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

aetna℠

Washington Cascade Employer's Health Insurance Trust (CEHIT) plan guide

The health of business, well planned.

Plans effective August 1, 2012
For businesses with 5–50 eligible employees

www.aetna.com

64.10.300.1-WA (3/13)

Team with Aetna for the health of your business

Products and services designed specifically for companies with 5 to 50 eligible employees.

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.

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

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64.43.300.1-WA (3/13)

Women's preventive health benefits

New changes effective August 1, 2012

As you may know, the Affordable Care Act (ACA, or Health Care Reform law) includes changes that are being phased in over a number of years. The latest set of changes includes additional benefits for certain Women's Preventive Health Services.

When plans renew or are effective on or after August 1, 2012, all of the following women's health services will be considered preventive (some were already covered). These services generally will be 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
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services

64.44.300.1-WA (3/13)

Aetna is dedicated to the health of your business

You and your employees can benefit from...

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

With Aetna, we know it's about greater employee choice

Options

You can offer any 5 of the 14 available plan options.* We provide a variety of health plan options to help meet your employees' needs, including medical, dental and life insurance.

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

Medical plans

- Consumer-directed health plans (CDHP)
- Value plans
- Saver plans
- Traditional plans

Dental plans

- PPO
- PPO Max
- Freedom-of-Choice
- Preventive

Life plans

- Basic term life insurance

Simplicity

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

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

Confidence

We work hard to provide health plan solutions you can trust. Our account executives, underwriters and customer service representatives are committed to providing you and your employees with service and care they can trust.

Aetna resources are designed to fortify the health of your business

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

Employee Assistance Program (EAP)**

Our Employee Assistance Program is a confidential program that gives employees and members of their household access to useful services and support to help them manage the everyday challenges of work and home. The EAP is available at no charge to members and their family members and includes:

Choice — They'll find a range of resources to help them balance their personal and professional lives.

Easy access — EAP representatives can be reached anytime toll free at **1-866-672-5417** or on the web at **www.aetnaeap.com.**

Management and human resource assistance — You get unlimited phone consultations with workplace-trained clinicians who can proved help in dealing with complex employee issues that may arise.

*One person must enroll and remain enrolled in each plan for it to be active.

**Discounts are not insurance and are not underwritten by Aetna.

Aetna Medical Overview

At Aetna, we are committed to putting the employee 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.

Medical
Overview

Washington network*

Washington has more than 33,500 providers and 102 hospitals**

Adams	Columbia	Grant	Kittitas	Pacific	Snohomish	Whatcom
Asotin	Cowlitz	Grays Harbor	Klickitat+	Pend Oreille	Spokane	Whitman
Benton	Douglas	Island	Lewis	Pierce	Stevens	Yakima
Chelan	Ferry	Jefferson	Lincoln	San Juan	Thurston	
Clallam	Franklin	King	Mason	Skagit	Wahkiakum+	
Clark+	Garfield	Kitsap	Okanogan	Skamania+	Walla Walla	

What is Pick-A-Plan 5?

Pick-A-Plan 5*** is our suite of plans designed specifically with small businesses in mind. These plans provide choice, flexibility and simplicity.

Pick-A-Plan 5 offers the following advantages:

Greater employee choice

You can offer any 5 of the 14 available plan designs.++

Flexibility and affordability

Create a customized benefits package from any of our plan types and plan designs. We offer a variety of plans at different price points. You may designate a level of contribution that meets your budget.

Freedom and choice

We offer 14 plan choices that range in price and benefits to help meet each individual employee's needs. This allows you to offer something for everyone.

Easy administration

Setting up this program is simple:

1. You choose up to 5 plans to offer on the Employer Application
2. You choose how much to contribute
3. Each employee chooses the plan that's right for him or her

Pick-A-Plan 5

Target audience	Every small business with 5+ enrolled employees
Plan choices	Up to 5 of the 14 available plans
Minimum participation	
5 or more enrolled employees	Up to 5 of the 14 available plans
Employer contribution	75% of employee coverage to a minimum of 50% when there is also 50% or more contribution for dependents
Rating options	5–9 employees — tabular 10–50 employees — composite

*Network subject to change.

**According to the Aetna Enterprise Provider Database as of January 31, 2012. Network subject to change.

***Available with 5 or more enrolled employees.

+Counties maintained through Oregon Network.

++One person must enroll and remain enrolled in each plan for it to be active.

Aetna PPO plan

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

- Emergency care coverage — anywhere, anytime, 24 hours a day
- Large provider network
- No claim forms in-network
- If members choose a provider from our network of participating physicians and hospitals, out-of-pocket costs will be lower
- If members choose a physician or hospital outside of the network, out-of-pocket costs will be higher, except for emergency treatment
- Deductibles and coinsurance apply

Consumer-directed health plans

Consumer-directed health plans are high-deductible health plans (HDHP) designed to give individuals greater flexibility and control when purchasing care. Aetna HDHP's are paired with account-based funds that include health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending accounts (FSAs).

HDHP's increase the flexibility and control employers and employees have by putting them in the center of their health care. In more traditional scenarios, employees may have a higher premium associated with a low-deductible plan, and never use it. With an Aetna HDHP, employees can lower their monthly premiums, and create a fund to pay for the services when needed. In an HSA or HRA fund, the monies can roll over from year to year and can be used toward future medical expenses.

When a HDHP is paired with an HSA, your qualified employees have a tax-advantaged solution that allows them to manage their qualified medical and dental expenses. You use tax-deductible dollars to reimburse employees for predetermined types of medical expenses. While FSAs allow individuals to use pretax salary dollars to help pay for health care and dependent care expenses.

Aetna high deductible PPO plan (HSA compatible)

The Aetna PPO insurance options that are compatible with a health savings account (HSA) provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

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

Aetna Indemnity plan

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

- Individual coordinates his or her own health care
- No PCP required
- No referral required
- Members can access any recognized physician or hospital for covered services

For specific plan information, please see your plan contract.

We offer two ways to meet your family deductible for high-deductible plans

Embedded aggregate	True integrated family aggregate
Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.	The entire family deductible must be met before coinsurance applies for any individual or family member.

Health Savings Account (HSA)

The Aetna HSA, when coupled with a HSA-compatible high-deductible health benefits and health insurance plan, is a tax-advantaged savings account. Once enrolled, you and your employees can make contributions. The HSA can be used to pay for qualified expenses tax free.

Member's HSA plan

- Members own the HSA
- Contribute tax free
- Member chooses how and when to use 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
- Pay 100% until deductible is met, then only pay a share of the cost
- Meet in-network out-of-pocket maximum, then plan pays 100%
- We provide a no-cost health savings account through preferred vendors

Health Reimbursement Arrangement (HRA)

The Aetna 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 you 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. Our 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 you manage the complex billing and notification processes that are required for COBRA compliance, while also helping to save you 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 waived with the purchase of medical and $20,000 in life insurance per employee.

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.

Administrative Fees

Fee description	Fee	
Premium Only Plan (POP)		
Initial set-up*	$190	
Renewal	$125	
Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA)**		
	Initial set-up	Renewal fee
5–25 Employees	$360	$235
26–50 Employees	$460	$285
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		
5–25 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 Plans

Plan Name	PPO $250 90/60 $20		PPO $250 80/60 $25	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	90%	60%	80%	60%
Calendar-Year Deductible (In network and out of network accumulate separately)	$250 per member	$500 per member	$250 per member	$500 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$2,000 per member	$4,000 per member	$2,500 per member	$5,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-member maximum		Three-member maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	$20 copay; ded waived	60%	$25 copay; ded waived	60%
Specialist Office Visit	$20 copay; ded waived	60%	$25 copay; ded waived	60%
Outpatient Lab & X-ray	$20 copay; ded waived	60%	$25 copay; ded waived	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	90%	60%	80%	60%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$20 copay; ded waived	60%	$25 copay; ded waived	60%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$20 copay; ded waived	60%	$25 copay; ded waived	60%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	90%	60%	80%	60%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	90%	60%	80%	60%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	60%	$0 copay; ded waived	60%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	60%	$0 copay; ded waived	60%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	60%	$0 copay; ded waived	60%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	60%	$0 copay; ded waived	60%
Inpatient Hospital	90%	60%	80%	60%
Outpatient Surgery	90%	60%	80%	60%
Transplants	90%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	90%	Paid as in-network	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$10 / $30 / $60	Not covered	$10 / $30 / $60	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

See page 17 for footnotes.

Traditional Plans

Plan Name	PPO $500 80/50 $25*		PPO $750 80/50 $25	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	80%	50%	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$500 per member	$1,000 per member	$750 per member	$1,500 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$3,000 per member	$6,000 per member	$3,500 per member	$7,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-member maximum		Three-member maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	$25 copay; ded waived	50%	$25 copay; ded waived	50%
Specialist Office Visit	$25 copay; ded waived	50%	$25 copay; ded waived	50%
Outpatient Lab & X-ray	$25 copay; ded waived	50%	$25 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$25 copay; ded waived	50%	$25 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$25 copay; ded waived	50%	$25 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants	80%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$10 / $30 / $60	Not covered	$10 / $30 / $60	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

*This plan is available for religious exemption.

See page 17 for footnotes.

Traditional Plans

Plan Name	PPO $1,000 80/50 $30		PPO $1,500 80/50 $30	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	80%	50%	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$1,000 per member	$2,000 per member	$1,500 per member	$3,000 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$3,500 per member	$7,000 per member	$4,000 per member	$8,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-member maximum		Three-member maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	$30 copay; ded waived	50%	$30 copay; ded waived	50%
Specialist Office Visit	$30 copay; ded waived	50%	$30 copay; ded waived	50%
Outpatient Lab & X-ray	$30 copay; ded waived	50%	$30 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$30 copay; ded waived	50%	$30 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$30 copay; ded waived	50%	$30 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants	80%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$10 / $30 / $60	Not covered	$10 / $30 / $60	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

See page 17 for footnotes.

Value Plans

Plan Name	PPO Value $750 80/50 $30		PPO Value $1,000 80/50 $35*	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	80%	50%	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$750 per member	$1,500 per member	$1,000 per member	$2,000 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$4,000 per member	$8,000 per member	$4,000 per member	$8,000 per member
Deductible and Coinsurance Maximum Accumulation	Per member		Per member	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	$30 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%	$35 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%
Specialist Office Visit	$30 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%	$35 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%
Outpatient Lab & X-ray	$30 copay; ded waived	50%	$35 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$30 copay; ded waived	50%	$35 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$30 copay; ded waived	50%	$35 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants	80%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$20 / $40 / $70	Not covered	$20 / $40 / $70	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

*This plan is available for religious exemption.

See page 17 for footnotes.

Value Plans

Plan Name	PPO Value $1,500 80/50 $40	
PCP/Referrals Required	No	N/A
Member Benefits	In network	Out of network[1]
Plan Coinsurance	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$1,500 per member	$3,000 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$4,500 per member	$9,000 per member
Deductible and Coinsurance Maximum Accumulation	Per member	
Lifetime Maximum Benefit	Unlimited	
Primary Physician	$40 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%
Specialist Office Visit	$40 copay; ded waived[4] (office visit limit applies; see footnote for details)	50%
Outpatient Lab & X-ray	$40 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$40 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$40 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%
Inpatient Hospital	80%	50%
Outpatient Surgery	80%	50%
Transplants	80%	Not covered
Emergency Services (Copay waived if admitted)	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$20 / $40 / $70	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included	

See page 17 for footnotes.

Saver Plans

Plan Name	PPO Saver $2,500 70/50*		PPO Saver $5,000 80/50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	70%	50%	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$2,500 per member	$5,000 per member	$5,000 per member	$10,000 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$5,000 per member	Unlimited	$5,000 per member	Unlimited
Deductible and Coinsurance Maximum Accumulation	Per member		Per member	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	$15 copay; ded waived	50%	$15 copay; ded waived	50%
Specialist Office Visit	70%	50%	80%	50%
Outpatient Lab & X-ray	$15 copay; ded waived	50%	$15 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	70%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$15 copay; ded waived	50%	$15 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	$15 copay; ded waived	50%	$15 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	70%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	70%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Inpatient Hospital	70%	50%	80%	50%
Outpatient Surgery	70%	50%	80%	50%
Transplants	70%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	70%	Paid as in-network	80%	Paid as in-network
Urgent Care	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived	$50 copay; ded waived
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$20 / $40 / $70	Not covered	$20 / $40 / $70	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

*This plan is available for religious exemption.

See page 17 for footnotes.

Consumer Directed Health Plans (CDHP)

Plan Name	PPO HSA HDHP $1,500 80/50*		PPO HSA HDHP $2,500 80/50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In network	Out of network[1]	In network	Out of network[1]
Plan Coinsurance	80%	50%	80%	50%
Calendar-Year Deductible (In network and out of network accumulate separately)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$2,000 Individual $4,000 Family	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Deductible and Coinsurance Maximum Accumulation	True integrated family aggregate[6]		Embedded aggregate[5]	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	80%	50%	80%	50%
Specialist Office Visit	80%	50%	80%	50%
Outpatient Lab & X-ray	80%	50%	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	$0 copay; ded waived	50%	$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants	80%	Not covered	80%	Not covered
Emergency Services (Copay waived if admitted)	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	80%	80%	80%	80%
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$20 / $40 / $70 after integrated Medical / Rx deductible	Not covered	$20 / $40 / $70 after integrated Medical / Rx deductible	Not covered
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included		Included	

*This plan is available for religious exemption.

See page 17 for footnotes.

Indemnity

Plan Name	Indemnity $500 80%
PCP/Referrals Required	NA
	No network[7]
Plan Coinsurance	80%
Calendar-Year Deductible (In network and out of network accumulate separately)	$500 per member
Calendar-Year Coinsurance Maximum (Deductible and certain payments do not apply)	$2,500 per member
Deductible and Coinsurance Maximum Accumulation	Three-member maximum
Lifetime Maximum Benefit	Unlimited
Primary Physician	80%
Specialist Office Visit	80%
Outpatient Lab & X-ray	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%
Chiropractic Services (Limited to 12 visits per member per calendar year)	80%
Acupuncture Services (Limited to 12 visits per member per calendar year)	80%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year)	80%
Speech Therapy (Limited to 20 visits per member per calendar year)	80%
Physical Exams – Adults (Age and frequency schedules apply)	$0 copay; ded waived
Well-Child Exams (Age and frequency schedules apply)	$0 copay; ded waived
Routine Gynecology (Frequency schedules apply)	$0 copay; ded waived
Mammography (Age and frequency schedules apply)	$0 copay; ded waived
Inpatient Hospital	80%
Outpatient Surgery	80%
Transplants	80%
Emergency Services (Copay waived if admitted)	80%
Urgent Care	80%
Prescription Drugs[2] Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	$10 / $30 / $60
90-Day Rx Transition of Coverage (TOC) for Precertification[3]	Included

See page 17 for footnotes.

Footnotes

The dollar amount indicates what the member is required to pay and percentage coinsurance amounts indicate what the plan is required to pay. Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify for certain services such as outpatient complex imaging and non-emergency hospital care. All services are subject to deductible, unless noted otherwise.

Amounts over allowable charges, failure to precertify penalty, copays, Rx (including self-injectables) and DME do not apply toward the PPO coinsurance maximums and continue to be payable after the maximum is reached. Note: On HSA HDHP plans only amounts over allowable charges and failure to precertify penalty do not apply toward the PPO out-of-pocket maximum and continue to be payable after the maximum is reached.

For a summary list of limitations and exclusions, refer to page 44.

[1]Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an in-network provider. These charges are referred to in your plan documents as "recognized" charges.

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

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

[4]Four-visit limit applies to all types of office visits, excluding preventive care, acupuncture, chiropractic, outpatient mental health and outpatient substance abuse services. Any lab or X-ray provided in the physician's office and billed with the office visit is included. Once the four-visit limit has been reached, all other office visits will be covered at coinsurance after deductible.

[5]Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.

[6]There is no individual deductible or coinsurance maximum to satisfy within the family deductible/coinsurance maximum. Once the family deductible/coinsurance maximum is met, all family members will be considered as having met their deductible/coinsurance maximum for the remainder of the calendar year.

[7]Payment for out-of-network care is determined based upon the lowest of the provider's usual for furnishing it or the charge determines to be appropriate, based on factors such as the cost of providing the same or similar or supply and then manner in which charges for the services or supply are made. These charges are referred to in you plan documents as "reasonable" or "recognized" charges.

Aetna Dental Plans

Choose from a variety of dental plans that are just right for your employees.

Dental
Overview

The Mouth Matters℠

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

The Dental Maintenance Organization (DMO®)

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

Preferred Provider Organization (PPO) plan

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

PPO Max plan

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

Freedom-of-Choice plan design option

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

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. You choose how the plan is funded. It can be entirely member-paid or employers can contribute up to 50 percent.

[1]MayoClinic.com. "Oral health: A window to your overall health." Available online at **www.mayoclinic.com/health/dental/DE00001**. Accessed November 2012.

*Discounts for non-covered services may not be available.

DMI may not be available in all states.

Small Group Standard Dental Plans

Available With or Without an Aetna Medical Plan to Groups with 5–50 Eligible Employees	**Option 2 Freedom-of-Choice —** Monthly selection between the DMO and the PPO		**Option 3-09 PPO $1,000, 90th**
	DMO Plan 100/90/60	PPO Max Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	$5	N/A	N/A
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	None	$50; 3X family maximum	$50; 3X family maximum
Annual Maximum Benefit	Unlimited	$1,000	$1,000
Diagnostic Services			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Limited oral exam – Problem focused	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%	80%	80%
Resin filling – 2 surfaces, anterior	90%	80%	80%
Oral Surgery			
Extraction – exposed root or erupted tooth	90%	80%	80%
Extraction of impacted tooth – soft tissue	90%	80%	80%
***Major Services**			
Complete upper denture	60%	50%	50%
Partial upper denture (resin base)	60%	50%	50%
Crown – porcelain with noble metal[1]	60%	50%	50%
Pontic – porcelain with noble metal[1]	60%	50%	50%
Inlay – metallic (3 or more surfaces)	60%	50%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	60%	50%	50%
Endodontic Services			
Bicuspid root canal therapy	90%	50%	50%
Molar root canal therapy	60%	50%	50%
Periodontic Services			
Scaling & root planing – per quadrant	90%	50%	50%
Osseous surgery – per quadrant	60%	50%	50%
***Orthodontic Services**	$2,300 copay	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

See page 25 for footnotes.

Small Group Standard Dental Plans

Available With or Without an Aetna Medical Plan to Groups with 5–50 Eligible Employees	**Option 4-09 PPO $1,000, 90th Ortho**	**Option 5 PPO Max**	**Option 6-09 PPO $1,500, 90th**	**Option 7-09 PPO $1,500, 90th Ortho**
	PPO Plan 100/80/50	PPO Max 1500 100/80/50	PPO Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum	$50; 3X family maximum
Annual Maximum Benefit	$1,000	$1,500	$1,500	$1,500
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Limited oral exam – Problem focused	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
***Major Services**				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – porcelain with noble metal[1]	50%	50%	50%	50%
Pontic – porcelain with noble metal[1]	50%	50%	50%	50%
Inlay – metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing – per quadrant	50%	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%	50%
***Orthodontic Services**	50%	50%	Not covered	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	Does not apply	$1,000

See page 25 for footnotes.

Small Group Standard Dental Plans

Available With or Without an Aetna Medical Plan to Groups with 5–50 Eligible Employees	**Option 8-09 PPO $2,000, 90th**	**Option 9-09 PPO $2,000, 90th Ortho**
	PPO Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	$50; 3X family maximum	$50; 3X family maximum
Annual Maximum Benefit	$2,000	$2,000
Diagnostic Services		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Limited oral exam – Problem focused	100%	100%
X-rays		
Bitewing – single film	100%	100%
Complete series	100%	100%
Preventive Services		
Adult cleaning	100%	100%
Child cleaning	100%	100%
Sealants – per tooth	100%	100%
Fluoride application – with cleaning	100%	100%
Space maintainers	100%	100%
Basic Services		
Amalgam filling – 2 surfaces	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%
Oral Surgery		
Extraction – exposed root or erupted tooth	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%
***Major Services**		
Complete upper denture	50%	50%
Partial upper denture (resin base)	50%	50%
Crown – porcelain with noble metal[1]	50%	50%
Pontic – porcelain with noble metal[1]	50%	50%
Inlay – metallic (3 or more surfaces)	50%	50%
Oral Surgery		
Removal of impacted tooth – partially bony	50%	50%
Endodontic Services		
Bicuspid root canal therapy	80%	80%
Molar root canal therapy	50%	50%
Periodontic Services		
Scaling & root planing – per quadrant	80%	80%
Osseous surgery – per quadrant	50%	50%
***Orthodontic Services**	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000

See page 25 for footnotes.

Small Group Standard Dental Plans

Available With or Without an Aetna Medical Plan to Groups with 5–50 Eligible Employees	**Option 10-09 Indemnity R&C**	**Option 11-09 DMO Access**
	100/80/50	Plan 42
Office Visit Copay	N/A	$10
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	$50; 3X family maximum	None
Annual Maximum Benefit	$1,000	Unlimited
Diagnostic Services		
Oral Exams		
Periodic oral exam	100%	No charge
Comprehensive oral exam	100%	No charge
Limited oral exam – Problem focused	100%	No charge
X-rays		
Bitewing – single film	100%	No charge
Complete series	100%	No charge
Preventive Services		
Adult cleaning	100%	No charge
Child cleaning	100%	No charge
Sealants – per tooth	100%	$10
Fluoride application – with cleaning	100%	No charge
Space maintainers	100%	$100
Basic Services		
Amalgam filling – 2 surfaces	80%	$32
Resin filling – 2 surfaces, anterior	80%	$55
Oral Surgery		
Extraction – exposed root or erupted tooth	80%	$30
Extraction of impacted tooth – soft tissue	80%	$80
***Major Services**		
Complete upper denture	50%	$500
Partial upper denture (resin base)	50%	$513
Crown – porcelain with noble metal[1]	50%	$488
Pontic – porcelain with noble metal[1]	50%	$488
Inlay – metallic (3 or more surfaces)	50%	$463
Oral Surgery		
Removal of impacted tooth – partially bony	50%	$175**
Endodontic Services		
Bicuspid root canal therapy	50%	$195
Molar root canal therapy	50%	$435**
Periodontic Services		
Scaling & root planing – per quadrant	50%	$65
Osseous surgery – per quadrant	50%	$445**
***Orthodontic Services**	Not covered	$2,300 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply

See page 25 for footnotes.

Small Group Voluntary Dental Plans

Available With or Without an Aetna Medical Plan to Groups with 5–50 Eligible Employees	**Voluntary Option 1-09 PPO $1,000**	**Voluntary Option 2-09 PPO $1,000, 90th**	**Voluntary Option 3-09 PPO $1,500**
	PPO 1000 Plan 100/80/50	PPO 1000 Plan 100/80/50	PPO 1500 Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to diagnostic & preventive services)	$75; 3X family maximum	$75; 3X family maximum	$75; 3X family maximum
Annual Maximum Benefit	$1,000	$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 – child	100%	100%	100%
Space maintainers – fixed	100%	100%	100%
Basic Services			
Amalgam filling – 2 surfaces	80%	80%	80%
Resin filling – 2 surfaces, anterior	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 metal[1]	50%	50%	50%
Pontic – porcelain with noble metal[1]	50%	50%	50%
Inlay – metallic (3 or more surfaces)	50%	50%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	50%	50%	50%
Endodontic Services			
Bicuspid root canal therapy	50%	50%	50%
Molar root canal therapy	50%	50%	50%
Periodontic Services			
Scaling & root planing – per quadrant	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%
***Orthodontic Services**	Not covered	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	$1,000

See page 25 for footnotes.

Footnotes

Standard Dental Footnotes

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. Does not apply to the DMO in plan options 2 & 11.

**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.

Fixed dollar amounts on the DMO in plan options 2 & 11 including the office visit and ortho copays are the member's responsibility.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan option 11.

Access to negotiated discounts: On the PPO plans in plan options 2–9, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the coverage waiting period.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 2 & 11 and on the PPO in plan options 8 & 9.

Out-of-network plan payments are limited by geographic area on the PPO in plan option 10 to the prevailing fee at the 80th and plan options 3, 4, 6, 7, 8 & 9 to the prevailing fees at the 90th percentile.

Plan options 2 & 5: 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.

Orthodontic coverage is available to dependent children only.

Above list of covered services is representative. Full list with limitations as determined by the plan appears in the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 45.

Voluntary Dental Footnotes

[1]Coverage waiting period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any major service including orthodontic services.

Access to negotiated discounts: On all voluntary PPO plans, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the coverage waiting period.

Out-of-network plan payments are limited by geographic area on the PPO in voluntary plan options 1 & 3 to the prevailing fee at the 80th and voluntary plan option 2 to the prevailing fees at the 90th percentile.

Orthodontic coverage is available to dependent children only.

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

Above list of covered services is representative. Full list with limitations as determined by the plan appears on the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 45.

Aetna Life

Group life is an affordable way to provide life insurance and benefits to employees that will help them establish financial protection for themselves and their families.

Life Overview

For groups of 5 to 50, Aetna Life Insurance Company (Aetna) Small Group packaged life 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 products for small groups. Or, simply choose from our portfolio of group basic term life 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 Essentials℠** 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.

Our fresh approach to life

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

AD&D Ultra®

AD&D Ultra comes standard with our small group term life plans, and provides employees and their families with the same coverage as a typical accidental death and dismemberment 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
- Dismemberment
- Loss of sight
- Loss of speech
- Loss of hearing
- Third-degree burns
- Paralysis
- Coma
- 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*

For a summary list of limitations and exclusions, refer to page 45.

Life insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).
*Only available if insured loses life.

Term Life Plan Options

	5–9 Employees	10–50 Employees
Basic Life Schedule	Flat $20,000, $50,000	Flat $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.

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

Underwriting guidelines

Underwriting guidelines

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

Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of 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.

Affiliated, Associated or Multiple Companies

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 business 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 2 of the 3 businesses to be enrolled, the group will be considered a carve out, will not be guarantee issue, and could be declined.
- The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined **must have the minimum number of employees required by the state.**
- There are 50 or fewer employees in the combined employer groups.
- A completed Common Ownership form is submitted.
- 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.
- SIC code will be based upon the group with the majority of the enrollment. Other documentation to prove this may be requested.
- Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception.

Example

One owner has controlling interest of all companies to be included:

- Company 1 – Jim owns 75% and Jack owns 25%
- Company 2 – Jim owns 55% and Jack owns 45%

Both companies can be written as one group since Jim has controlling interest in both

Benefit Waiting Period

- Benefit waiting periods **must be consistently applied to all employees,** including newly hired key employees.
- The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days.
- The eligibility date will be the first day of the **policy month** following the waiting period.

Example 1

Effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period.

Example 2

Effective date is July 15th; employees will be issued an effective date of the 15th of the month following the chosen waiting period.

- At initial submission of the group the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application and consistently applied to all employees.
- Changes to the benefit waiting period may be requested 6 months after the original effective date.
- Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date.
- **No retroactive benefit waiting period changes will be allowed.**

Carve Outs	• The general types of carve out that could be considered by Aetna include Washington Branch Location and Management/Non-Management, Salary/Hourly, Union vs. Non-Union. • Aetna must enroll and maintain a minimum of eight (8) employees who reside within our Washington Network Service Area. • Employers may request to carve out a specific class of employees for coverage, subject to underwriting approval, which can be declined, even if the standard participation requirements are met.
Case Submission Dates	• In order for Aetna to honor the requested effective date, all completed paperwork must be received by Total Benefits Solutions no later than the end of day, 10 business days prior to the requested effective date.
Census Data	• Census data on all eligible, including COBRA/State Continuation eligible employees must include name, age or date of birth, date of hire, gender, dependent status, and residence zip code. • Retirees are not eligible. • COBRA/State enrollees should be included on the census and noted as COBRA/State Continuation.
Composite Rating	**Composite Rating for New Business** • Employer may offer a maximum of five plans. • At least one person must enroll in each plan for it to be offered to new hires. • The composite rate for each plan will be determined based on the census quoted. • Upon final enrollment, the composite rate for each plan will be processed based upon the final enrolled employees. **Composite Rating for Renewing Business** • Renewal rates will be based on the enrolled employees in each plan at the time the renewal is processed. • Only the plans available after the initial enrollment will be rated for the renewal. • If you have had a census increase or decrease of less than 20% from your prior year's census, your rating calculation will not change. **Example** If you were composite rated last year with 10 employees, and now you have nine employees, you will still receive composite rating since your change in census is less than 20%. This policy serves to reduce the frequency of employee's having to switch between tabular and composite rates from year to year.
Deductible Credit	• Employees who are eligible and want to receive credit for deductible paid to prior company should submit a copy of the Explanation of Benefits to Aetna. They may do this at initial small group submission or with their first claim.
Definition of Employer Eligibility	• Employer means any sole proprietor, partnership, or corporation that satisfies and completes the Adoption Agreement for enrollment into the Cascade Employer's Health Insurance Trust (CEHIT). • Based on the Trust Agreement, the employer must enroll and maintain enrollment of at least five employees in order to qualify for coverage. If on, or after January 1, 2005, a participating employer has or had less than five employees, such employer shall continue to be eligible to renew its coverage. If a group falls below five employees, they will continue to be renewed. • Employers must not be formed solely for the purpose of obtaining health coverage. • Taft Hartley and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible for enrollment in CEHIT.

Dental	**Open enrollments are prohibited.** **Coverage Waiting Period** • For major and orthodontic services, employees must be enrolled members of the plan for one year (not applicable to DMO). • Waiting period is waived separately for major and orthodontic for employees who were covered by the group's immediately preceding dental plan. • To waive the waiting period for major services, the group's immediately preceding group plan must have covered major services. • To waive the waiting period for orthodontic services, the group's immediately preceding group plan must have covered orthodontic services. **Example** Group had prior major coverage but no orthodontic coverage, however the new plan has both major and orthodontic coverage, the waiting period is waived for major services but not for the orthodontic services. **Product Packaging** • DMO can be sold as standalone or packaged with any PPO option as a dual option. • PPO can be sold standalone or packaged with the DMO as a dual option. • Freedom-of-Choice cannot be packaged with any other option. **It must be the only plan sold.** • Voluntary dental plans **cannot** be sold or packaged with any other plan as a dual option offering. **Reinstatement** • For voluntary dental plan options: Members who were once enrolled then terminated their coverage by discontinuing their contributions may be not re-enroll for a period of 24 months. All coverage rules apply from the new effective date including, but not limited to, the coverage waiting period.
Dependent Eligibility	• Eligible dependents include an employee's spouse. If both husband and wife work for the same company they may enroll together or separately. • Children can only be covered under one parent's plan. • Domestic partners are eligible. • Grandchildren are eligible if court ordered. • Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26. • For medical and dental, dependents must enroll in the same benefits as the employee (participation is not required). • Employees may select coverage for eligible dependents under the dental plan even if they select single coverage under the medical plan. • Individuals cannot be covered as an employee and dependent under the same plan.
Effective Date	• Effective date must be the 1st or the 15th of the month. • Effective date requested by the employer may be up to 60 days in advance. • When replacing an employer-sponsored group plan, the effective date must coincide with the premium date on the prior carrier, without regard to the grace period. For example, if the prior plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.
Electronic Funds Transfer	• Once the group is issued coverage, customers can pay their monthly premiums online at **www.aetna.com/employer-plans** or by calling Aetna at **1-866-350-7644** to perform an electronic funds transfer by phone using their checking account and routing number. For details you can contact Total Benefit Solutions. There is no extra charge for this service.

Employee Eligibility	• An eligible employee is defined as an employee who works on a full-time basis with a normal work week of 20 or more hours. • Eligible Employees includes self employed individuals, sole proprietors, partners of a partnership and may include an independent contractor (subject to Aetna Underwriting approval) if included as an employee under a health benefit plan of the employer, but not working less than 20 hours per week. • Part-time employees, working less than 20 hours per week, seasonal and substitute employees are not eligible. • Employees reported on the IRS 1099 forms who meet our standard criteria for determining 1099 status may be considered only if all 1099 employees are offered coverage. Subject to Aetna Underwriting approval. **Retirees** • Retiree coverage is not available. **COBRA** • COBRA/State Continuation eligible employees are required to be included on the census. • COBRA/State Continuation qualifying reason, length, start and end date must be provided.
Employer Contribution	**Single Choice Medical** • 75% of employee coverage to a minimum of 50% when there is also 50% or more contribution for dependents. • Coverage may be denied based upon inadequate contributions. **Pick-A-Plan 5 (Medical)** • 75% of employee coverage to a minimum of 50% when there is also 50% or more contribution for dependents. • Coverage may be denied based upon inadequate contributions. **Dental** • The employer must contribute at least 50 percent of the employee-only cost or 25 percent of the total plan. • Voluntary Dental plans: Employer contribution can be from zero to 49 percent of the cost of the employee only coverage. • Coverage may be denied based upon inadequate contributions. **Term Life** • Employers with less than 10 eligible lives: Employer must contribute 100 percent of the cost of the plan. • Employers with 10 to 50 eligible lives: 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.
Employers leaving an Aetna PEO	• Employers leaving a PEO that is not currently insured with Aetna will be required to complete the Aetna PEO form. Underwriting will determine eligibility based upon this completed form. • Employers leaving a PEO that is currently insured with Aetna do not need to complete the Aetna PEO form. A statement signed by the employer will be sufficient. • The PEO Form will only be requested from an Aetna PEO client when the employer is still receiving services from the Aetna PEO.
Employers Replacing Other Group Coverage	• A copy of the most recent billing statement that includes the employee listing must be submitted. • The employer should be told **not to cancel any existing medical coverage** until they have been notified of approval from the Aetna Underwriting unit.

Holding Companies

- Holding company – A holding company is a company that owns part, all, or a majority of other companies' outstanding stock. It usually refers to a company which does not produce goods or services itself; rather its only purpose is owning shares of other companies. Holding companies allow the reduction of risk for the owners and can allow the ownership and control of a number of different companies.
- Parent Company – A parent company is a holding company that owns enough voting stock in another firm (subsidiary) to control management and operations by influencing or electing its board of directors. A parent company could simply be a company that wholly owns another company.

Example

- Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).
- Bank A (the holding company) has no ownership; it is simply an umbrella company for the 3 Bank B locations.
- Bank B has 3 locations and all under one TIN.
- Bank A (the holding company) is under a separate TIN.
- The holding company and banks have no ownership because the owners are all stockholders and bank employees or bank executives.
- There are no articles of incorporation only stock certificates.
- Bank B is the only group enrolling. Bank A is listed as an associated company with no employees and the group is not to be enrolled.
- Documentation needed: QWTS for Bank B which should include all 3 locations.

Initial Premium Check

- The company check should be in the amount of the first month's premium and may be in the form of a check or electronic funds transfer.
- Either submit a "copy" of the Initial Premium check payable to Aetna Inc. or complete the EFT/ACH form (Aetna Form).
- If the EFT/ACH method is selected, Aetna 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 premium only. If a copy of the check is provided, once coverage is approved you will be advised where to mail the initial premium check.
- The initial premium check is not a binder check. Final premium will be determined upon underwriting review.
- If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will not be processed and the check will be returned to the employer.
- If the initial premium check is returned due to insufficient funds, coverage will be terminated retroactive to the effective date.

Late Entrants

- An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee.
- Applicants without a qualifying life event (i.e. 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.

Medical

- Late applicants without a qualifying event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll.

Dental

- An employee or dependent may enroll at any time; however, coverage is limited to preventive and diagnostic services for the first 12 months.
- No coverage for most basic and major services for the first 12 months (24 months for orthodontics).
- Late entrant provision does not apply to enrollees less than age 5.

Life

- Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.
- The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).
- Life late enrollee example: Group has $50,000 life with $20,000 guarantee issue limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late they must medically qualify for the entire $50,000.

Life – Basic Term

Open Enrollments are prohibited.
All classes must be clearly defined either on the employer application or on company letterhead.

Job Classifications (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 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit.
For example, a schedule may be structured as follows:

Position/Job Class	Basic Term Life Amount
Executives	$75,000
Managers, Supervisors	$50,000
All Other Employees	$20,000

Guaranteed Issue Coverage

Aetna provides certain amounts of life insurance without requiring an employee to answer any medical questions. These insurance amounts are called "Guaranteed Issue". Employees wishing to obtain increased insurance amounts will be required to submit Evidence of Insurability, which means they must complete a medical questionnaire and may be required to submit medical records. Depending on the customer's size, life insurance amounts are Guaranteed Issue up to the maximums listed below:

Case Size	Basic Term Life Amount
5 to 9 Eligible lives	$20,000
10 to 25 Eligible lives	$75,000
25 to 50 Eligible lives	$100,000

Evidence of Insurability (EOI)

EOI is required when one or more of the following conditions exist:

1. Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit.
2. New coverage is requested during the renewal period.
3. Reinstatement or restoration of coverage is requested.
4. 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.
5. Requesting life or disability at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the Guaranteed Issue Limit.

   Example

   Group has $50,000 life with $20,000 Guaranteed Issue Limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late, they must medically qualify for the entire $50,000.

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, we will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.

Live/Work Guidelines	• Product availability for group benefit offerings are always determined by the Zip code of the employer. • If the employee resides at a distance further than the 30-mile radius, exception requests should be directed to Underwriting for a feasibility determination. • Employees enrolled in dental who reside in a Non-DMO network code may enroll in an DMO product offered by their employer if they live within a 30-mile radius of their work site that is within the DMO service area.
Medical	• All eligible groups are required to complete the group health questionnaire for groups of 5 to 50. Failure to do so may result in a maximum 3.00 RAF (risk adjustment factor) determination. • Eligible employees must complete the waiver section of the employee application for either the employee and/or their dependents when declining coverage. • If the employee is requesting coverage above the Guaranteed Issue amount for life they will need to complete the individual health questionnaire. • Groups with 5 to 9 employees enrolled will be tabular rated. • Groups with 10 to 50 employees enrolled will be composite rated.
Mental Health Parity and Addiction Equity Act (MHPAEA)	• If the employer employed an average of 51 or MORE total employees (including part-time and seasonal employees) during the preceding calendar year, the plan DOES NOT qualify for the MHPAEA small employer exemption and your plan IS SUBJECT to MHPAEA. • If the employer employed an average of 50 or FEWER total employees (including part-time and seasonal employees) during the preceding calendar year, the plan DOES qualify for the MHPAEA small employer exemption and your plan is NOT SUBJECT to MHPAEA. • Does your plan qualify for the small employer exemption under Federal Mental Health Parity? Yes means the employer is exempt and is not required to offer MHP, thus MHP does NOT apply. No means MHP does apply. • Plan sponsors should consult with legal counsel to determine their status under the mental health parity law.
Newly Formed Business (in operation less than 3 months)	Employers must provide the following documentation for consideration: • Employer identification number/Federal tax I.D. number; and • Quarterly Wage and Tax Statement., If not available, when will one be filed; and • At least 2 weeks worth of payroll (which includes hours worked and wages earned) or a letter from the employer listing the names of all employees and number of hours worked each week. • The following documents are also required: - If Sole Proprietor: State Business License (not a professional license). - If Partnership or Limited Liability Partnership: Partnership Agreement. - If Limited Liability Corporation: Articles of Organization and the Operating Agreement. - If Corporation: Articles of Incorporation including signature pages of all officers.
Option Sales Alongside other Carriers	**Medical** • Standard participation of 75 percent must be met in order for a group to qualify for Aetna coverage. • Underwriter approval is required. **Dental** • Options sales alongside another dental carrier are not allowed. **Life** • Not applicable
Out of Area Within Washington	**Medical** • Employees residing outside of the Aetna PPO network service area will be enrolled in an Aetna Indemnity Plan. **Dental** • Employees who reside within Washington but outside of a DMO service area may be offered an in-state PPO plan. **Life** • Not Applicable

Out-of-State Employees	• Employees residing outside the state of Washington and reside in an Aetna PPO network service area will be enrolled into a Washington PPO plan. • Employees residing outside the state of Washington and reside in an Aetna Indemnity network service area will be enrolled into the Washington Indemnity plan. **Network Availability for Out-of-State** • Louisiana employees need to be rated independently and installed on a separate Louisiana contract. • No PPO is available in the following states: Alabama, Idaho, Minnesota, Montana, New Mexico, North Dakota, Rhode Island, Wisconsin, and Wyoming. • No Indemnity or PPO products are available in Hawaii or Vermont. **Dental** • Employees who live/work outside of Washington are eligible to be enrolled into the Washington Dental PPO plan when residing in a Dental PPO network service area. • Maximum out-of-state employee percentage and/or number of employees will match the medical guidelines.
Participation	**Medical** • For Non Contributory plans, 100 percent participation is required. All employees, excluding those with other qualifying existing medical coverage, must enroll. • Employers with 5 to 50 eligible employees: 75 percent of eligible, excluding those with coverage through another employer's plan, must participate. • Employees waiving due to individual, governmental (Medicare, Champus, Medi-Cal) or spousal coverage may be required to provide proof of their other coverage by providing a copy of their insurance card if the group does not appear to be meeting the standard participation guidelines (75 percent). • Individual coverage is not considered a valid waiver and will count toward the participation. Copies of ID cards may be requested for confirmation. • All employees waiving coverage must complete Section B and the waiver section of the application. • If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement. **Standard Dental with Medical or Standalone** • Employers paying 100 percent of the employee premium: 100% participation is required. All employees, excluding those with other qualifying existing Dental coverage, must enroll. • Groups with 5 to 50 eligible employees: 75 percent participation is required, excluding those with other qualifying existing Dental coverage. A minimum of 50 percent of total eligible employees must enroll in the dental plan. **Voluntary Dental with Medical or Standalone** • Not available for groups with less than 5 eligible employees. • At least 30 percent of the employees must participate, excluding employees with other qualifying coverage. Enrollees excluding those with other qualifying existing dental coverage or a minimum of 3 enrollees whichever is greater is required. **Life** • For Non Contributory plans, 100 percent participation is required. • Groups with less than 10 eligible employees, 100 percent participation is required. • Groups with 10 to 50 eligible employees, life participation must match medical participation. • Life is required when enrolled in medical. **All** • Coverage can be denied based on inadequate participation.
PEO (Professional Employer Organization)	• As long as we can determine the group is a small employer via a QWTS or payroll records, the group may be considered. • If the small employer may contract for services with a PEO as long as the PEO provides payroll specific to our small group and we can determine it is a small group even though the small group may be reported under the PEO Tax ID, the group may be considered subject to underwriting approval.

Pick-A-Plan 5	• Employers may offer up to five Aetna plans to their employees. • The group must have 5 or more enrolled employees. • One person must be enrolled into each plan and remain in the plan for it to be offered at renewal. • 5 to 9 enrolled will be tabular rated; 10 to 50 enrolled will be composite rated. **Mid-Policy Benefit Changes** • Groups that have selected Pick-A-Plan 5 are not eligible for mid year policy changes. **Carve Outs** • Allowed (See Carve Out section) **1099 Employees** • Subject to Underwriting Approval (See 1099 Employee Section)
Plan Change Ancillary Additions (Life or Dental)	• Employers may request plan changes up to the renewal date for changes that are to be effective on the renewal date. • Employers must request plan changes off of the renewal date at least 2 weeks prior to the desired effective date. • The future renewal date of the ancillary products will be the same as the medical plan renewal date.
Plan Changes – Employees	• 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).
Plan Changes – Employer	• After the first 30 days of enrollment, Employers may request a change in medical benefits 6 months after the original effective date. • Upgrades are only allowed once in a twelve month rolling period and are subject to medical underwriting. • The requests for changes must be submitted to Aetna Small Group Underwriting 75 days prior to the requested effective date. • Late requests will be moved to the next applicable effective date pending underwriting approval.

Product Availability

Medical

- Pick-A-Plan 5 allows each employee the option to choose their medical product from a selection of product offerings selected by the employer.
- Carve Outs: Allowed (See Carve Out section)
- Pick-A-Plan 5: Allowed (See Pick-A-Plan 5 section)
- 1099 Employees: Allowed (See 1099 Employee Section)

Dental

- **Employers with 5 or more eligible,** dental may be sold on a standalone basis or along with the medical on a bundled or unbundled basis.
- If the Employer selects both medical and dental coverage's, it must be offered to all employees.
- Eligible employees do not have to enroll in both plans. Employees may enroll in dental and not medical and vice-versa.
- Orthodontic coverage is included for groups with 10 or more eligible employees and is available for dependent children.
- Carve Outs: Not Allowed
- 1099 Employees: Not Allowed

Life

- **Employers with 5 to 9 eligible employees,** Life must be sold with medical and cannot be sold on a standalone basis.
- **Employers with 10 to 25 eligible employees,** Basic Term Life is available packed with either medical or dental.
- **Employer with 26 to 50 eligible employees,** Basic Term Life is available either packaged with medical or dental or on a standalone basis.
- Employees may elect life coverage even if they do not elect medical coverage or vice versa.
- Employers with less than 10 eligible employees, certain plan differences apply.
- Carve Outs: Not allowed
- 1099 Employees: Underwriting approval required

Rates – Tabular or Composite

Tabular Rate Structure

- For groups with 5 to 9 employees they will be tabular rated.
- All rates are based upon the employer Zip code.

Composite Rate Structure

- For groups with 10 to 50 employees will be composite rated.
- Employers can offer a maximum of 5 Aetna medical plans to their employees.
- One employee must enroll into each plan and remain in a plan for it to be available at renewal.
- New hires may only enroll into one of the 5 plans that are offered.
- Upon final enrollment, the composite rate for each plan will be processed based upon the **final enrolled employees.**
- If the total premium varies by more than 10 percent, the new business rates will be adjusted to match the final rates.

Composite Rating for Renewing Business:

- Renewal rates will be based on the enrolled employees in each plan at the time the renewal is processed.
- Only the plans available after the initial enrollment will be rated for the renewal.
- If you have had a census increase or decrease of less than 20 percent from your prior year's census, your tabular or composite rate structure will not change.

Example

If you were composite rated last year with 10 employees, and now you have nine 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 employee's having to switch between tabular and composite rates from year to year.

Rate Guarantee	• Medical rates are guaranteed for one year (12 months). • Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date this does not apply. • Life rates are guaranteed for 2 years (24 months). • More than a 20 percent change in group census during the policy period may result in underwriting review and possible change in rates for medical, dental and life.
Renewal Benefit Changes	• Requests for plan changes to be effective on the renewal date must be submitted prior to the renewal date. • Requests for plan changes to be effective off of the renewal date must be submitted within 75 days of the requested effective date. • The effective date for the plan change will be based upon notification receipt (this will be the date the email or fax was sent to Aetna).
Signature Dates	• The Aetna Employer Application and all employee applications must be signed and dated **prior to and** within ninety (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 guarantee issue 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. • 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 Documentation

- For groups of 5 to 9 enrolling employees, the employer **must submit** a copy of the most recent 5208A and 5208B (Quarterly Wage and Tax Statement), which must contain the names, salaries, and withholdings for all employees of the employer group.
- If an employee is missing from the 5208A and 5208B payroll must be provided.
- In the event that a 5208A and 5208B are not available because the employer was not in business during the preceding calendar quarter or the employer has outsourced payroll functions, a copy of the payroll documentation from the company or the company's payroll administrator or employee leasing company, organization documents or other reasonable proof must be provided.
- Payroll records should have the tax identification number for the employer on them if submitted from an outsourced payroll company.
- When a 5208A and 5208B or payroll records are submitted:
  - Employees who have terminated, work part-time, are seasonal, or are newly hired should be noted accordingly on the document.
  - Any handwritten comments added to the document must be signed and dated by the employer.
  - Newly hired employees should be written in on the Quarterly Wage & Tax Statement and signed by the employer.
  - The underwriter may request payroll in questionable situations.
  - Churches must provide Form 941 including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.
- **For groups of 10 to 50 enrolling employees who do not appear on the prior carrier billing statement;** Proprietors, partners or corporate officers must complete the Aetna Proof of Eligibility Form and submit one of the documents listed below.
- **For groups of 10 to 50 enrolling employees who appear on the prior carrier billing statement;** Proprietors, partners, or corporate officers must complete the Aetna Proof of Eligibility Form and do not need to submit one of the following documents (we reserve the right to request IRS forms upon receipt and review of the group):

C-Corporation	• W2
S-Corporation	• IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)
Partnership	• IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) • Limited Liability Company (LLC)
Sole Proprietor	• May file as either C Corporation or Partnership • IRS Schedule SE and Schedule C filed with Form 1040; or IRS Form 1040 • Schedule F or K-1

- Aetna Proof of Eligibility Form – one form per individual is to be completed.
- Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status.
- Other documentation may be requested by Aetna Underwriting upon receipt and review of sold case documents.
- Altered legal documentation will not be accepted at any time.

1099 Employees

Employees reported on the IRS 1099 forms who meet our standard criteria for determining 1099 status may be considered only if all 1099 employees are offered coverage. They must meet the following requirements:

- No more than 50 percent of the group's employees can be 1099 employees.
- 1099 employees must be employed by the company full time and year round.
- All present and future 1099 employees are subject to the same eligibility requirements as taxed employees.
- The employer must contribute the same amount for 1099 employees as for all other employees qualifying for coverage.
- The employer must have at least two taxed employees, with tax documents that verify the company is a valid business.
- The new group must include a list of all 1099 employees and a completed and signed 1099 contractor form.

Townships and Municipalities

- Townships – A township is generally a small unit that has the status and powers of local government.
- Municipality – A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town, or village. A municipality is typically governed by a mayor and city council, or municipal council. In most countries a municipality is the smallest administrative subdivision to have its own democratically elected officials.

Underwriting Requirements

- 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 and should provide 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 and participation will be maintained.

Limitations & exclusions

Medical

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your 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 your plan documents
- Nonmedically necessary services or supplies
- Orthotics, except 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

Pre-existing conditions exclusion provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if the member has a medical condition before coming to our plan, he or she 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 three months.

Generally, this period ends the day before coverage becomes effective. However, if the employee was in a waiting period for coverage, the three-month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to three months from the employees first day of coverage, or, if he or she is in a waiting period, from the first day of the waiting period.

If your employees had less than three months of group or three months of individual (including Medicare, Medicaid) of creditable coverage immediately before the date they enrolled, the plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage. Creditable coverage includes health coverage issued on a group or individual basis; Medicare; Medicaid; health care for members of the uniformed services; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan (any plan established by a state, the government of the United States, or a foreign country); any health benefit plan under Section 5(e) of the Peace Corps Act; and the State Children's Health Insurance Program (S-Chip).

If your employees had no prior creditable coverage within the three months prior to their enrollment date (either because they had no prior coverage or because there was more than a three-month gap from the date their prior coverage terminated to the enrollment date), we will apply the plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate the exclusion period based on their creditable coverage, members should provide us a copy of any Certificates of Creditable Coverage they have. Please contact your Aetna Member Services representative at **1-888-802-3862** if members need help getting a Certificate of Creditable Coverage from their prior carriers or if they have any questions on the information noted above. Pre-existing condition exclusion provisions are waived for any individual under the age of 19 and do not apply to pregnancy.

Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; if applicable, the pre-existing exclusion will be applied from the individual's effective date of coverage.

Dental and AD&D Ultra

The Dental and AD&D Ultra 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

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

- Dental services or supplies that are primarily used to alter, improve or enhance appearance.
- Experimental services, supplies or procedures.
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder.
- Replacement of lost, missing or stolen appliances and certain damaged appliances.
- Those services that the plan 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 and 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 will 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.

AD&D Ultra

Not all events which 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. 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.)
- Bodily or mental infirmity.
- Commission of or attempting 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*.
- 3rd 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 you or your covered dependent were:
  - Operating the motor vehicle while under the influence of alcohol is a level which 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).

*These do not apply if the loss is caused by:
- An infection which results directly from the injury.
- Surgery needed because of the injury.

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

Submission details and guidelines

Effective dates may be the first or 15th day of the month only.

Applications must be received by Aetna no later than the end of business day, 10 business days before the requested effective date.

Send paperwork to:

Total Benefit Solutions
155 108th Ave NE Suite 800
Bellevue, WA 98004
1-425-897-7150
www.tbsmga.com

Employer Information

Employer Application

- Complete all pages of the application.
- Employer signature must be of an office or corporate officer.
- Number of eligible and enrolled employees.
- Premium percentage paid by employer.
- Indicate selected products in Section II — Medical Coverage Selection.
- Completed COBRA/State Continuation form for any employees currently eligible or enrolled on COBRA or State Continuation.
- Applications will not be accepted more than 60 days from the date signed.
- No altered applications (a new application will be required).

5208A and 5208B or other applicable tax documents

- Part-time, terminated, seasonal or temporary must be indicated on this wage and tax report.
- For seasonal industries such as farming laborers or season processing fruit plants, four (4) consecutive quarters of wage and tax reports may be requested by underwriting.
- All enrolling employees must be represented on the wage and tax form or included on a payroll report.
- Out-of-state employees require proof of employment if not identified on the 5208A and 5208B. This would be the quarterly wage and tax statement filed in that particular state where the employee is living and/or working.
- If owner, partner, or corporate officer is not listed on the 5208A and 5208B, submit the Small Group Proof of Eligibility form signed by the employee along with the requested documents.
- If newly hired employees are not identified on the 5208A and 5208B, submit a minimum of two weeks payroll indicating compensation and taxes withheld.

Premium Check made payable to Aetna

- A premium check on company stock for 100 percent of the first month's medical and life premiums payable to "Aetna."

Copy of current/prior medical/dental carrier's latest bill

- Include employee roster and premium summary page.

Employee Information

Employee applications completed and signed by each employee

- Any alterations must be initialed and dated by the employee.
- Individual waiver forms completely filled out for each employee and/or family member waiving coverage (to be signed by the employee).
- Employees need to sign and date the signature page prior to the requested effective date.

Dental Submissions (in addition to items under Employee Information section)

- Employee Enrollment Forms
- Waiver completed for employees not electing dental

Group Insurance Submissions (in addition to items under Employer Information section)

- Employee Enrollment Form
- Individual Health Statement required if selecting life amount in excess of Guaranteed issue amount
- Waiver completed for employees not electing life

Complete/Review Broker and General Agent information

- Complete, sign, and date the Agent/Broker Certification section of the Employer Application.
- Review all items on this page for completion prior to submissions.
- Verify underwriting guidelines were reviewed and understood.
- Submit a copy of the Aetna quote package.
- Complete and provide the Aetna Agent Agreement, if applicable.

Avoid potential delays in getting your client approved and enrolled. Make sure your new case submissions are complete.

For more information about our small business solutions, please contact your local Aetna sales manager or the Small Group Service Center from 8 a.m. to 5 p.m. PT.

Toll Free #: **1-877-249-2472**
Fax #: **1-888-258-4530**

New Business Case Submission
Total Benefit Solutions
155 108th Ave NE Suite 800
Bellevue, WA 98004

Effective dates may be the first of the month only.

We must receive required paperwork by no later than the requested effective date.

Contact Information

Broker Sales Support Unit

Phone #: **1-877-249-2472**
Fax #: **1-888-258-4530**

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

Prompt 2 – Claims
Prompt 3 – Commission questions
Prompt 4 – Licensing & appointments
Prompt 5 – Renewal assistance
Prompt 6 – Broker liaisons for fulfillment requests & all other questions

E-mail Addresses
ASGBLAZ_NV_WA@aetna.com

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

Overnight Mail
1385 East Shaw Avenue
Fresno, CA 93710

New Business Quoting & Sales

Total Benefit Solutions
Phone #: **1-425-897-7150**
Fax #: **1-877-653-2118**
Quotes@tbstrust.com

New Business Case Submission

Total Benefit Solutions
155 108th Ave NE Suite 800
Bellevue, WA 98004

Phone #: **1-425-897-7150**
www.tbsmga.com

Aetna Navigator® & Producer World®

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

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

Prompt 1 – (Aetna Navigator)
Prompt 3 – (Producer World)
Prompt 1 – Assistance with password or user name
Prompt 2 – Assistance with registration
Prompt 3 – Access assistance
Prompt 4 – All other website technical assistance

Plan Sponsor Services

Phone #: **1-877-249-7235**

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

Prompt 1 – Renewals
Prompt 2 – Claims
Prompt 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

Enrollment e-mail: **FresnoCEHIT@aetna.com**
Online: **www.aetna.com/employer-plans**

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 insurance, dental insurance and life insurance plans/policies contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. 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. 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 and dental 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. 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.**

www.aetna.com

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