWTS is not needed if a bill roster is provided and at least 75 percent of the eligible employees are on the prior carrier billing statement.
 - Newly hired employees should be written in on the prior carrier bill.
 - Employees who have terminated or work part-time must be noted accordingly on the prior carrier bill.
 - Reconciled prior carrier bill must be signed and dated by the employer.
 - Any hand written comments added to the prior carrier bill must be signed and dated by the employer. This may be requested at the discretion of the underwriter.
 - If no prior carrier, then a QWTS is needed and documented as noted above.
- All Groups – if a QWTS or prior carrier bill is not available, explain why and provide a copy of payroll records.
- Two life groups – If a group had one eligible last year and is now adding a second eligible within one month of the effective date, additional documentation for the newly eligible employee is needed. Supply payroll for two consecutive payroll periods that show all applicable federal and state taxes being withheld AND provide documentation that the payroll was issued and deposited within an appropriate time frame. Include copies of front and back of cancelled checks. Checks cannot be in consecutive order.
- For seasonal industries such as lawn and garden services, construction, concrete and paving, golf courses, farm laborers, etc., must provide four consecutive quarters of wage and tax reports should be submitted to verify the full-time, consistent, continuous, employment of the eligible employees.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.

**Tax Information/
Documents**
(continued)

- Sole proprietors, partners, corporate officers not listed on the QWTS need to complete our Small Group Proof of Eligibility Form (located at www.aetna.com/producers/smallgroup) and submit one of the following identified documents. This list is not all-inclusive. The employer may provide any other documentation to establish eligibility.

Sole Proprietor

- Franchise
- Limited Liability Company (operating as a Sole Proprietor)
- IRS Form 1040 along with Schedule C (Form 1040)
- IRS Form 1040 along with Schedule SE (Form 1040)
- IRS Form 1040 along with Schedule F (Form 1040)
- IRS 1040 along with Schedule K1 (Form 1065)
- Any other documentation the owner would like to provide to determine eligibility

Partner

- Partnership
- Limited Liability Partnership
- IRS Form 1065 Schedule K-1
- IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)
- Partnership agreement if established within 2 years – eligible partners must be listed on agreement
- Any other documentation the owner would like to provide to determine eligibility

Corporate Officer

- Limited Liability Company (operating as C Corp)
- C-Corporation
- Personal Service Corporation
- S-Corporation
- IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040)
- IRS Form 1120 W (C-Corp & Personal Service Corp)
- 1040 ES (Estimated Tax) (S-Corp)
- IRS Form 8832 (Entity classification as a corporation)
- W2
- Articles of Incorporation if established within 2 years – corporate officers must be listed
- Any other documentation the owner would like to provide to determine eligibility

Tobacco Rates

- Tobacco rates for medical plans apply to any person who has used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) an average of four or more times per week within the past six months. This only applies to enrolling person(s) that meets or exceeds the state-defined legal tobacco age.
- Tobacco rates do not apply to:
 - Individuals who are participating in a cessation program;
 - Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives).

Two or More Companies – Affiliated, Associated or Multiple Companies, Common Ownership

Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following are met:

- One owner has controlling interest of all businesses to be included; or
- The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and
- All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only two of the three businesses to be enrolled, the group will be considered a carve-out.
- There are 50 or fewer employees in the combined employer groups.
- Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups.
- Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case basis.

Example

- One owner has controlling interest of all companies to be included:
 - Company 1 – Jim owns 75 percent and Jack owns 25 percent
 - Company 2 – Jim owns 55 percent and Jack owns 45 percent
- Both companies can be written as one group since Jim has controlling interest in both.

Waiting Period

- At initial submission of the group, the benefit waiting period (BWP) may be waived for current employees upon the employer's request. This should be checked on the Employer Application.
- The benefit waiting period (BWP) for future employees may be the 1st or 15th of the policy month following 0 days, 30 days, or 60 days.
- A change to the benefit waiting period (BWP) may only be made on the plan anniversary date.
- No retroactive changes will be allowed.
- One or two benefit waiting periods (BWP) may be selected and must be consistently applied within a class of employees as defined by the employer, such as management versus non-management, hourly versus salaried, etc.
- Benefit waiting periods (BWP) must be consistently applied to all employees, including newly hired key employees.
- For new hires, the eligibility date will be the first day of the policy month following the waiting period.
- If "0" days is selected and the employee is hired on the 1st of the month, the effective date will be the date of hire.

Examples	1st of the month following the BWP	15th of the month following the BWP
0 days	Date of hire: 4/1 Effective date: 4/1	Date of hire: 4/1 Effective date: 4/15
	Date of hire: 4/18 Effective date: 5/1	Date of hire: 4/18 Effective date: 5/15
30 days	Date of hire: 4/18 Effective date: 6/1	Date of hire: 4/18 Effective date: 6/15
60 days	Date of hire: 4/18 Effective date: 7/1	Date of hire: 4/18 Effective date: 7/15

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Product Availability	<ul style="list-style-type: none"> • May be written standalone or with ancillary coverage as noted in the following columns. 	<p>2 eligible employees</p> <ul style="list-style-type: none"> • Standard dental available with medical. • Voluntary dental not available. • Orthodontic coverage not available <p>3 – 50 eligible employees</p> <ul style="list-style-type: none"> • Standard and voluntary dental plans are available with or without medical. • Standalone available. • Standalone dental has ineligible Industries. <p>Orthodontia coverage</p> <ul style="list-style-type: none"> • Available with 10 or more eligible employees with a minimum of five enrolled employees for dependent children only. 	<p>Life and/or Disability</p> <ul style="list-style-type: none"> • 2 – 9 eligible employees if packaged with medical • 10 – 50 eligible employees if packaged with medical or dental. • 26 – 50 eligible employees on a standalone basis <p>Packaged Life and Disability</p> <ul style="list-style-type: none"> • 2 – 50 eligible employees if packaged with medical • 10 – 50 eligible employees on a standalone basis. • A plan sponsor cannot purchase both life and packaged life and disability plans • Product packaging rule is a group level requirement. Employees will be able to individually elect life, disability or packaged life & disability insurance even if they do not elect medical coverage. <p>Disability</p> <ul style="list-style-type: none"> • Groups are ineligible for coverage if 60 percent or more of eligible employees or 60 percent or more of eligible payroll are for employees over 50 years old. • Conversion options are not available. • Available to employees only; dependents are not eligible. • Employees may elect disability coverage even if they do not elect medical coverage.

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Excluded Class/ Carve Outs	<ul style="list-style-type: none"> We will allow an employer to consider certain distinct classes of employees as ineligible for health care benefits (management versus non-management, salary versus hourly, union versus non-union). A key provision is that the ineligible class must not be offered any other group coverage through the employer. The class being offered coverage would be subject to our participation requirements. Union employees are included in the total count of eligible employees in determining the case size, while other excluded classes are not included. Groups that do not meet participation criteria are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. 	<ul style="list-style-type: none"> Union employees if packaged with medical. 	<ul style="list-style-type: none"> Union employees if packaged with medical.
Employer Contribution	<ul style="list-style-type: none"> Minimum of 50 percent of the employee-only cost of the lowest cost plan offered. Groups that do not meet contribution guidelines are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. 	<ul style="list-style-type: none"> Employer must contribute at least 25 percent of the total cost or 50 percent of the cost of employee only coverage for dental plans. If the employer contributes less than the above guideline, or if the coverage is 100 percent paid by the employee coverage is deemed voluntary. Coverage can be denied based on inadequate contributions. 	<ul style="list-style-type: none"> 2 – 9 eligible employees – employer must contribute 100 percent of the total cost of the basic term life plan. 10 – 50 eligible employees – employer must contribute at least 50 percent of the cost of the plan (excluding optional dependent life). Coverage may be denied based upon inadequate contributions.

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Late Applicants	<ul style="list-style-type: none"> An employee or dependent enrolling for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. Applicants without a qualifying life event (that is, marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the late entrant guidelines as noted below. Voluntary cancellation of coverage is not a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added. Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days before the anniversary date. 	<ul style="list-style-type: none"> An employee or dependent may enroll at any time; however, coverage is limited to preventive & diagnostic services for the first 12 months. No coverage for most basic and major services for first 12 months (24 months for orthodontics). Late entrant provision does not apply to enrollees under age five. 	<ul style="list-style-type: none"> Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days before the anniversary date. The applicant will be required to complete an individual health statement/questionnaire and provide EOI. Life late enrollee example: Group has \$50,000 life with \$20,000 guaranteed issue limit. Late enrollee enrolling for \$50,000 would not automatically get the \$20,000. Since the applicant is late he or she must medically qualify for the entire \$50,000.
Live/Work Situs	<ul style="list-style-type: none"> Eligible employees who live or work in PA, NJ, DE, MD, DC, VA, NY and CT (the situs region) will receive the same rates and benefits as the headquarters location. 	<ul style="list-style-type: none"> Eligible employees who live or work in PA, NJ, DE, MD, DC, VA, NY and CT (the situs region) will receive the same rates and benefits as the headquarters location. 	<ul style="list-style-type: none"> Not applicable.
Out-of-Area	<ul style="list-style-type: none"> Out-of-area employees must be enrolled in a PPO plan if available; otherwise, an indemnity plan. 	<ul style="list-style-type: none"> Out-of-area employees must be enrolled in a PPO plan if available; otherwise, an indemnity plan. 	<ul style="list-style-type: none"> Employees are eligible for the same life plan selected by the employer.

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Out-of- Situs employees	<ul style="list-style-type: none"> Any active employee who lives and works outside of PA, NJ, DE, MD, DC, VA, NY and CT is considered outside the situs region. Out-of-situs employees can enroll in a Pennsylvania PPO plan (or indemnity plan if PPO network is not available). Out-of-state employees residing in Louisiana are required to have a separate plan quoted and sold based on Louisiana rates and benefits. These employees are still underwritten as part of the group, however, the plans and rates for the Louisiana members will not be based on where the Employer is located. This will require Louisiana Employer and Employee applications to be completed. 	<ul style="list-style-type: none"> Any active employee who lives and works outside of PA, NJ, DE, MD, DC, VA, NY and CT is considered outside the situs region. Out-of-situs employees will be offered one of the dental PPO plans. Employees who fall outside a dental PPO network area will default to a comparable indemnity plan. 	<ul style="list-style-type: none"> Employees are eligible for the same life plan selected by the employer.

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Participation	<p>Non-contributory plans (Employer pay all)</p> <ul style="list-style-type: none"> 100 percent of all employees must enroll, excluding valid waivers. <p>Contributory plans</p> <ul style="list-style-type: none"> 2 – 4 eligible employees – 100% of the eligible employees must participate, excluding those with valid waivers. 5 – 50 eligible employees – 75% of the eligible employees must participate, excluding valid waivers, rounding down. <p>Example:</p> <p>30 eligible employee Five covered under spouse: $30 - 5 = 25 \times 75\% = 18.75 = 18$ (rounded down) must enroll.</p> <p>Waivers</p> <ul style="list-style-type: none"> Valid waivers include <ul style="list-style-type: none"> spousal coverage, parental group coverage, Medicare, Medicaid, TRICARE/CHAMPUS/CHAMPVA, military coverage, religious reasons, retiree coverage through a previous employer, group coverage through a second full-time job, surviving spouse, association coverage, and COBRA enrollees (active eligible employee waiving coverage based on current COBRA coverage through prior employer once they waive coverage under our plan they are not eligible to enroll until open enrollment OR they exhaust the entire continuation period). Individual coverage (on and off exchange) is not a valid waiver. A minimum of 2 employees must enroll. 	<p>Noncontributory plans (Employer pay all)</p> <ul style="list-style-type: none"> 100 percent participation is required, excluding those with other qualifying dental coverage with a minimum of two enrolled. <p>Contributory plans with medical or standalone (round to the nearest)</p> <p>Standard plans</p> <ul style="list-style-type: none"> 2 – 3 eligible employees – 100%, excluding those with other qualifying dental coverage with a minimum of two enrolled. <p>Example:</p> <p>Three eligibles, one spousal dental $3 - 1 = 2 \times 100\% = 2$ must enroll</p> <ul style="list-style-type: none"> 4 – 50 eligible employees 75 percent, excluding those with other qualifying dental coverage. A minimum of two and 50 percent of total eligible employees must enroll in the dental plan. <p>Voluntary plans</p> <ul style="list-style-type: none"> 3 – 50 eligible employees – 30 percent participation, excluding those with other qualifying existing dental coverage Minimum of three must enroll. If a group does not qualify for a standard plan and has 30 percent or more participation then group qualifies for voluntary. <p>Standard and Voluntary</p> <ul style="list-style-type: none"> 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. 	<p>2 – 9 eligible employees</p> <ul style="list-style-type: none"> 100 percent participation <p>10 – 50 eligible employees</p> <ul style="list-style-type: none"> Noncontributory – 100 percent participation Contributory – 75 percent participation <p>Stand-alone Life</p> <ul style="list-style-type: none"> 75 percent participation is required. <p>All plans</p> <ul style="list-style-type: none"> COBRA and state continues are not eligible. Retirees are not eligible. Employees may elect life insurance even if they do not elect medical coverage and the group must meet the required participation percentage. If not, then life insurance will be declined for the group. <p>Example:</p> <p>9 employees 3 waiving medical 9 must enroll for life</p> <p>Coverage can be denied based on inadequate participation.</p>

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Participation (continued)	<ul style="list-style-type: none"> Any eligible employees waiving coverage must complete the waiver section of the Employee Application. Groups that do not meet the participation guidelines are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. 		
Plan Change Group Level	<ul style="list-style-type: none"> Plan anniversary date only. 	<ul style="list-style-type: none"> Dental plans must be requested five days before the desired effective date. The future renewal date of the change will be the same as the medical plan anniversary date. 	<ul style="list-style-type: none"> Packaged Life/Disability must be requested 30 days before the desired effective date. Nonpackaged plans are only available on the plan anniversary date. The future renewal date of the change will be the same as the medical plan anniversary date.
Plan Change Employee Level	<ul style="list-style-type: none"> Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events). 	<ul style="list-style-type: none"> Freedom-of-Choice – May change from DMO to PPO and vice versa at any time but must be received in Aetna underwriting by the 15th to be effective the next month. 	<ul style="list-style-type: none"> Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events).

Product specifications

	Medical	Dental	Life, AD&D, Disability and Packaged Life & Disability
Standard Industrial Classification Code (SIC)	<ul style="list-style-type: none"> Underwriting will use a variety of tools, including Dun & Bradstreet, to verify a group's industry code and classify the business correctly. All industries are eligible. 	<ul style="list-style-type: none"> All industries are eligible if sold with medical. The following industries are not eligible when dental is sold stand-alone or packaged only with life. <p>7933– Bowling Centers</p> <p>7933</p> <p>8611– Business</p> <p>8611 Associations</p> <p>7911– Dance Studios,</p> <p>7911 Schools</p> <p>7361– Employment</p> <p>7363 Agencies</p> <p>7999– Miscellaneous</p> <p>7999 Amusement/ Recreation</p> <p>8699– Miscellaneous</p> <p>8699 Membership Org</p> <p>8999– Miscellaneous</p> <p>8999 Services</p> <p>7991– Physical Fitness</p> <p>7991 Facilities</p> <p>8811– Private Households</p> <p>8811</p> <p>8621– Professional</p> <p>8651 Membership Organizations, Labor Unions, Civic Social and Fraternal Orgs, Political Orgs</p> <p>7941– Professional Sports</p> <p>7948 Clubs & Producers, Race Tracks</p> <p>7992– Public Golf Courses,</p> <p>7997 Amusements, Membership Sports & Recreation Clubs</p> <p>8661– Religious</p> <p>8661 Organizations</p> <p>7922– Theatrical</p> <p>7929 Producers, Bands, Orchestras, Actors</p>	<ul style="list-style-type: none"> Basic Term Life - All industries are eligible Packaged Life/Disability and Disability only - the following industries are not eligible, <p>3291– Asbestos Products</p> <p>3292</p> <p>7500– Automotive</p> <p>7599 Repairs/Services</p> <p>7381 Detective Services</p> <p>8010– Doctor's Offices</p> <p>8043 Clinics</p> <p>2892– Explosives, Bombs</p> <p>2899 & Pyrotechnics</p> <p>3480– Fire Arms &</p> <p>3489 Ammunition</p> <p>5921 Liquor Stores</p> <p>8600– Membership</p> <p>8699 Associations</p> <p>1000– Mining</p> <p>1499</p> <p>7800– Motion Picture/</p> <p>7999 Amusement & Recreation</p> <p>9999 Non-classified Establishments</p> <p>3310– Primary Metal</p> <p>3329 Industries</p> <p>8800– Private Household</p> <p>8899</p> <p>6531 Real Estate – Agents</p> <p>6211 Security Brokers</p>

Dental only

Coverage Waiting Period

Standard 2 – 9 eligible employees and Voluntary 3 – 50 eligible employees

- PPO and indemnity plans – for major and orthodontic services employees must be an enrolled member of the employer’s plan for one year before becoming eligible.
- DMO – there is no waiting period.
- Discount plans do not qualify as previous coverage.
- Future hires – waiting period applies regardless if takeover for voluntary.
- Virgin group (no prior coverage) – the waiting periods apply to employees at case inception as well as any future hires.
- Takeover/Replacement cases (prior coverage) – you must provide a copy of the last billing statement and schedule of benefits in order to provide credit. If a group’s prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a dental plan in place that covered major (and ortho, if applicable) immediately preceding our takeover of the business.

Example:

Prior major coverage but no ortho coverage. Aetna plan has coverage for both major and ortho. The waiting period is waived for major services but not for ortho services

Standard 10 – 50 eligible employees

- No waiting period

An open enrollment is a period when any employee can elect to join the dental plan without penalty, regardless if they previously declined coverage during the first 31 days of initial eligibility.

Standard Plans with medical or standalone

- 2 – 9 eligible employees: No open enrollment
- 10 – 50 eligible employees: Employees/dependents who do not enroll when initially eligible are now eligible to enroll during a subsequent open enrollment period without being subject to the late entrant provision.

Voluntary Plans with medical or standalone

- 2 – 50 eligible employees: No open enrollment

Option Sales

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

Reinstatement (applies to Voluntary Plans only)

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

Life and disability only

Job Classification
(Position)
Schedules

- Varying levels of coverage based on job classifications are available for groups with 10 or more lives.
- Up to three separate classes are allowed (with a minimum requirement of three employees in each class).
- Items such as probationary periods must be applied consistently within a class of employee.
- The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit even if only two classes are offered. For example, a schedule may be structured as follows:

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

Guarantee Issue Coverage

- Aetna provides certain amounts of life insurance to all timely entrants without requiring an employee to answer any medical questions. These insurance amounts are called “guaranteed issue.”
- Employees wishing to obtain increased insurance amounts will be required to submit evidence of insurability which means they must complete a medical questionnaire and may be required to provide medical records.
- On-time enrollees who do not meet the requirements of evidence of insurability will receive the guaranteed issue life amount.
- Late enrollees must qualify for the entire amount and are not guaranteed any coverage.

Actively-at-work

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

Continuity of Coverage (no loss/
no gain)

- The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers.
- If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage for a maximum of 12 months from the policy effective date, except no benefits are payable if the prior plan is liable. If the employee has not returned to active work prior to the end of the 12 month period, conversion must be offered.

Evidence of Insurability (EOI)

Evidence of Insurability (EOI) means the person must complete an individual health statement and may have to submit to medical evidence via medical records at their expense. EOI is required when one or more of the following conditions exist:

1. Life insurance coverage amounts requested are above the guaranteed standard issue limit.
2. Late entrant - coverage is not requested within 31 days of eligibility for contributory coverage.
3. New coverage is requested during the anniversary period.
4. Coverage is requested outside of the employer’s anniversary period due to qualifying life event, such as marriage, divorce, newborn child, adoption or loss of spousal coverage.
5. Reinstatement or restoration of coverage is requested.
6. 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.
7. Requesting life or disability insurance at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the guaranteed issue limit.

Example:

- Group has \$50,000 life with \$20,000 guaranteed issue limit.
- Late enrollee enrolling for \$50,000 would not automatically get the \$20,000.
- Since the applicant is late, they must medically qualify for the entire \$50,000.

Limitations and exclusions

HMO/HNOnly/QPOS/Health Network Option plans

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, the plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical and hospital services not specifically covered in, or that 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
- 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

PPO/Indemnity plans

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, the plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

- All medical or hospital services not specifically covered in, or that 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
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Treatment of those services for or related to treatment of obesity or for diet or weight control

Dental, AD&D Ultra and Disability

Dental, AD&D Ultra and disability plans include limitations, exclusions and charges or services that these plans do not cover. For a complete listing of all limitations and exclusions or charges and services that are not covered, please refer to your Aetna group plan documents. Limitations, exclusions and charges or services may vary by state or group size.

Dental

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges for the following services or supplies are limited or may be excluded:

- Dental services or supplies that are primarily used to alter, improve or enhance appearance
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost, missing or stolen appliances and certain damaged appliances
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- Specific service limitations:
 - DMO plans: Oral exams (4 per year)
 - PPO plans: Oral exams (2 routine and 2 problem-focused per year)
 - All plans:
 - Bitewing X-rays (1 set per year)
 - Complete series X-rays (1 set every 3 years)
 - Cleanings (2 per year)
 - Fluoride (1 per year; children under 16)
 - Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)
 - Scaling & root planing (4 quadrants every 2 years)
 - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in the plan documents.

Employee and Dependent Life Insurance:

The plan may not pay a benefit for deaths caused by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of the person's coverage. If death occurs after two years of the effective date but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

*These do not apply if the loss is caused by:

- An infection that results directly from the injury.
- Surgery needed because of the injury.

The injury must not be one that is excluded by the terms of this section.

AD&D Ultra®

Not all events that may be ruled accidental are covered by this plan. No benefits are payable for a loss caused or contributed to by:

- Air or space travel 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)
- Bodily or mental infirmity
- Commission of or attempt to commit a criminal act
- Illness, ptomaine or bacterial infection*
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Ligature strangulation resulting from auto-erotic asphyxiation
- Intentionally self-inflicted injury
- Medical or surgical treatment*
- Third-degree burns resulting from sunburn
- Use of alcohol
- Use of drugs, except as prescribed by a physician
- Use of intoxicants
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident the member was:
 - Operating the motor vehicle while under the influence of alcohol is a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
 - Operating the motor vehicle while under the influence of an intoxicant or illegal drug; or
 - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician; or
 - Operating the motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions
- Suicide or attempted suicide (while sane or insane).
- War or any act of war (declared or not declared).

Disability

Disability coverage also does not cover any disability that:

- Is due to an occupational illness or occupational injury except in the case of sole proprietors or partners who cannot be covered by workers' compensation
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion
- Is due to intentionally self-inflicted injury (while sane or insane)
- Is due to war or any act of war (declared or not declared)
- Results from committing or attempting to commit a criminal act
- Results from a motor vehicle accident caused by operating the vehicle while the member is under the influence of alcohol. A motor vehicle accident will be deemed to be caused by the use of alcohol if it is determined that at the time of the accident the member was operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred.) If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.

Disability coverage does not cover any disability on any day that the member is confined in a penal or correctional institution for conviction of a criminal act or other public offense. The member will not be considered to be disabled, and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three months before the coverage effective date.

SBC Requirements under the Affordable Care Act

The Affordable Care Act mandates a new plan document entitled Summary of Benefits and Coverage (SBC). You can view and download a new brochure that describes the SBC requirements and your distribution obligations at www.aetna.com/externalweb/documents/SBCBrochure.pdf.

To retrieve the SBCs from the Producer World[®] website, go to www.aetna.com, click on the link for Producers and then Producer Log In.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules and are unfunded liabilities of your employer. Fund balances are not vested benefits. Investment services are independently offered through HealthEquity, Inc. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.

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