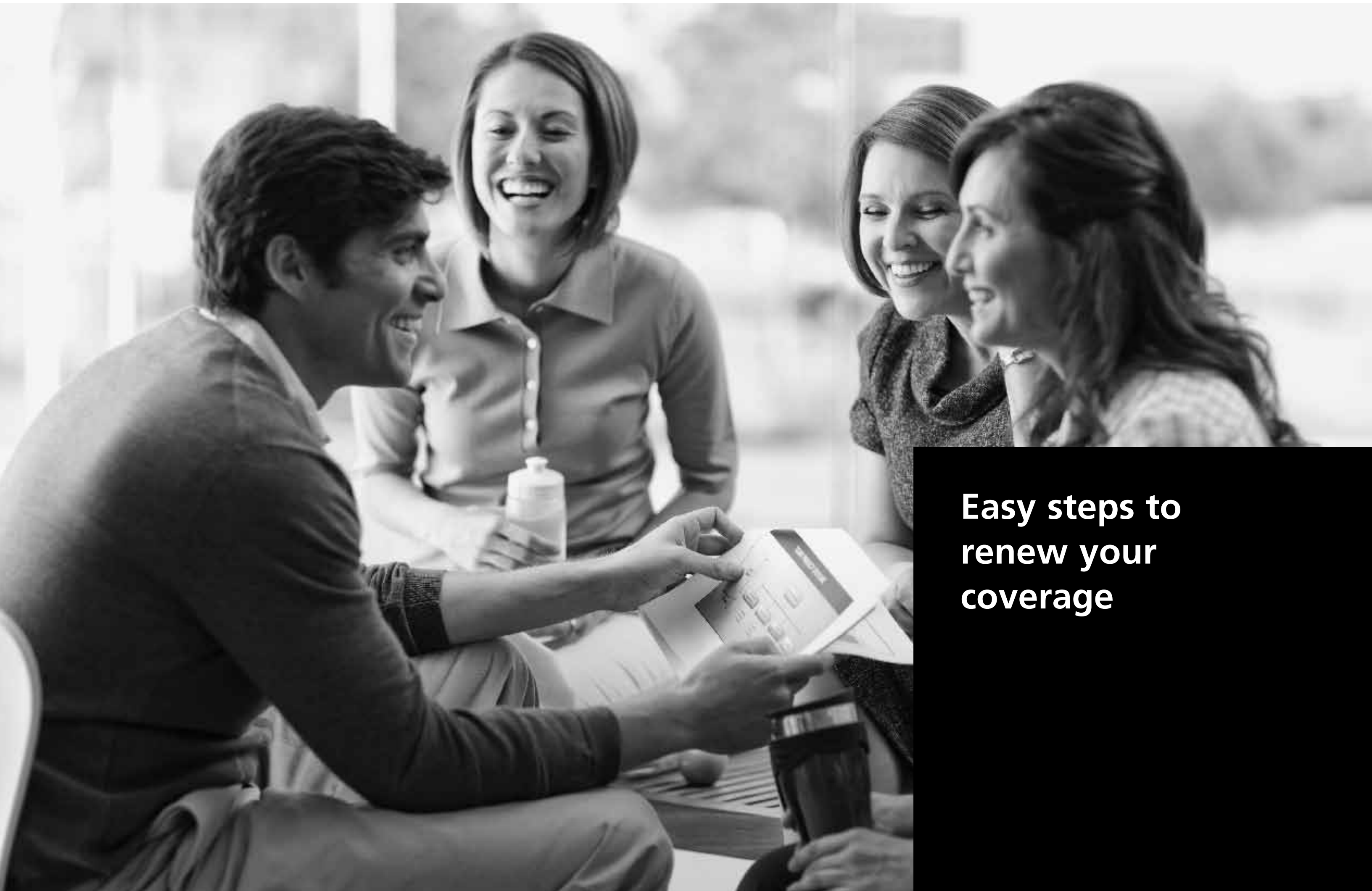
Utah Renewal Instructions

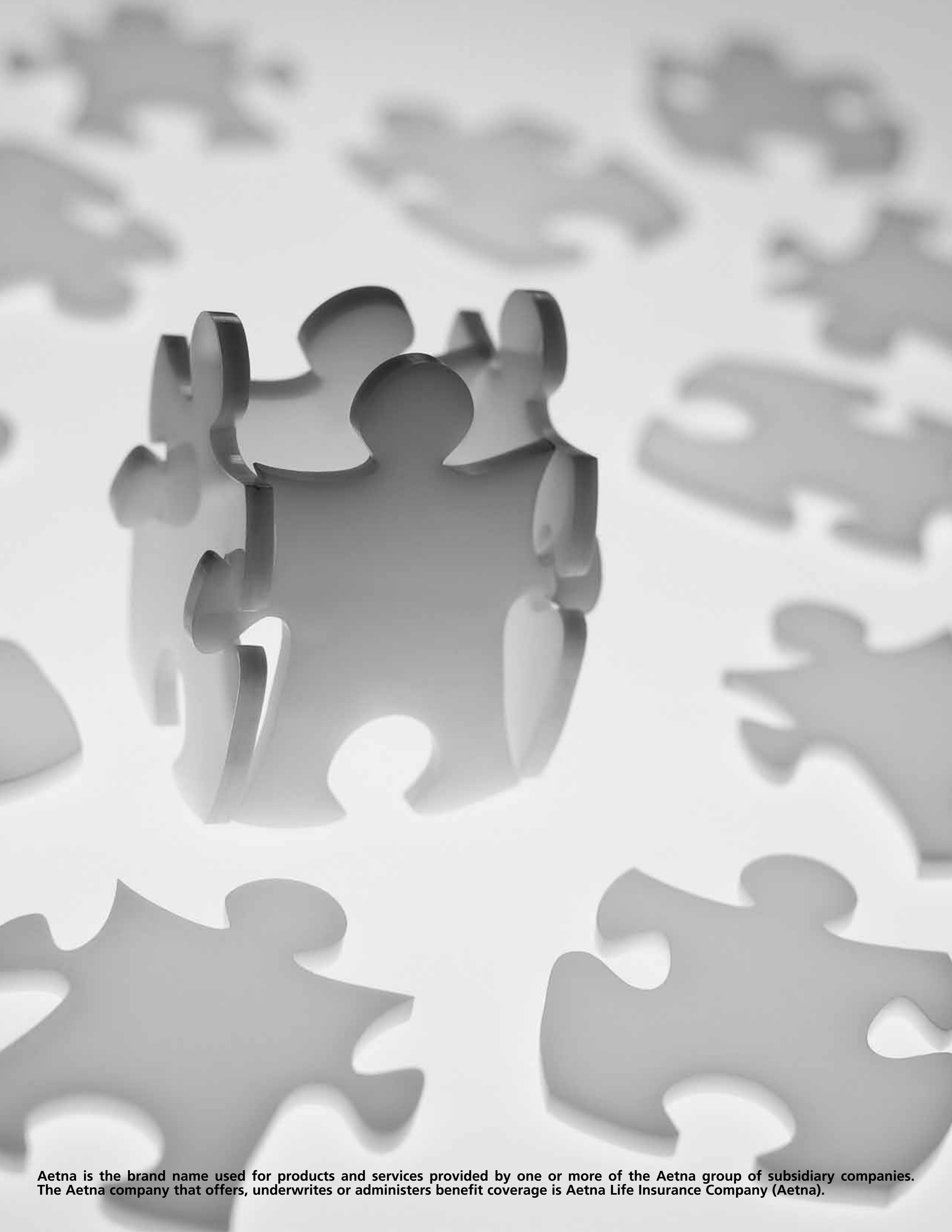
FOR 2 – 50 ELIGIBLE EMPLOYEES

Effective 1/1/2010



Aetna®

14.02.138.1-UT B (10/09)



Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna company that offers, underwrites or administers benefit coverage is Aetna Life Insurance Company (Aetna).

It’s renewal time, with Aetna

Aetna makes the renewal process easy

Dear Valued Aetna Customer:

We appreciate your business and look forward to renewing your health insurance benefits. If you are pleased with your current plan and don’t wish to make changes — the renewal process is complete and your coverage will automatically renew prior to the effective date.

Aetna Avenue® – Your Destination for Small Business Solutions℠

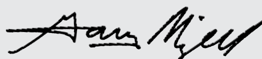
You’ll notice a new look and feel with the materials you receive from us this year. Aetna Avenue is our commitment to value for your premium dollars. Whether or not you decide to make any medical health insurance plan changes, you and your employees will have continued access to all of our value-add discount programs and health resources, including our award-winning member website, Aetna Navigator®.

Aetna Avenue also means access to care from Utah’s largest health provider network and the flexibility of Pick-A-Plan 3. With the option to choose any 2-3 plans from our 2009 portfolio, you control the bottom line while providing employees superior health benefits coverage.

This booklet serves as your guide to complete your 2009 renewal. If you have questions or need more information, contact your benefits producer or Aetna Small Group at **1-877-249-7235**, prompt #1.

We understand you have a choice of carriers and thank you for placing your confidence in Aetna.

Sincerely,



Gary Mizell
Vice President and Market Head of Sales and Service
Aetna Small and Middle Market Business
Arizona, Nevada and Utah

Contact information

Aetna Small Group Broker & General Agents

BROKER SALES SUPPORT UNIT

1-877-249-2472 phone
1-888-258-4530 fax

Choose the following numbers, when prompted, to access the information you need.

1 If you know your party's extension

2 Claims

3 Commissions

4 Licensing and Appointment

5 Billing, Enrollment and Eligibility

6 Broker Liaison

E-mail Address

Utah:
ASGBLUT@aetna.com

Regular Mail

P.O. Box 24004
Fresno, CA 93779-4004

Overnight Mail

1385 East Shaw Avenue
Fresno, CA 93710

New Business Quoting

Utah:
1-866-748-9094 phone
1-866-572-1273 fax
ASGQuoteUT@aetna.com

New Business Case Submission

Aetna New Business Underwriting
P.O. Box 24004
Fresno, CA 93779-4004

Aetna Navigator® & Producer World®

1-800-225-3375 Monday – Friday
7:00 a.m. – 9:00 p.m. ET

Choose the following numbers, when prompted, to access the information you need.

Prompt 1 (Aetna Navigator)
Prompt 3 (Producer World)

1 Assistance with password or user name

2 Assistance with registration

3 Access assistance

4 All other website technical assistance

PLAN SPONSOR SERVICES

1-877-249-7235 phone
1-888-258-4528 fax

Choose the following numbers, when prompted, to access the information you need.

1 Renewals

2 Claims

3 Billing & Enrollment

Billing

For Lockbox information, see customer bill or please contact the Plan Sponsor Services toll-free number for more information.

Enrollment

Aetna
P.O. Box 24005
Fresno, CA 93779-4005

Member Services

MEDICAL

1-888-802-3862 (prompt 1)
For benefit questions or claims for Aetna PPO Plan, Aetna Indemnity Plan

Claims Addresses

For Aetna PPO Plan, Aetna Indemnity Plan

Aetna
P.O. Box 981106
El Paso, TX 79998-1106

DENTAL

1-877-238-6200

Prompt 1 (Dental Plan Member)
Prompt 2 (Dental Care Provider)

Claims Address

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

LIFE

1-800-523-5065

Claims Address

Aetna Life Insurance
P.O. Box 14549
Lexington, KY 40512-4549

PHARMACY

1-800-AETNA RX or 1-800-238-6279

Prompt 2 (Member or Calling on Behalf of a Member)

Claims Address

Aetna Pharmacy Management
Attn: Claims
P.O. Box 14024
Lexington, KY 40512
Fax: 1-860-262-9437

Mail-Order Drug

1-866-612-3862

Ordering Address
Aetna Rx Home Delivery
P.O. Box 417019
Kansas City, MO 64179-9892

OTHER PROGRAMS

Aetna Vision℠ Discount Program

1-800-793-8616
Call for closest eye care provider

Informed Health® Line

1-800-556-1555
24-Hour Nurse Help Line

Aetna Behavioral Health

Please call the number on your Member ID card.

Alternative Health Care Programs, Fitness Program, DocFind®, Aetna Navigator and Other Information

Information can be accessed through our website at Aetna.com.

How to renew your Aetna health plans

To keep your *existing benefits* AND select an *alternate plan(s)* —

- Please check off the "**Renewal**" plan and also check off any "**Alternate**" plans you'd like to add on the Plan Sponsor Signature Page in your renewal packet and fax it to **1-888-258-4530**.
- Please submit a letter or list of employees to identify the correct plan selection of all employees.

To delete your existing benefits and move to an *alternate plan(s)* —

- Please check off any "**Alternate**" plans you'd like to add on the Plan Sponsor Signature Page in your renewal packet and fax it to **1-888-258-4530**.
- Please submit a letter or list of employees to identify the correct plan selection of all employees.

To request an *upgrade* in benefits not listed in your renewal —

If you're not enrolled in Pick-A-Plan 3, medical underwriting is required on all upgrade requests and may be declined.

- Please submit a letter on company letterhead requesting the upgraded plan(s).
- Employee Change of Coverage Form, with the medical question completed only for those employees wishing to move.
- A completed Employer Application (pages 1 and 4).
- Copy of the most recent filed 3H.
- Please fax all information to **1-888-258-4530**.

All items (completed in full) are to be received by Aetna no later than the day before the requested effective date. Ancillary adds need to be submitted 15 days in advance of the requested effective date.

Correspondence can also be mailed to:

Aetna
P.O. Box 24005
Fresno, CA 93779

TRADITIONAL PLATFORM

PPO Plans

PPO HDHP Plans

Indemnity Plans

2009 Summary Comparison

Aetna has redesigned several of our 2008 plans and developed new options for 2009 to provide greater choice, simplicity and affordability to meet your health benefit needs. Please refer to the guide below to determine how your current benefit plan is changing for 2009.

YOUR CURRENT PLAN		YOUR RENEWAL PLAN	CHANGES
PPO 250 80/60	compared to	PPO 250 80/60	See page 6
PPO 500 80/60	compared to	PPO 500 80/60	See page 7
PPO 750 80/60	compared to	PPO 750 80/60	See page 8
PPO 1000 80/60	compared to	PPO 1000 80/60	See page 9
PPO 1500 80/60	compared to	PPO 1500 80/60	See page 10
PPO 2000 80/60	compared to	PPO 2000 80/60	See page 11
PPO 1500 100%	compared to	PPO 1500 80/60	See page 12
PPO 2500 100%	compared to	PPO 2000 80/60	See page 13
HDHP 2300 80%	compared to	2500 80% HSA	See page 14
HDHP 2500 100%	compared to	2500 100% HSA	See page 15
HDHP 3000 80%	compared to	3500 80% HSA	See page 16
HDHP 3000 100%	compared to	3500 80% HSA	See page 17
HDHP 3500 80%	compared to	3500 80% HSA	See page 18
Limited Benefit 50/50	compared to	LIMITED BENEFIT 50/50	See page 19
Basic 1500	compared to	BASIC 1500	See page 20
2008 Indemnity	compared to	INDEMNITY	See page 21

NEW AETNA BENEFIT PLANS EFFECTIVE AUGUST 1, 2009

		PPO 750 VALUE	See page 22
		PPO 1000 VALUE	See page 23
		PPO 1500 VALUE	See page 24
		PPO 3000 80/60	See page 25
		PPO 10,000 100%	See page 26
		UTAH 2500 COINSURANCE	See page 27

NEW AETNA BENEFIT PLANS EFFECTIVE JANUARY 1, 2010

		UTAH BASIC HSA $1,200 PLAN	See page 28

PPO 250 80/60 Compared to PPO 250 80/60

Plan Name	Current Plan PPO 250 80/60		Renewal Plan PPO 250 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$10 copay	40% after deductible	$10 copay	40% after deductible
Routine GYN and Mammography	$20 copay	40% after deductible	$20 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$20 copay	40% after deductible	$20 copay	40% after deductible
Calendar Year Deductible	$250 per member Two-member maximum	$500 per member Two-member maximum	$250 per member Two-member maximum	$500 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after $100 copay (deductible waived)	Paid as in-network	20% after $100 copay (deductible waived)	Paid as in-network
Prescription Drugs	$10/$30/$50	$10/$30/$50 + 20%	$10/$30/$50	$10/$30/$50 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care and Mental Health have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 500 80/60 Compared to PPO 500 80/60

Plan Name	Current Plan PPO 500 80/60		Renewal Plan PPO 500 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$15 copay	40% after deductible	$15 copay	40% after deductible
Routine GYN and Mammography	$25 copay	40% after deductible	$25 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$25 copay	40% after deductible	$25 copay	40% after deductible
Calendar Year Deductible	$500 per member Two-member maximum	$1,000 per member Two-member maximum	$500 per member Two-member maximum	$1,000 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$2,000 per member Two-member maximum	$4,000 per member Two-member maximum	$2,000 per member Two-member maximum	$4,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	40% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after $150 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network
Prescription Drugs	$10/$30/$50	$10/$30/$50 + 20%	$10/$30/$50	$10/$30/$50 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 750 80/60 Compared to PPO 750 80/60

Plan Name	Current Plan PPO 750 80/60		Renewal Plan PPO 750 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations	$15 copay	40% after deductible	$15 copay	40% after deductible
Routine GYN and Mammography	$25 copay	40% after deductible	$25 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$25 copay	40% after deductible	$25 copay	40% after deductible
Calendar Year Deductible	$750 per member Two-member maximum	$1,500 per member Two-member maximum	$750 per member Two-member maximum	$1,500 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$2,250 per member Two-member maximum	$4,500 per member Two-member maximum	$2,250 per member Two-member maximum	$4,500 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after $150 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network
Prescription Drugs	$15/$30/$50	$15/$30/$50 +20%	$15/$30/$50	$15/$30/$50 +20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 1000 80/60 Compared to PPO 1000 80/60

Plan Name	Current Plan PPO 1000 80/60		Renewal Plan PPO 1000 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$20 copay	40% after deductible	$20 copay	40% after deductible
Routine GYN and Mammography	$30 copay	40% after deductible	$30 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$30 copay	40% after deductible	$30 copay	40% after deductible
Calendar Year Deductible	$1,000 per member Two-member maximum	$2,000 per member Two-member maximum	$1,000 per member Two-member maximum	$2,000 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$2,500 per member Two-member maximum	$5,000 per member Two-member maximum	$2,500 per member Two-member maximum	$5,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible		
Emergency Room (copay waived if admitted)	20% after $150 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network
Prescription Drugs	$15/$30/$60	$15/$30/$60 + 20%	$15/$30/$60	$15/$30/$60 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 1500 80/60 Compared to PPO 1500 80/60

Plan Name	Current Plan PPO 1500 80/60		Renewal Plan PPO 1500 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$25 copay	40% after deductible	$25 copay	40% after deductible
Routine GYN and Mammography	$35 copay	40% after deductible	$35 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$35 copay	40% after deductible	$35 copay	40% after deductible
Calendar Year Deductible	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$3,000 per member Two-member maximum	$5,000 per member Two-member maximum	$3,000 per member Two-member maximum	$5,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after $200 copay (deductible waived)	Paid as in-network	20% after $200 copay (deductible waived)	Paid as in-network
Prescription Drugs*	$15/$40/$60 Subject to $150 deductible	$15/$40/$60 + 20% Subject to $150 deductible	$15/$40/$60	$15/$40/$60 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

*The Prescription Drug Deductible has been removed on the 2009 plan.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 2000 80/60 Compared to PPO 2000 80/60

Plan Name	Current Plan PPO 2000 80/60		Renewal Plan PPO 2000 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$30 copay	40% after deductible	$30 copay	40% after deductible
Routine GYN and Mammography	$40 copay	40% after deductible	$40 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$40 copay	40% after deductible	$40 copay	40% after deductible
Calendar Year Deductible	$2,000 per member Two-member maximum	$4,000 per member Two-member maximum	$2,000 per member Two-member maximum	$4,000 per member Two-member maximum
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (excludes deductible)	$3,500 per member Two-member maximum	$7,000 per member Two-member maximum	$3,500 per member Two-member maximum	$7,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after $200 copay (deductible waived)	Paid as in-network	20% after $200 copay (deductible waived)	Paid as in-network
Prescription Drugs*	$20/$40/$60 Subject to $200 deductible	$20/$40/$60 + 20% Subject to $200 deductible	$20/$40/$60	$20/$40/$60 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

*The Prescription Drug Deductible has been removed on the 2009 plan.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 1500 100% Compared to PPO 1500 80/60

Plan Name	Current Plan PPO 1500 100%		Renewal Plan PPO 1500 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$20 copay	25% after deductible	$25 copay	40% after deductible
Routine GYN and Mammography	$30 copay	25% after deductible	$35 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$30 copay	25% after deductible	$35 copay	40% after deductible
Calendar Year Deductible	$1,500 per member Three-member maximum	$3,000 per member Three-member maximum	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum
Coinsurance	0%	25%	20%	40%
Coinsurance Maximum (excludes deductible)	N/A	$6,000 per member Three-member maximum	$3,000 per member Two-member maximum	$5,000 per member Two-member maximum
Outpatient Lab	$0 copay	25% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	25% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	0% after deductible	25% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	$200 copay Deductible waived	Paid as in-network	20% after $200 copay Deductible waived	Paid as in-network
Prescription Drugs	$15/$30/$60	$15/$30/$60 + 20%	$15/$40/$60	$15/$40/$60 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 2500 100%
Compared to
PPO 2000 80/60

Plan Name	Current Plan PPO 2500 100%		Renewal Plan PPO 2000 80/60	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$25 copay	25% after deductible	$30 copay	40% after deductible
Routine GYN and Mammography	$35 copay	25% after deductible	$40 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$35 copay	25% after deductible	$40 copay	40% after deductible
Calendar Year Deductible	$2,500 per member Three-member maximum	$3,500 per member Three-member maximum	$2,000 per member Two-member maximum	$4,000 per member Two-member maximum
Coinsurance	0%	25%	20%	40%
Coinsurance Maximum (excludes deductible)	N/A	$7,000 per member Three-member maximum	$3,500 per member Two-member maximum	$7,000 per member Two-member maximum
Outpatient Lab	$0 copay	25% after deductible	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	25% after deductible	$0 copay	40% after deductible
Outpatient Complex Imaging	0% after deductible	25% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	$250 copay Deductible waived	Paid as in-network	20% after $200 copay Deductible waived	Paid as in-network
Prescription Drugs	$20/$40/$60	$20/$40/$60 + 20%	$20/$40/$60	$20/$40/$60 + 20%
Self Injectables (retail and mail order)	50%	50%	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

HDHP 2300 80% Compared to 2500 80% HSA Compatible

	Current Plan		Renewal Plan	
Plan Name	**HDHP 2300 80%**		**2500 80% HSA Compatible**	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Routine GYN and Mammography	$30 copay (deductible waived)	40% after deductible	$0 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Calendar Year Deductible	$2,300 Individual $4,600 Family	$4,500 Individual $9,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (includes deductible)	$5,200 Individual $10,400 Family	$13,500 Individual $27,000 Family	$5,800 Individual $11,600 Family	$12,000 Individual $24,000 Family
Outpatient Lab	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient X-ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after deductible	Paid as in-network	20% after deductible	Paid as in-network
Prescription Drugs	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 30% after integrated medical deductible	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible
Self Injectables (retail and mail order)	50% for formulary and non-formulary	50% for formulary and non-formulary	20% after integrated medical deductible	20% after integrated medical deductible

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

HDHP 2500 100% Compared to 2500 100% HSA Compatible

Plan Name	Current Plan HDHP 2500 100%		Renewal Plan 2500 100% HSA Compatible	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Routine GYN and Mammography	$0 copay	25% after deductible	$0 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Calendar Year Deductible	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Coinsurance	0%	25%	0%	25%
Coinsurance Maximum (includes deductible)	$2,500 Individual $5,000 Family	$10,000 Individual $20,000 Family	$2,500 Individual $5,000 Family	$10,000 Individual $20,000 Family
Outpatient Lab	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Outpatient X-ray	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Outpatient Complex Imaging	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Hospital Inpatient	0% after deductible	25% after deductible	0% after deductible	25% after deductible
Emergency Room (copay waived if admitted)	0% after deductible	Paid as in-network	0% after deductible	Paid as in-network
Prescription Drugs	0% after integrated medical deductible	25% after integrated medical deductible	0% after integrated medical deductible	25% after integrated medical deductible
Self Injectables (retail and mail order)	0% after integrated medical deductible	25% after integrated medical deductible	0% after integrated medical deductible	25% after integrated medical deductible

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

HDHP 3000 80% Compared to 3500 80% HSA Compatible

Plan Name	Current Plan HDHP 3000 80%		Renewal Plan 3500 80% HSA Compatible	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Routine GYN and Mammography	$35 copay after deductible	40% after deductible	$0 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Calendar Year Deductible	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family	$3,500 Individual $7,000 Family	$6,000 Individual $12,000 Family
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (includes deductible)	$5,250 Individual $10,500 Family	$15,000 Individual $30,000 Family	$5,800 Individual $11,600 Family	$12,000 Individual $24,000 Family
Outpatient Lab	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient X-ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after deductible	Paid as in-network	20% after deductible	Paid as in-network
Prescription Drugs	$15/$30/$60 after integrated medical deductible	$15/$30/$60 + 30% after integrated medical deductible	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible
Self Injectables (retail and mail order)	50% for formulary and non-formulary	50% for formulary and non-formulary	20% after integrated medical deductible	20% after integrated medical deductible

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

HDHP 3000 100% Compared to 3500 80% HSA Compatible

Plan Name	Current Plan HDHP 3000 100%		Renewal Plan 3500 80% HSA Compatible	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Routine GYN and Mammography	$0 copay	25% after deductible	$0 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Calendar Year Deductible	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$3,500 Individual $7,000 Family	$6,000 Individual $12,000 Family
Coinsurance	0%	25%	20%	40%
Coinsurance Maximum (includes deductible)	$3,000 Individual $6,000 Family	$16,000 Individual $32,000 Family	$5,800 Individual $11,600 Family	$12,000 Individual $24,000 Family
Outpatient Lab	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Outpatient X-ray	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Outpatient Complex Imaging	0% after deductible	25% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	0% after deductible	25% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	0% after deductible	Paid as in-network	20% after deductible	Paid as in-network
Prescription Drugs	0% after integrated medical deductible	25% after integrated medical deductible	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible
Self Injectables (retail and mail order)	0% after integrated medical deductible	25% after integrated medical deductible	20% after integrated medical deductible	20% after integrated medical deductible

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

HDHP 3500 80% Compared to 3500 80% HSA Compatible

Plan Name	Current Plan HDHP 3500 80%		Renewal Plan 3500 80% HSA Compatible	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Routine GYN and Mammography	$0 copay	40% after deductible	$0 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Calendar Year Deductible	$3,500 Individual $7,000 Family	$6,000 Individual $12,000 Family	$3,500 Individual $7,000 Family	$6,000 Individual $12,000 Family
Coinsurance	20%	40%	20%	40%
Coinsurance Maximum (includes deductible)	$5,500 Individual $11,000 Family	$12,000 Individual $24,000 Family	$5,800 Individual $11,600 Family	$12,000 Individual $24,000 Family
Outpatient Lab	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient X-ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after deductible	Paid as in-network	20% after deductible	Paid as in-network
Prescription Drugs	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible
Self Injectables (retail and mail order)	50% after integrated medical deductible	50% after integrated medical deductible	0% after integrated medical deductible	25% after integrated medical deductible

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

LIMITED BENEFIT 50/50 Compared to LIMITED BENEFIT 50/50

Plan Name	Current Plan LIMITED BENEFIT 50/50		Renewal Plan LIMITED BENEFIT 50/50	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$25,000 annual lifetime benefit maximum $2 million lifetime		$25,000 annual lifetime benefit maximum $2 million lifetime	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Routine GYN and Mammography	$30 copay	50% after deductible	$30 copay	50% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Calendar Year Deductible	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum
Coinsurance	50%	50%	50%	50%
Coinsurance Maximum (excludes deductible)	$4,500 per member Two-member maximum	$9,000 per member Two-member maximum	$4,500 per member Two-member maximum	$9,000 per member Two-member maximum
Outpatient Lab	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient X-ray	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Complex Imaging	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Limit	Outpatient lab, x-ray and complex imaging limited to $500 max benefit per calendar year		Outpatient lab, x-ray and complex imaging limited to $500 max benefit per calendar year	
Hospital Inpatient	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Surgery (Hospital)	50% includes any associated ancillary and professional charges	50% includes any associated ancillary and professional charges	$200 copay +50% includes any associated ancillary and professional charges	$200 copay +50% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	50% after deductible	Paid as in-network	50% after deductible	Paid as in-network
Prescription Drugs	$15/50%/50% after integrated medical deductible	$15/50%/50% +20% for generics; after integrated medical deductible	$10 generics; member pays 100% for Brand	$10 generics + 20%; member pays 100% for Brand
Mail Order Drugs	2.5 times retail copay; 31- to 90-day supply	Not Covered	3 times retail copay; 31- to 90-day supply	Not Covered
Self Injectables (retail and mail order)	50% after integrated medical deductible	50% after integrated medical deductible	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

BASIC 1500 Compared to BASIC 1500

Plan Name	Current Plan BASIC 1500		Renewal Plan BASIC 1500	
Benefit	In-Network	Out of Network	In-Network	Out of Network
Lifetime Maximum	$2,000,000		$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$35 copay	45% after deductible	$35 copay	45% after deductible
Routine GYN and Mammography	$35 copay	45% after deductible	$35 copay	45% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$35 copay	45% after deductible	$35 copay	45% after deductible
Calendar Year Deductible	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum	$1,500 per member Two-member maximum	$3,000 per member Two-member maximum
Coinsurance	30%	45%	30%	45%
Coinsurance Maximum (excludes deductible)	$4,500 per member Two-member maximum	$9,000 per member Two-member maximum	$4,500 per member Two-member maximum	$9,000 per member Two-member maximum
Outpatient Lab	30% after deductible	45% after deductible	30% after deductible	45% after deductible
Outpatient X-ray	30% after deductible	45% after deductible	30% after deductible	45% after deductible
Outpatient Complex Imaging	30% after deductible	45% after deductible	30% after deductible	45% after deductible
Limit	Outpatient lab, x-ray and Outpatient Complex Imaging limited to $500 max benefit per calendar year		Outpatient lab, x-ray and Outpatient Complex Imaging limited to $500 max benefit per calendar year	
Hospital Inpatient	30% after deductible	45% after deductible	30% after deductible	45% after deductible
Outpatient Surgery (Hospital)	50% includes any associated ancillary and professional charges	50% includes any associated ancillary and professional charges	$200 copay +50% includes any associated ancillary and professional charges	$200 copay +50% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	30% after deductible	Paid as in-network	30% after deductible	Paid as in-network
Prescription Drugs	$15/50%/50% after integrated medical deductible	$15/50%/50% +20% for generics; after integrated medical deductible	$10 Generics; member pays 100% for Brand	$10 generics + 20%; member pays 100% for Brand
Mail Order Drugs	2.5 times retail copay; 31- to 90-day supply	Not Covered	3 times retail copay; 31- to 90-day supply	Not Covered
Self Injectables (retail and mail order)	50% after integrated medical deductible	50% after integrated medical deductible	20%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

2008 INDEMNITY Compared to INDEMNITY

Plan Name	Current Plan 2008 INDEMNITY	Renewal Plan INDEMNITY
Benefit	Out of Network	Out of Network
Lifetime Maximum	$2,000,000	$2,000,000
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	30% after deductible	30% after deductible
Routine GYN and Mammography	30% after deductible	30% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	30% after deductible	30% after deductible
Calendar Year Deductible	$1,000 per member Two-member maximum	$1,000 per member Two-member maximum
Coinsurance	30%	30%
Coinsurance Maximum (excludes deductible)	$3,000 per member Two-member maximum	$3,000 per member Two-member maximum
Outpatient Lab	30% after deductible	30% after deductible
Outpatient X-ray	30% after deductible	30% after deductible
Outpatient Complex Imaging	40% after deducible	40% after deducible
Hospital Inpatient	30% after deductible	30% after deductible
Emergency Room (copay waived if admitted)	30% after deductible	30% after deductible
Prescription Drugs	$20/$40/$60	$20/$40/$60
Self Injectables (retail and mail order)	50%	20%

The limits on Hospice Care have been removed.

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 750 VALUE

Plan Name	New Plan PPO 750 VALUE	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$20 copay	40% after deductible
Routine GYN and Mammography	$40 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$40 copay	40% after deductible
Calendar Year Deductible	$750 per member Three-member maximum	$1,500 per member Three-member maximum
Coinsurance	20%	40%
Coinsurance Maximum (excludes deductible)	$2,500 per member Three-member maximum	$5,000 per member Three-member maximum
Outpatient Lab	$20 copay	40% after deductible
Outpatient X-ray	$20 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50%
Hospital Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	$200 copay +20% includes any associated ancillary and professional charges	$200 copay +40% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	20% after $150 copay	Paid as in-network
Prescription Drugs	$15/$40/$60	$15/$40/$60 + 20%
Self Injectables	20%	20%
Mail Order Drugs	3 times retail copay; 31- to 90-day supply	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 1000 VALUE

Plan Name	New Plan PPO 1000 VALUE	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$25 copay	40% after deductible
Routine GYN and Mammography	$40 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$40 copay	40% after deductible
Calendar Year Deductible	$1,000 per member Three-member maximum	$2,000 per member Three-member maximum
Coinsurance	20%	40%
Coinsurance Maximum (excludes deductible)	$2,500 per member Three-member maximum	$5,000 per member Three-member maximum
Outpatient Lab	$25 copay	40% after deductible
Outpatient X-ray	$25 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	$200 copay +20% includes any associated ancillary and professional charges	$200 copay +40% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	20% after $200 copay	Paid as in-network
Prescription Drugs	$15/$40/$60	$15/$40/$60 + 20%
Self Injectables	20%	20%
Mail Order Drugs	2.5 times retail; 31- to 90-day supply	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

Plan Name	New Plan PPO 1500 VALUE	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$30 copay	40% after deductible
Routine GYN and Mammography	$50 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$50 copay	40% after deductible
Calendar Year Deductible	$1,500 per member Three-member maximum	$3,000 per member Three-member maximum
Coinsurance	20%	40%
Coinsurance Maximum (excludes deductible)	$3,000 per member Three-member maximum	$5,000 per member Three-member maximum
Outpatient Lab	$30 copay	40% after deductible
Outpatient X-ray	$30 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	$200 copay +20% includes any associated ancillary and professional charges	$200 copay +40% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	20% after $200 copay	Paid as in-network
Prescription Drugs	$15/$40/$60	$15/$40/$60 +20%
Self Injectables	20%	20%
Mail Order Drugs	2.5 times retail; 31- to 90-day supply	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 3000 80/60

Plan Name	New Plan PPO 3000 80/60	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations)	$30 copay	40% after deductible
Routine GYN and Mammography	$50 copay	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	$50 copay	40% after deductible
Calendar Year Deductible	$3,000 per member Two-member maximum	$6,000 per member Two-member maximum
Coinsurance	20%	40%
Coinsurance Maximum (excludes deductible)	$4,000 per member Two-member maximum	$8,000 per member Two-member maximum
Outpatient Lab	$0 copay	40% after deductible
Outpatient X-ray	$0 copay	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	$200 copay +20% includes any associated ancillary and professional charges	$200 copay +40% includes any associated ancillary and professional charges
Emergency Room (copay waived if admitted)	20% after $200 copay	Paid as in-network
Prescription Drugs	$20/$40/$60	$20/$40/$60 + 20%
Self Injectables	20%	20%
Mail Order Drugs	2.5 times retail; 31- to 90-day retail	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

PPO 10,000 100%

Plan Name	New Plan PPO 10,000 100%	
Benefit	**In-Network**	**Out of Network**
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations	$15 copay	25% after deductible
Routine GYN and Mammography	$15 copay	25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	0% after deductible	25% after deductible
Calendar Year Deductible	$10,000 Individual $10,000 Family	$10,000 Individual $10,000 Family
Coinsurance	0%	25%
Coinsurance Maximum (excludes deductible)	$10,000 Individual $10,000 Family	$20,000 Individual $20,000 Family
Outpatient Lab	0% after deductible	25% after deductible
Outpatient X-ray	0% after deductible	25% after deductible
Outpatient Complex Imaging	0% after deductible	25% after deductible
Hospital Inpatient	0% after deductible	25% after deductible
Emergency Room (copay waived if admitted)	0% after deductible	Paid as in-network
Prescription Drugs	$20/$40/$60	$20/$40/$60 + 20%
Self Injectables	20%	20%
Mail Order Drugs	2.5 times retail; 31- to 90-day retail	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

Plan Name	New Plan UTAH 2500 COINSURANCE	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations	20% after deductible	40% after deductible
Routine GYN and Mammography	$0 copay	shows both 40% and 25% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams and Chiropractic)	20% after deductible	40% after deductible
Calendar Year Deductible	$2,500 per member Two-member maximum	$5,000 per member Two-member maximum
Coinsurance	20%	40%
Coinsurance Maximum (excludes deductible)	$5,000 per member Two-member maximum	$10,000 per member Two-member maximum
Outpatient Lab	20% after deductible	40% after deductible
Outpatient X-ray	20% after deductible	40% after deductible
Outpatient Complex Imaging	30% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after deductible	Paid as in-network
Prescription Drugs	$15/$40/$60	$15/$40/$60 + 20%
Self Injectables	20%	20%
Mail Order Drugs	2.5 times retail; 31- to 90-day retail	Not Covered

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

Plan Name	New Plan UTAH BASIC HSA 1200	
Benefit	In-Network	Out of Network
Lifetime Maximum	$2,000,000	
Primary Care Office Visit (Same cost share applies to Well Baby/Well Child, Adult Physical Exams and Immunizations	20% after deductible	40% after deductible
Routine GYN and Mammography	$0 copay (deductible waived)	40% after deductible
Specialist Office Visit (Same cost share applies to Routine Vision Exams, Outpatient Mental health and Substance Abuse and Chiropractic)	20% after deductible	40% after deductible
Calendar Year Deductible	$1,200 Individual $3,600 Family	$4,000 Individual $8,000 Family
Coinsurance	20%	40%
Coinsurance Maximum (includes deductible)	$3,600 Individual $7,200 Family	$8,000 Individual $16,000 Family
Outpatient Lab	20% after deductible	40% after deductible
Outpatient X-ray	20% after deductible	40% after deductible
Outpatient Complex Imaging	20% after deductible	40% after deductible
Hospital Inpatient	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	20% after deductible	Paid as in-network
Prescription Drugs	$15/$30/$50 after integrated medical deductible	$15/$30/$50 + 20% after integrated medical deductible

For additional benefit descriptions please refer to the summary of benefits which can be provided by either your Broker or Aetna.

Utah 2008
Buy up / Buy down guide

U = Upgrade, subject to medical underwriting

D = Downgrade, no medical underwriting required

YOUR CURRENT PLAN IS:	YOUR RENEWAL PLAN IS:	PPO 250 80/60	PPO 500 80/60	PPO 750 80/60	PPO 750 VALUE	VALUE 1000 80/60	PPO 1000 VALUE	PPO 1500 80/60	PPO VALUE 1500
PPO 250 80/60	PPO 250 80/60		D	D	D	D	D	D	D
PPO 500 80/60	PPO 500 80/60	U		D	D	D	D	D	D
PPO 750 80/60	PPO 750 80/60	U	U		D	D	D	D	D
PPO 1000 80/60	PPO 1000 80/60	U	U	U	D		D	D	D
PPO 1500 80/60	PPO 1500 80/60	U	U	U	U	U	U		D
PPO 2000 80/60	PPO 2000 80/60	U	U	U	U	U	U	U	D
PPO 1500 100%	PPO 1500 80/60	U	U	U	U	U	U		D
PPO 2500 100%	PPO 2000 80/60	U	U	U	U	U	U	U	D
PPO HSA 2300 80%	2500 80% HSA	U	U	U	U	U	U	U	U
PPO HSA 3000 80%	3500 80% HSA	U	U	U	U	U	U	U	U
PPO HDHP 2500 100%	2500 100% HSA	U	U	U	U	U	U	U	D
PPO HDHP 3000 100%	3500 80% HSA	U	U	U	U	U	U	U	U
PPO HDHP 3500 80/60	3500 80% HSA	U	U	U	U	U	U	U	U
PPO BASIC 1500 70/55	BASIC 1500	U	U	U	U	U	U	U	U
LIMITED 50/50	LIMITED BENEFIT 50/50	U	U	U	U	U	U	U	U

PPO 2000 80/60	PPO 3000 80/60	PPO HDHP 2500 100%	PPO HDHP 3500 80%	PPO HDHP 2500 80/60	UTAH 2500 COINSURANCE	UTAH BASIC	Utah Basic HSA $1,200	LIMITED 50/50	PPO 10,000 100%	UTAH INDEMNITY
D	D	D	D	D	D	D	D	D	D	U
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UTAH PLAN CHANGE REQUIREMENTS

BENEFIT CHANGES	WHEN ELIGIBLE	REQUEST MUST BE RECEIVED	REQUIRED DOCUMENTATION
UPGRADE MEDICAL BENEFITS (to include adding Medical Plans to existing medical plans)	**New Business** During the initial plan year a group may only change plans 6 months post sale **(no changes are allowed within the 4-month period prior to the renewal date).** **Existing Business** Upgrades are allowed once* in a 12-month rolling period, limited to the 8-month period following the renewal date. Example: A 1-1 renewal may request a plan change through 8-1.	**On Renewal** — request must be submitted on or prior to the effective date of the renewal. **Off Renewal** — request must be submitted **30 days** prior to the requested effective date.	1. A new employer application (complete pages 1 and 4 and indicate the requested effective date) **or** a letter from the group requesting the change. 2. Completed Employee Change of Coverage application. 3. A copy of the most recent filed 3H. 4. A Joinder agreement where applicable.
DOWNGRADE MEDICAL BENEFITS	**New Business** During the initial plan year a group may only change plans 6 months post sale **(no changes are allowed within the 4-month period prior to the renewal date)** **Existing Business** Downgrades are allowed twice* in a 12-month rolling period, limited to the 8-month period following the renewal date. Example: A 1-1 renewal may request a plan change through 8-1.	**On Renewal** — request must be submitted on or prior to the effective date of the renewal. **Off Renewal** — request must be submitted **30 days** prior to the requested effective date.	1. A Plan Sponsor Signature Page or a new employer application (complete pages 1 and 4 and indicate the requested effective date **or** a letter from the group requesting the change) **or** a letter from the group requesting the change. 2. Completed Employee Change of Coverage application. 3. A Joinder agreement where applicable.
ADD DENTAL TO EXISTING MEDICAL PLANS (refer to Dental Guidelines)	Anytime	**On Renewal** — request must be submitted on or prior to the effective date of the renewal. **Off Renewal** — request must be submitted two weeks prior to the requested effective date.	1. A new employer application (complete pages 1 – 4) **is required** for all dental adds. Plan Sponsor Signature Page **or** a letter from the group requesting the change may be submitted in **addition** to the ER application. 2. New employee enrollment forms **are required** for all employees enrolling or declining dental benefits (please provide a copy of the ID cards for those employees waiving coverage).
ADD LIFE TO EXISTING MEDICAL PLANS (refer to Life Underwriting Guidelines)	Anytime	**On Renewal** — request must be submitted on or prior to the effective date of the renewal. **Off Renewal** — request must be submitted two weeks prior to the requested effective date.	1. A new employer application (complete page 1, 2 and 4) **is required** for all life adds. Plan Sponsor Signature Page or a letter from the group requesting the change may be submitted in **addition** to the ER application. 2. New employee enrollment forms **are required** for all employees enrolling or declining life benefits (if the group is electing 100% contribution — 100% participation is required).
ADD ANOTHER CLASS OF EMPLOYEE COVERAGE	Renewal date only	Request must be submitted on or prior to the effective date of the renewal.	1. A letter from the group requesting the change or a new employer application. 2. New employee enrollment forms for all eligible part-time employees who are enrolling or declining the coverage (please provide a copy of the ID cards for those employees waiving coverage). 3. A copy of the most recent filed 3H.
NAME CHANGE	Anytime	Anytime	1. A letter from the group requesting the change. 2. A completed name change form. 3. A copy of the most recent filed 3H.
BWP CHANGE	May be requested anytime. Can only be requested once in a 12-month rolling period — NO EXCEPTIONS.	Request must be submitted prior to the requested effective date.	1. A letter from the group requesting the change or a new employer application.
DOWNGRADES New hires must always submit an enrollment form, pages 1 – 4	Anytime a change in coverage is "across platforms" an **Employee Change of Coverage** application is required.	If a group makes a plan change within the same platform where more than 1 plan is involved, the Employee Plan Change Template or a letter may be submitted by the employer on company letterhead. The letter must list each individual employee, and what plan they are going to be enrolled in (regardless if the employee is moving plans).	If a group makes a plan change within the same platform where more than 1 plan is involved and more than 1 platform is involved, the Employee Plan Change Template or a letter must be submitted by the Employer on company letterhead. This letter must list each individual employee and the plan they are enrolling to (regardless if the employee is moving plans). Additionally, any employee moving platforms **must** complete the **Employee Change of Coverage** application.
DENTAL AND LIFE ADDS	Require all employees to complete an enrollment or waiver form (if applicable).		
UPGRADES**	Require all employees moving to the upgraded plan to complete the **Employee Change of Coverage** application.		

CHANGES TO THE RENEWAL DATE ARE NOT ALLOWED

Renewal plan changes are counted towards the maximum number of allowable changes.

**Buy Ups are subject to Medical Underwriting and may receive a new RAF based on medical conditions reviewed.

Frequently asked questions

How do I secure a quote for Dental and Life coverage?

If you are already participating in an Aetna Group Life product, your plan options are included in your renewal package. If you would like to add new life coverage, please contact your broker or the Aetna Sales Support Unit at **1-877-249-2472**.

What are participation requirements?

Your plan is contingent upon meeting participation guidelines as follows:

- Employers with 2 to 9 employees: Enrollment in an Aetna plan must be equal to 100 percent of total eligible employees excluding valid waivers, such as coverage through a spouse. Waiver forms are required.
- Employers with 10 to 50 employees: Enrollment in an Aetna plan must be equal to 75 percent of eligible employees excluding valid benefit waivers, such as coverage through a spouse. Waiver forms are required.
- Option sales alongside other carriers: Standard Participation of 75 percent of all eligible employees must be met in order for a group to qualify for coverage.

How are renewal rates calculated?

Renewal rates include census characteristics, trends in health care costs, coverage selected (single vs. family), location of employees, our group’s benefits and demographics.

Current medical and pharmacy trend is also an important component of your medical premium. Some of the most significant causes for increases include:

- Advances in medical technology and new drug development
- An aging population
- Increased use of health services
- Escalating costs of treatment for serious illness
- Employee contributions — shifting medical expenses from the public to the private sector

Can I get a blended (i.e., composite) rate?

- Tabular rates (rates for individual employees based on age, rating area and benefit tier) allow for more accurate premiums.
- Composite rates are available in Utah for employers with 10 or more employees.
- If you have had a census increase or decrease of less than 20 percent from your prior year’s census, your rating calculation will not change. For example, if you were composite rated last year with 10 employees, and now you have 9 employees, you will still receive composite rating since your change in census is less than 20 percent. This policy serves to reduce the frequency of employees having to switch between tabular and composite rates from year to year.

Besides alternative plans presented as part of our proposal, are there additional options that we may consider?

If available, Aetna has included a number of lower cost alternative plan designs for your consideration. Generally, the alternative plans listed in your proposal do not require underwriting approval and may represent potential savings versus your current plan design. There are, however, richer plan options from this portfolio that may not be included in your renewal, but would be available for quoting and may require underwriting approval.

- Utah now offers Pick-A-Plan 3, which will allow an employer to offer any 3 of the 15 available plans. A change to a plan that is considered an upgrade will require medical underwriting approval. One person must enroll and remain enrolled in each plan for it to be active.
- Rates for medical are guaranteed for a 12-month period.
- If there is an employee on COBRA and the employer moves plans, the former employee has to move as well.

How much may our employees contribute to premiums?

You may choose to have your employees pay a portion of the medical premium up to a maximum of 50 percent of the employee only rate. For Life coverage, the employer must contribute 100 percent of the cost for groups with 2 to 9 lives and at least 50 percent of the cost for groups with 10 to 50 lives (excluding Optional Dependent Life).

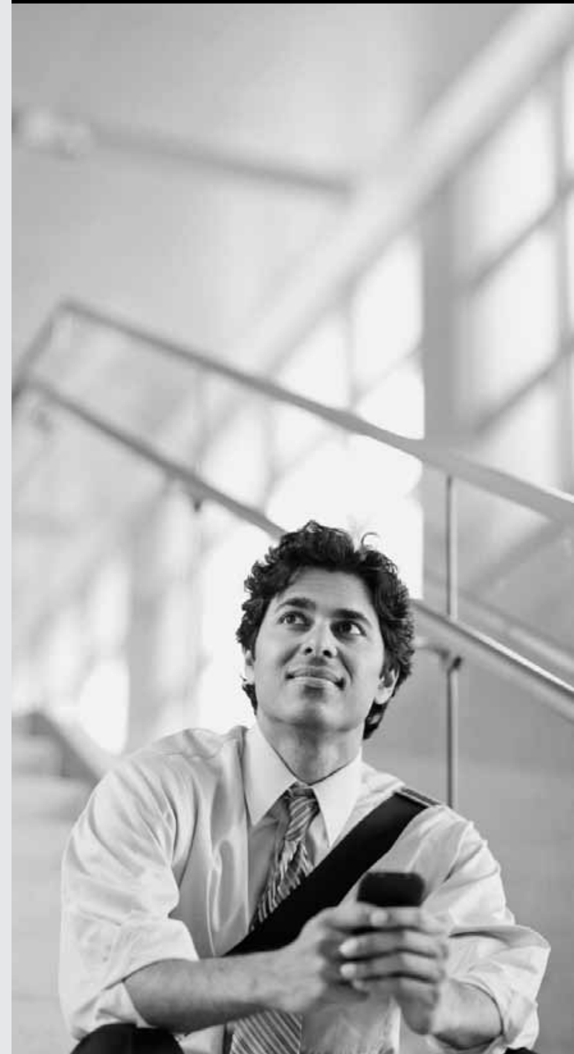
For Pick-A-Plan 3, the employer must contribute 50 percent of the employee premium OR the employer may choose to offer a defined contribution of at least $120 or the actual cost of the plans picked, whichever is less.

How much may our employees' dependents contribute to premiums?

You may choose to have your employees pay all or part of the premium cost for their dependent coverage.

Are new ID cards issued at renewal time?

If you are covered under a new plan, new ID cards will be issued. ID cards will be sent directly to enrollee's home address.



Special notices

Out-of-state employees

Aetna will offer the in-state portfolio and rating structure to out-of-state employees that live in an out-of-state network area. Out-of-state employees that do not live in an out-of-state network area will be eligible for the in-state indemnity plans.

Renewing plan sponsor

1. Renewal plan sponsors are eligible for this solution **upon their next renewal only**.
2. Beginning with February 1, 2008 renewals, requests for in-state PPO offerings for out-of-state employees must be sent to underwriting.
3. If a renewing plan sponsor has a current 2007 in-state PPO plan with out-of-state PPO employees, and wants the in-state plan for new out-of-state employees, all other out-of-state PPO membership must also move to an in-state PPO plan. If the employee does not reside in an Aetna PPO network, he or she will be offered the in-state indemnity plan.
4. If renewing plan sponsors do not have a current 2007 in-state plan, they must switch to a currently marketed in-state plan in addition to offering their out-of-state employees the in-state plan.

Underwriting requirements

- Plan sponsors must have 51 percent of their employees living within the Headquartered State.
- The rating structure will follow the Headquartered State rating methodology.

Limitations and exclusions

Medical

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

Aetna PPO & Indemnity

All medical or hospital services not specifically covered or which are limited or excluded in the plan documents.

- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in the plan documents
- Nonmedically necessary services or supplies
- Orthotics, as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special-duty nursing
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Aetna PPO and Indemnity: Pre-existing conditions exclusion provision

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

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

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

If you had less than six months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you may have. Please contact your Aetna Member Services representative at **1-888-802-3862** if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.

The pre-existing conditions exclusion does not apply to pregnancy nor to a child under age 18, who is enrolled in the plan within 31 days after birth, adoption or placement for adoption. **Note:** For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

AD&D Ultra®

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

- A bodily or mental infirmity
- A disease, ptomaine or bacterial infection*
- Medical or surgical treatment*
- Suicide or attempted suicide (while sane or insane)
- An intentionally self-inflicted injury
- A war or any act of war (declared or not declared)
- Voluntary inhalation of poisonous gases
- Commission of or attempt to commit a criminal act
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of the motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel — This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

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

Limitations and exclusions

Disability

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from your committing or attempting to commit, a criminal act
- Is due to war or any act of war (declared or not declared)
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Results from an automobile accident caused by you while you are intoxicated ("intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred)

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense, the person will not be deemed to be disabled and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three (3) months prior to coverage effective date.

Notes

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care or dental services and, therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. Participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Aetna assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied by Aetna InteliHealth®. Information supplied by InteliHealth is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Informed Health® Line nurses cannot diagnose, prescribe or give medical advice. Specific questions should be addressed to your doctor. Alternative health care programs, Aetna Vision℠ Discount and the Fitness program are rate-access programs and may be in addition to any plan benefits. Program providers are solely responsible for the products and services provided thereunder. Aetna does not endorse any vendor, product, or service associated with these programs. Discounts offered hereunder are not insurance.

Some benefits are subject to limitations or visit maximums. Members and providers may be required to precertify, or obtain prior approval of coverage, for certain services such as non-emergency inpatient hospital care. Depending upon the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under the plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received upon enrollment) are not covered, and medical exceptions are not available for them.

Information is believed to be accurate as of the production date; however, it is subject to change.

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