

# AETNA AVE

*Aetna Avenue® — Your Destination for Small Business Solutions®*

## CALIFORNIA PLAN GUIDE



Pending Regulatory Approval

**PLANS EFFECTIVE OCTOBER 1, 2010**

For businesses with 2–50 eligible employees  
Updated July 2011

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The Aetna logo, featuring a stylized figure and the word "Aetna" with a registered trademark symbol.

*Health care is a journey...*

## **AETNA AVENUE** IS THE WAY

### **IN THIS GUIDE:**

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

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

Aetna offers a variety of plans for small business — from Medical plans to Dental and Life plans.

## CHOICE

### *For business owners and employees*

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

**Medical plans** — supporting members on their health care journey

- HMO plans
- HSA\* and HRA-compatible plans
- MC and PPO plans

**Dental and Life plans** — providing valuable protection

- DMO®
- PPO
- Freedom-of-Choice plan design
- Basic term life insurance

## EASE

### *Allowing you to focus on your business*

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

**Administration** — making it work for your business

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

**Ready on day one** — making it work for your employees

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

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

- Look up rates for providers, facilities and hospitals for common services and treatment
- Track medical claims online
- Personal Health Record, providing a complete picture of health
- Simple Steps To A Healthier Life®, an online health and wellness program
- Temporary ID cards available for members to print as needed

## REPUTATION

### *In business it's everything*

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

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

## AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that small business owners' health insurance benefits needs are often different from a larger employer. Aetna Avenue focuses on employers with 2–50 employees, and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for your business and assist you through implementation.

### AETNA'S MARKET MAP

#### *Guiding your small business health care journey*

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

**DO  
YOU  
VALUE...**



\*HSAs are currently not available to HMO members.

## HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

### YOUNG SINGLES

Consumer-directed health plans  
HSA-compatible plans\*

### YOUNG SINGLES

*Includes singles and couples without children*

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

### ESTABLISHED FAMILIES

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

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

### YOUNG FAMILIES

Traditional plans  
Consumer-directed health plans

### YOUNG FAMILIES

*Includes married couples and single parents with young children and teens*

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

### EMPTY NESTERS

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

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

### ESTABLISHED FAMILIES

Consumer-directed health plans  
Traditional plans

### EMPTY NESTERS

Consumer-directed health plans  
HSA-compatible plans\*

\*HSAs are currently not available to HMO members.

### Large physician network\*

More than 65,000 physicians and 400 hospitals.

- Aetna Value Network = 34,684\* doctors and 451 hospitals
- HMO Network = 62,728\* doctors and 451 hospitals
- Managed Choice Network = 69,470\* doctors and 467 hospitals
- PPO Network = 69,464\* doctors and 467 hospitals

### CALIFORNIA PROVIDER NETWORK\*

County	Aetna Value Network <sup>SM</sup>	HMO	MC	PPO	Vitalidad	Vitalidad Plus
Alameda	•	•	•	•		
Alpine						
Amador			•	•		
Butte			•	•		
Calaveras				•		
Colusa				•		
Contra Costa**	•	•	•	•		
Del Norte				•		
El Dorado		•	•	•		
Fresno†		•	•	•		
Glenn				•		
Humboldt			•	•		
Imperial			•	•		
Inyo						
Kern	•	•	•	•		
Kings		•	•	•		
Lake			•	•		
Lassen				•		
Los Angeles**,*††	•	•	•	•		•
Madera		•	•	•		
Marin		•	•	•		
Mariposa				•		
Mendocino						
Merced		•	•	•		
Modoc				•		
Mono				•		
Monterey			•	•		
Napa			•	•		
Nevada†		•	•	•		
Orange	•	•	•	•		•

\*According to the Aetna Enterprise Provider Database as of July 1, 2009. Network subject to change.

\*\*The Aetna Value Network HMO plans are available in select areas of Contra Costa, Los Angeles, Riverside, San Bernardino, San Diego, San Joaquin, San Mateo and Sonoma counties. Contact Aetna for more information.

†The HMO network is available in select areas of Fresno, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Solano, Sonoma and Yolo Counties. Contact Aetna for more information.

††The Vitalidad Plus network is available in select areas of Los Angeles, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara Counties. Contact Aetna for more information.

County	Aetna Value Network <sup>SM</sup>	HMO	MC	PPO	Vitalidad	Vitalidad Plus
Placer <sup>†</sup>	•	•	•	•		
Plumas				•		
Riverside <sup>**†,††</sup>	•	•	•	•		•
Sacramento <sup>†</sup>	•	•	•	•		
San Benito			•	•		
San Bernardino <sup>**†,††</sup>	•	•	•	•		•
San Diego <sup>**††</sup>	•	•	•	•	•	•
San Francisco	•	•	•	•		•
San Joaquin <sup>**†</sup>	•	•	•	•		
San Luis Obispo		•	•	•		
San Mateo <sup>**††</sup>	•	•	•	•		•
Santa Barbara		•	•	•		
Santa Clara <sup>††</sup>	•	•	•	•		•
Santa Cruz	•	•	•	•		
Shasta			•	•		
Sierra						
Siskiyou				•		
Solano <sup>†</sup>		•	•	•		
Sonoma <sup>**†</sup>	•	•	•	•		
Stanislaus	•	•	•	•		
Sutter			•	•		
Tehama			•	•		
Trinity				•		
Tulare		•	•	•		
Tuolumne			•	•		
Ventura		•	•	•		
Yolo <sup>†</sup>	•	•	•	•		
Yuba			•	•		

The following IPAs are not available to HMO Deductible/ HMO Coinsurance members:

**Kern**

- Independence Medical Group

**Los Angeles**

- All Care Medical Group
- Cedars-Sinai Health Associates
- Cedars-Sinai Medical Care Foundation
- Family Care Specialists IPA, A Medical Group
- Prudent Medical Care
- Torrance Hospital IPA Medical Group

**Orange**

- Mission Hospital Affiliated Physicians
- St. Joseph Heritage Medical Group
- St. Joseph Hospital Affiliated Physicians
- St. Jude Affiliated Physicians
- St. Jude Heritage Medical Group

**San Diego**

- Scripps Clinic Medical Group
- Scripps Coastal Medical Center

\*According to the Aetna Enterprise Provider Database as of July 1, 2009. Network subject to change.

\*\*The Aetna Value Network HMO plans are available in select areas of Sonoma, Contra Costa, San Joaquin, San Mateo, Los Angeles, San Bernardino, Riverside and San Diego Counties. Contact Aetna for more information.

†The HMO network is available in select areas of Fresno, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Solano, Sonoma and Yolo Counties. Contact Aetna for more information.

††The Vitalidad Plus network is available in select areas of Los Angeles, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara Counties. Contact Aetna for more information.

## Aetna Avenue

## MEDICAL OVERVIEW

Product Name	Product Description	PCP Required	Referrals Required	Network
<b>Health Maintenance Organization (HMO)</b>	Each family member selects a primary care physician (PCP) participating in our network. The PCP provides routine and preventive care and helps coordinate the member's total health care. The PCP refers members to participating specialists and facilities for medically necessary specialty care. Only services provided or referred by the PCP are covered except for emergency, urgently needed care or direct access benefits, unless approved by the HMO in advance of receiving services.	Yes	Yes	HMO
<b>Aetna HMO Deductible Plan</b>	Utilizes all the services of the HMO with a subset of the HMO Network with additional savings by applying a deductible for certain medical services.	Yes	Yes	HMO Deductible
<b>Aetna HMO Coinsurance Plan</b>	Utilizes all the services of the HMO with a subset of the HMO Network with additional savings by applying a coinsurance for certain medical services.	Yes	Yes	HMO Deductible
<b>Aetna Value Network<sup>SM</sup> HMO</b>	All the services of the HMO provided by a subset of the full HMO network. Aetna Value Network plans offer similar benefits of Aetna's HMO plan, with premium savings by accessing only a select network of providers.	Yes	Yes	Aetna Value Network <sup>SM</sup> HMO
<b>Vitalidad Mexico con Aetna<sup>SM*</sup></b> (Available for California employers)	HMO plans that feature the Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) provider network in Northern Mexico service area. San Diego county employees access health care services from participating providers in the Mexican cities of Tijuana, Tecate and Mexicali. Members choose a Mexico-based primary care physician (PCP). Only services provided or referred by their PCP, except for emergency or urgent care, are covered unless approved by the HMO in advance of receiving services.	Yes	Yes	Vitalidad HMO*
<b>Vitalidad Plus<sup>SM</sup> California con Aetna*</b> (Available for California employers)	Coverage for employees in select zip codes in California and in the Mexican cities of Tijuana, Tecate, or Mexicali through a specially developed provider network. Plans are available to California employers who provide employees and their dependents access to care from a California-based primary care physician (PCP) or a Mexican-based PCP. Covered benefits differ based on PCP country location.	Yes	Yes	Vitalidad Plus HMO*
<b>Managed Choice (MC)</b>	Members can access any recognized provider for covered services without a referral. Members have the freedom to choose network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs at any time. Members are able to receive emergency services at the in-network coinsurance/copay level.	No	No	Managed Choice <sup>®</sup> POS
<b>PPO</b>	Members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs. Members are able to receive emergency services at the in-network coinsurance/copay level.	No	No	Open Choice <sup>®</sup> PPO
<b>Indemnity</b>	Employees who live outside the plan's network service area are eligible. Members coordinate their own health care and may access any recognized provider for covered services without a referral.	No	No	N/A

Aetna will offer the in-state portfolio (MC and PPO only) and rating structure to out-of-state employees who live in an out-of-state network area. Out-of-state employees who do not live in an out-of-state network area will be eligible for an in-state indemnity plan.

\*Provider network through Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA). This Health Plan may be limited in benefits, rights and remedies under U.S. federal and state law. *Este Plan de Salud puede tener limitaciones en sus beneficios, derechos y resoluciones bajo las leyes federales estatales de Los Estados Unidos.*

**AN EXPLANATION OF COINSURANCE MAXIMUMS, OUT-OF-POCKET MAXIMUMS**

<b>MC/HRA HDHP/PPO</b>	<b>HSA HDHP*</b>	<b>HMO/AVN HMO/HMO Deductible/ HMO Coinsurance/Vitalidad HMO/ Vitalidad Plus HMO</b>
Amounts over allowable charges, copays, failure to precertify penalty, payments for non-serious mental disorders, substance abuse, Rx (including self-injectables), infertility and DME do not apply toward coinsurance maximum and continue to be payable after the maximum is reached.	Amounts over allowable charges and failure to precertify penalty do not apply toward the out-of-pocket maximum and continue to be payable after the maximum is reached.	All member copays and coinsurance accumulate toward the out-of-pocket maximum, excluding member cost-sharing for Prescription Drugs.

**WAYS TO MEET THE FAMILY DEDUCTIBLE AND COINSURANCE / OUT-OF-POCKET MAXIMUM**

<b>MC HSA HDHP*</b>	<b>HMO/AVN HMO/HMO Deductible/ HMO Coinsurance/Vitalidad HMO/ Vitalidad Plus HMO/MC HRA HDHP</b>	<b>MC/PPO</b>
True Integrated Family (TIF) The family deductible and/or out-of-pocket maximum can be met by a combination of family members or by a single individual within the family. There is no individual deductible and/or out-of-pocket maximum to satisfy within the family deductible and/or out-of-pocket maximum.	Embedded Aggregate Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket maximum, not the entire family deductible and/or out-of-pocket maximum.	Two-Member Maximum Once two members of a family have satisfied their individual deductible and/or coinsurance maximum, all family members will be considered as having met their deductible and/or coinsurance maximum for the remainder of the calendar year.

\*HSAs are currently not available to HMO members.

## Administrative fees

FEE DESCRIPTION	FEE
<b>HSA</b>	
Initial Set-Up	\$0
Monthly Fees	\$0
<b>POP</b>	
Initial Set-Up*	\$175
Renewal	\$100
<b>HRA and FSA**</b>	
Initial Set-Up*	
2–25 Employees	\$350
26–50 Employees	\$450
Renewal Fee	
2–25 Employees	\$225
26–50 Employees	\$275
Monthly Fees***	\$5.25 per participant
Additional Set-Up Fee for “stacked” plans (those electing an Aetna HRA and FSA simultaneously)	\$150
Participation Fee for “stacked” participants	\$10.25 per participant
Minimum Fees	
0–25 Employees	\$25 per month minimum
26–50 Employees	\$50 per month minimum
<b>TRA</b>	
Annual Fee	\$350
Transit Monthly Fees	\$4.25 per participant
Parking Monthly Fees	\$3.15 per participant
<b>COBRA (Federal)</b>	
Annual Fee 20–50 Employees	\$100
Monthly Fee	\$0.88 per employee

## HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

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

## COBRA ADMINISTRATION

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

## SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

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

### Premium Only Plans (POP)

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

### Flexible Savings Account (FSA)

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

### Transit Reimbursement Account (TRA)

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

\*Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for \$75 fee. Non-discrimination testing only available for FSA and POP products.

\*\*Aetna FSA pricing is inclusive for POP. Debit cards are available for FSA only. Contact Aetna for further information.

\*\*\*For HRA, if the employer opts out of Streamline, the fee is increased \$1.50 per participant.

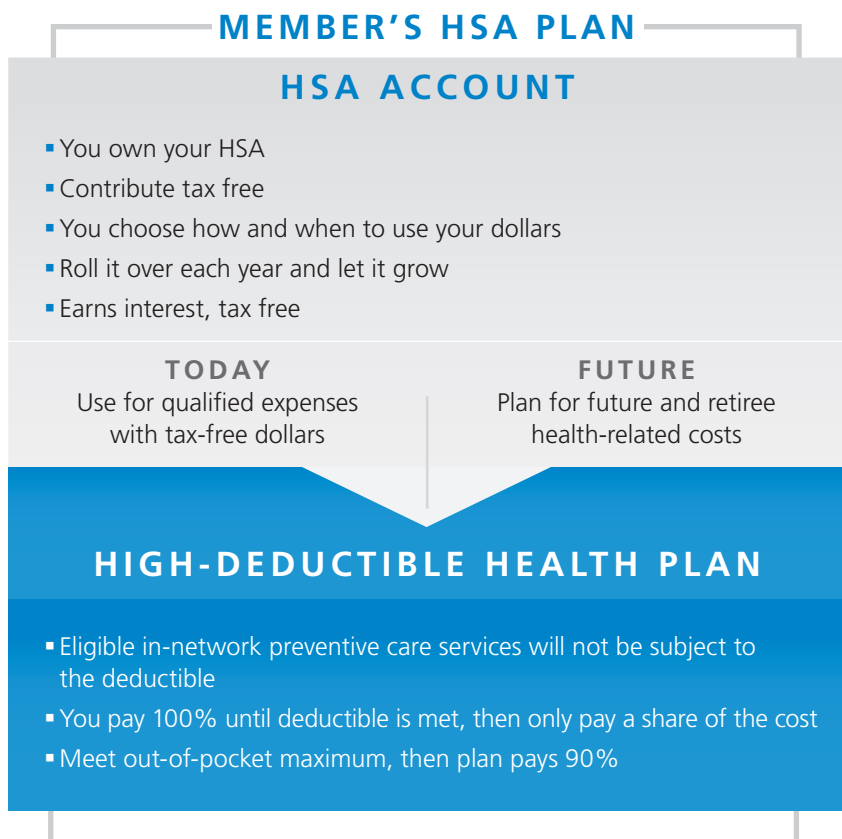
Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules, and are unfunded liabilities of your employer. Fund balances are not vested benefits. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other 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.

## HEALTH SAVINGS ACCOUNT (HSA)\*

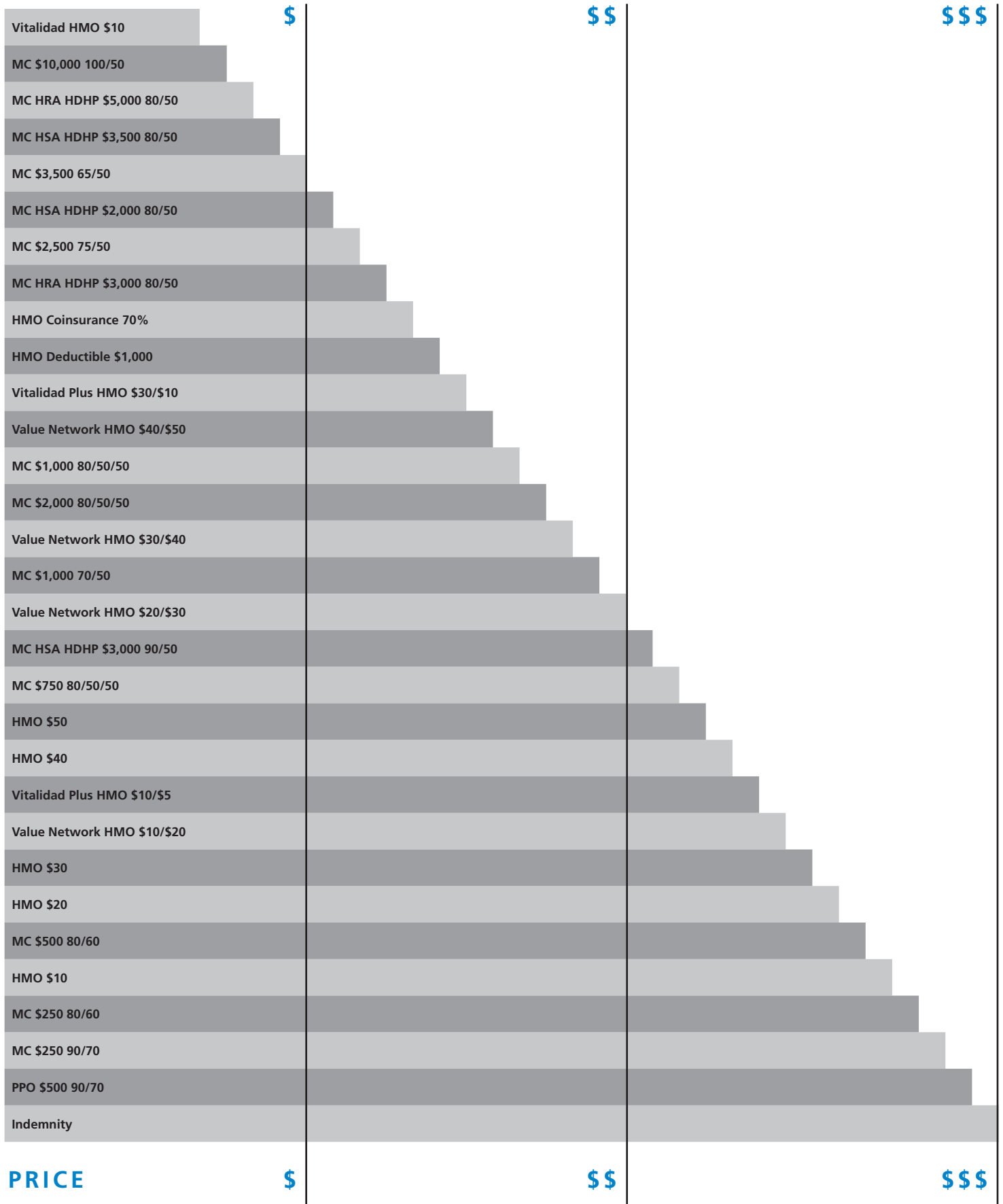
### *No set-up or administrative fees*

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



\*HSAs are currently not available to HMO members.

PLAN TYPE AND VALUE BY PRICE\*



\*Average prices may vary by county.

# HMO PLANS

PLAN NAME	HMO \$10	HMO \$20	HMO \$30	HMO \$40	HMO \$50	HMO Deductible \$1,000 <sup>2</sup>	HMO Coinsurance 70% <sup>2</sup>
<b>PCP/Referrals Required</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>MEMBER BENEFITS</b>	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
<b>Plan Coinsurance</b>	N/A	N/A	N/A	N/A	N/A	70%	70%
<b>Calendar Year Deductible</b>	None	None	None	None	None	\$1,000 Individual, \$2,000 family	None
<b>Calendar Year Copay Maximum</b> (Certain payments do not apply)	\$1,500 Individual, \$3,000 family	\$2,500 Individual, \$5,000 family	\$3,000 Individual, \$6,000 family	\$3,500 Individual, \$7,000 family	\$4,000 Individual, \$8,000 family	\$3,500 Individual, \$7,000 family	\$3,500 Individual, \$7,000 family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>Primary Physician Office Visit*</b>	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay	\$40 Copay; deductible waived	\$40 Copay
<b>Specialist Office Visit*</b>	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay	\$40 Copay; deductible waived	\$50 Copay
<b>Chiropractic Services</b> (20 visits per calendar year)	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay; deductible waived	\$15 Copay
<b>Outpatient Lab &amp; X-Ray*</b>	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay	\$40 Copay; deductible waived	\$40 Copay
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans)	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay	\$100 Copay; deductible waived	\$100 Copay
<b>Physical Exams — Adult</b>	No charge	No charge	No charge	No charge	No charge	No charge	No charge
<b>Well-Child Exams</b>	No charge	No charge	No charge	No charge	No charge	No charge	No charge
<b>Routine GYN</b>	No charge	No charge	No charge	No charge	No charge	No charge	No charge
<b>Inpatient Hospital</b>	No charge	\$200 Copay per day up to 3 days per admission	\$500 Copay per day up to 3 days per admission	\$750 Copay per day up to 3 days per admission	\$1,000 Copay per day up to 3 days per admission	70% After deductible	70%
<b>Outpatient Surgery OP Hospital Department</b>	\$100 Copay	\$250 Copay	\$300 Copay	\$400 Copay	\$500 Copay	70% After deductible	60%
<b>Outpatient Surgery Freestanding Facility</b>	No charge	\$100 Copay	\$150 Copay	\$200 Copay	\$250 Copay	70% After deductible	70%
<b>Emergency Services</b> (Copay waived if admitted)	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay; after deductible	\$200 Copay
<b>Urgent Care</b>	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay; deductible waived	\$50 Copay
<b>Prescription Drugs<sup>1</sup></b> <b>Retail:</b> per 30-day supply <b>Mail Order:</b> two times retail copay, 31- to 90-day supply	\$15/\$35/\$50	\$15/\$35/\$50	\$15/\$35/\$50	\$15/\$35/\$50	\$15/\$35/\$50	\$20/\$40/\$60; Deductible waived	\$20 / \$40 / \$60; Deductible waived
<b>Self-Injectable Drugs</b> (Excludes insulin)	Covered under Medical	Covered under Medical	Covered under Medical	Covered under Medical	Covered under Medical	Covered under Medical	Covered under Medical

See page 23 for Footnotes.

## AVN HMO PLANS

PLAN NAME	Value Network HMO \$10/\$20	Value Network HMO \$20/\$30	Value Network HMO \$30/\$40	Value Network HMO \$40/\$50
<b>PCP/Referrals Required</b>	Yes	Yes	Yes	Yes
<b>MEMBER BENEFITS</b>	In-Network	In-Network	In-Network	In-Network
<b>Plan Coinsurance</b>	N/A	N/A	N/A	N/A
<b>Calendar Year Deductible</b>	None	None	None	None
<b>Calendar Year Copay Maximum</b> (Certain payments do not apply)	\$2,000 Individual, \$4,000 family	\$2,500 Individual, \$5,000 family	\$3,000 Individual, \$6,000 family	\$3,500 Individual, \$7,000 family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Primary Physician Office Visit*</b>	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay
<b>Specialist Office Visit*</b>	\$20 Copay	\$30 Copay	\$40 Copay	\$50 Copay
<b>Chiropractic Services</b> (20 visits per calendar year)	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
<b>Outpatient Lab &amp; X-Ray*</b>	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans)	\$10 Copay	\$20 Copay	\$30 Copay	\$40 Copay
<b>Physical Exams — Adult</b>	No charge	No charge	No charge	No charge
<b>Well-Child Exams</b>	No charge	No charge	No charge	No charge
<b>Routine GYN</b>	No charge	No charge	No charge	No charge
<b>Inpatient Hospital</b>	\$100 Copay per day, up to 3 days per admission	\$400 Copay per day, up to 3 days per admission	\$600 Copay per day, up to 3 days per admission	\$800 Copay per day, up to 3 days per admission
<b>Outpatient Surgery OP Hospital Department</b>	\$100 Copay	\$200 Copay	\$300 Copay	\$400 Copay
<b>Outpatient Surgery Freestanding Facility</b>	No charge	\$100 Copay	\$150 Copay	\$200 Copay
<b>Emergency Services</b> (Copay waived if admitted)	\$100 Copay	\$100 Copay	\$100 Copay	\$100 Copay
<b>Urgent Care</b>	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay
<b>Prescription Drugs<sup>1</sup></b> <b>Retail:</b> per 30-day supply <b>Mail Order:</b> two times retail copay, up to 90-day supply	\$20/\$40/\$60	\$20/\$40/\$60	\$20/\$40/\$60	\$20/\$40/\$60
<b>Self-Injectable Drugs</b> (Excludes insulin)	Covered under Medical	Covered under Medical	Covered under Medical	Covered under Medical

See page 23 for Footnotes.

<b>VITALIDAD HMO</b>	
<b>PLAN NAME</b>	<b>Vitalidad HMO \$10<sup>2</sup></b>
<b>PCP/Referrals Required</b>	Yes
<b>MEMBER BENEFITS</b>	In-Network
<b>Calendar Year Deductible</b>	None
<b>Calendar Year Copay Maximum</b> (Certain payments do not apply)	\$2,000 Individual, \$4,000 family
<b>Lifetime Maximum Benefit</b>	Unlimited
<b>Primary Physician Office Visit*</b>	\$10 Copay
<b>Specialist Office Visit*</b>	\$10 Copay
<b>Routine Physical Exams</b>	No charge
<b>Well-Child Exams</b>	No charge
<b>Routine GYN</b>	No charge
<b>Outpatient Lab, X-Ray* &amp; Complex Imaging</b>	No charge
<b>Inpatient Hospital</b>	\$100 Copay per day, up to 7 days per admission
<b>Outpatient Surgery</b>	No charge
<b>Emergency Services</b> (In SIMNSA Network)	\$20 Copay
<b>Emergency Services</b> (Out of SIMNSA Network)	\$100 Copay
<b>Ambulance</b> (In SIMNSA Network)	No charge
<b>Ambulance</b> (Out of SIMNSA Network)	\$50 Copay
<b>Urgent Care</b> (In SIMNSA Network)	\$20 Copay
<b>Urgent Care</b> (Out of SIMNSA Network)	\$35 Copay
<b>Prescription Drugs</b> (In SIMNSA Network)	\$10 Generic and brand
<b>Prescription Drugs</b> (Out of SIMNSA Network/Closed Formulary — Closed Formulary is based on medications related to an Emergency Room or Urgent Care visit.)	\$10 Generic, \$20 brand
<b>Self-Injectable Drugs</b> (Excludes insulin)	Covered under copay
<b>Mail Order Prescription Drugs</b>	Not covered

## VITALIDAD PLUS HMO PLANS

PLAN NAME	Vitalidad Plus HMO \$10/\$5		Vitalidad Plus HMO \$30/\$10	
	Yes		Yes	
PCP/Referrals Required <sup>3</sup>	California PCP Selected		Mexico PCP Selected	
MEMBER BENEFITS	California PCP Selected	Mexico PCP Selected	California PCP Selected	Mexico PCP Selected
Plan Coinsurance	N/A		N/A	
Calendar Year Deductible	None		None	
Calendar Year Copay Maximum (Certain payments do not apply)	\$2,000 Individual, \$4,000 family		\$3,000 Individual, \$6,000 family	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician Office Visit*	\$10 Copay	\$5 Copay	\$30 Copay	\$10 Copay
Specialist Office Visit*	\$10 Copay	\$5 Copay	\$30 Copay	\$10 Copay
Chiropractic Services	\$15 Copay	Not covered	\$15 Copay	Not covered
Visit Limits	20 Visits per calendar year	NA	20 Visits per calendar year	NA
Outpatient Lab & X-Ray*	\$10 Copay	No charge	\$30 Copay	No charge
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	\$10 Copay	No charge	\$30 Copay	No charge
Physical Exams — Adult	No charge	No charge	No charge	No charge
Well-Child Exams	No charge	No charge	No charge	No charge
Routine GYN	No charge	No charge	No charge	No charge
Inpatient Hospital	\$100 Copay per day, up to 3 days per admission	No charge	\$600 Copay per day, up to 3 days per admission	\$100 Per day, up to \$700 per admission
Outpatient Surgery OP Hospital Department	\$100 Copay	No charge	\$300 Copay	No charge
Outpatient Surgery Freestanding Facility	\$50 Copay	No charge	\$150 Copay	No charge
Emergency Services (Copay waived if admitted)	\$100 Copay	\$10 Copay	\$100 Copay	\$20 Copay
Urgent Care	\$50 Copay	\$10 Copay	\$50 Copay	\$20 Copay
Prescription Drugs <sup>1</sup> Retail: per 30-day supply	\$15/\$35/\$50	\$5 Generic and brand	\$15/\$35/\$50	\$10 Generic and brand
Mail Order Prescription Drugs Up to 90-day supply	2x Retail copay	Not covered	2x Retail copay	Not covered
Self-Injectable Drugs (Excludes insulin)	Covered under Medical	Covered under copay	Covered under Medical	Covered under copay

See page 23 for Footnotes.

# STANDARD MC PLANS

PLAN NAME	MC \$250 90/70 <sup>5</sup>		MC \$250 80/60 <sup>5</sup>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>PCP/Referrals Required</b>	No	N/A	No	N/A
<b>MEMBER BENEFITS</b>	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Coinsurance</b>	90%	70%	80%	60%
<b>Calendar Year Deductible</b>	\$250 Per member	\$250 Per member	\$250 Per member	\$250 Per member
<b>Calendar Year Coinsurance Maximum</b> (Deductible and certain payments do not apply)	\$3,000 Per member	\$6,000 Per member	\$3,500 Per member	\$7,000 Per member
<b>Deductible and Coinsurance Maximum Accumulation</b>	Two-Member Maximum		Two-Member Maximum	
<b>Lifetime Maximum Benefit</b>	Unlimited		Unlimited	
<b>Primary Physician Office Visit*</b>	\$15 Copay; deductible waived	70%	\$20 Copay; deductible waived	60%
<b>Specialist Office Visit*</b>	\$15 Copay; deductible waived	70%	\$20 Copay; deductible waived	60%
<b>Primary and Specialist Physician E-Visit</b> (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	\$10 Copay; deductible waived	Not covered
<b>Walk-In Clinics</b>	\$15 Copay; deductible waived	Not covered	\$20 Copay; deductible waived	Not covered
<b>Outpatient Lab &amp; X-Ray*</b>	No charge	70%	No charge	60%
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans; precertification required)	90%	60%; Aetna pays up to \$800 per service	80%	50%; Aetna pays up to \$800 per service
<b>Outpatient Physical, Occupational and Chiropractic Therapy</b> (24 visits per calendar year, IN and OON combined)	90%	70%; Aetna pays up to \$25 per visit	80%	60%; Aetna pays up to \$25 per visit
<b>Physical Exams — Adult</b>	No charge	70%	No charge	60%
<b>Well-Child Exams</b>	No charge	70%	No charge	60%
<b>Routine GYN</b>	No charge	70%	No charge	60%
<b>Inpatient Hospital</b>	90%	70% After \$250 copay per admission	80%	60% After \$250 copay per admission
<b>Outpatient Surgery OP Hospital Department</b>	80%	60% After \$150 copay per surgery	70%	50% After \$150 copay per surgery
<b>Outpatient Surgery Freestanding Facility</b>	90%; Deductible waived	70% After \$150 copay per surgery	80%; Deductible waived	60% After \$150 copay per surgery
<b>Emergency Services</b> (Copay waived if admitted)	90% After \$100 copay	Paid as in-network	80% After \$100 copay	Paid as in-network
<b>Urgent Care</b>	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived
<b>Prescription Drugs<sup>4</sup></b> <b>Retail:</b> per 30-day supply <b>Mail Order:</b> two times retail copay, up to 90-day supply	\$10/\$25/\$50	Not covered	\$15/\$40/\$50	Not covered
<b>Self-Administered Injectables/ Aetna Specialty CareRx<sup>SM</sup></b> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70%; Deductible waived	Not covered	70%; Deductible waived	Not covered

See page 23 for Footnotes.

## STANDARD MC PLANS

PLAN NAME	MC \$500 80/60 <sup>6</sup>		MC \$1,000 70/50 <sup>6</sup>	
PCP/Referrals Required	No	N/A	No	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	80%	60%	70%	50%
Calendar Year Deductible	\$500 Per member	\$500 Per member	\$1,000 Per member	
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,000 Per member	\$8,000 Per member	\$5,000 Per member	\$10,000 Per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician Office Visit*	\$35 Copay; deductible waived	60%	\$25 Copay; deductible waived	50%
Specialist Office Visit*	\$35 Copay; deductible waived	60%	\$25 Copay; deductible waived	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	\$10 Copay; deductible waived	Not covered
Walk-In Clinics	\$35 Copay; deductible waived	Not covered	\$25 Copay; deductible waived	Not covered
Outpatient Lab & X-Ray*	No charge	60%	No charge	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	80%	50%; Aetna pays up to \$800 per service	70%	50%; Aetna pays up to \$800 per service
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year, IN and OON combined)	80%	60%; Aetna pays up to \$25 per visit	70%	50%; Aetna pays up to \$25 per visit
Physical Exams — Adult	No charge	60%	No charge	50%
Well-Child Exams	No charge	60%	No charge	50%
Routine GYN	No charge	60%	No charge	50%
Inpatient Hospital	80%	60% After \$250 copay per admission; Aetna pays up to \$750 per day	70%	50% After \$250 copay per admission; Aetna pays up to \$750 per day
Outpatient Surgery OP Hospital Department	70% After \$150 copay	50% After \$150 copay per surgery; Aetna pays up to \$400 per surgery	60% After \$150 copay	50% After \$150 copay per surgery; Aetna pays up to \$400 per surgery
Outpatient Surgery Freestanding Facility	80%	60% After \$150 copay per surgery; Aetna pays up to \$400 per surgery	70%	50% After \$150 copay per surgery; Aetna pays up to \$400 per surgery
Emergency Services (Copay waived if admitted)	80% After \$100 copay	Paid as in-network	70% After \$100 copay	Paid as in-network
Urgent Care	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived
Prescription Drugs <sup>4</sup> Retail: per 30-day supply Mail Order: two times retail copay, up to 90-day supply	\$15/\$40/\$50	Not covered	\$15/\$40/\$50	Not covered
Self-Administered Injectables/ Aetna Specialty CareRx <sup>SM</sup> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70%; Deductible waived	Not covered	70%; Deductible waived	Not covered

# STANDARD MC PLANS

PLAN NAME	MC \$750 80/50/50 <sup>6</sup>		MC \$1,000 80/50/50 <sup>6</sup>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>PCP/Referrals Required</b>	No	N/A	No	N/A
<b>MEMBER BENEFITS</b>	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Coinsurance</b>	80% Professional, 50% facility	50%	80% Professional, 50% facility	50%
<b>Calendar Year Deductible</b>	\$750 Per member		\$1,000 Per member	\$1,000 Per member
<b>Calendar Year Coinsurance Maximum</b> (Deductible and certain payments do not apply)	\$5,000 Per member	\$10,000 Per member	\$5,000 Per member	\$10,000 Per member
<b>Deductible and Coinsurance Maximum Accumulation</b>	Two-Member Maximum		Two-Member Maximum	
<b>Lifetime Maximum Benefit</b>	Unlimited		Unlimited	
<b>Primary Physician Office Visit*</b>	\$25 Copay; deductible waived	50%	\$25 Copay; deductible waived	50%
<b>Specialist Office Visit*</b>	\$25 Copay; deductible waived	50%	\$25 Copay; deductible waived	50%
<b>Primary and Specialist Physician E-Visit</b> (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	\$10 Copay; deductible waived	Not covered
<b>Walk-In Clinics</b>	\$25 Copay; deductible waived	Not covered	\$25 Copay; deductible waived	Not covered
<b>Outpatient Lab &amp; X-Ray*</b>	No charge	50%	No charge	50%
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans; precertification required)	50%	50%; Aetna pays up to \$800 per service	50%	50%; Aetna pays up to \$800 per service
<b>Outpatient Physical, Occupational and Chiropractic Therapy</b> (24 visits per calendar year, IN and OON combined)	80%	50%; Aetna pays up to \$25 per visit	80%	50%; Aetna pays up to \$25 per visit
<b>Physical Exams — Adult</b>	No charge	50%	No charge	50%
<b>Well-Child Exams</b>	No charge	50%	No charge	50%
<b>Routine GYN</b>	No charge	50%	No charge	50%
<b>Inpatient Hospital</b>	80% Professional, 50% facility	50%; Aetna pays up to \$750 per day	80% Professional, 50% facility	50%; Aetna pays up to \$750 per day
<b>Outpatient Surgery OP Hospital Department</b>	70% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery	70% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery
<b>Outpatient Surgery Freestanding Facility</b>	80% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery	80% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery
<b>Emergency Services</b> (Copay waived if admitted)	80% Professional, 50% facility after \$100 copay	Paid as in-network	80% Professional, 50% facility after \$100 copay	Paid as in-network
<b>Urgent Care</b>	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived
<b>Prescription Drugs<sup>4</sup></b> <b>Retail:</b> per 30-day supply <b>Mail Order:</b> two times retail copay, up to 90-day supply	\$15/\$40/\$50	Not covered	\$15/\$40/\$50	Not covered
<b>Self-Administered Injectables/ Aetna Specialty CareRx<sup>SM</sup></b> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70%; Deductible waived	Not covered	70%; Deductible waived	Not covered

See page 23 for Footnotes.

## STANDARD MC PLANS

PLAN NAME	MC \$2,000 80/50/50 <sup>6</sup>		MC \$2,500 75/50 <sup>6</sup>	
PCP/Referrals Required	No	N/A	No	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	80% Professional, 50% facility	50%	75%	50%
Calendar Year Deductible	\$2,000 Per member	\$2,000 Per member	\$2,500 Per member	
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$5,000 Per member	\$10,000 Per member	\$5,000 Per member	\$10,000 Per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician Office Visit*	\$25 Copay; deductible waived	50%	\$25 Copay; deductible waived	50%
Specialist Office Visit*	\$25 Copay; deductible waived	50%	\$25 Copay; deductible waived	50%
Primary and Specialist Physician E-Visit (Register at <a href="http://www.relayhealth.com">www.relayhealth.com</a> )	\$10 Copay; deductible waived	Not covered	\$10 Copay; deductible waived	Not covered
Walk-In Clinics	\$25 Copay; deductible waived	Not covered	\$25 Copay; deductible waived	Not covered
Outpatient Lab & X-Ray*	No charge	50%	75%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	50%	50%; Aetna pays up to \$800 per service	75%	50%; Aetna pays up to \$800 per service
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year, IN and OON combined)	80%	50%; Aetna pays up to \$25 per visit	75%	50%; Aetna pays up to \$25 per visit
Physical Exams — Adult	No charge	50%	No charge	50%
Well-Child Exams	No charge	50%	No charge	50%
Routine GYN	No charge	50%	No charge	50%
Inpatient Hospital	80% Professional, 50% facility	50%; Aetna pays up to \$750 per day	75%	50%; Aetna pays up to \$750 per day
Outpatient Surgery OP Hospital Department	70% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery	75%	50%; Aetna pays up to \$400 per surgery
Outpatient Surgery Freestanding Facility	80% Professional, 50% facility	50%; Aetna pays up to \$400 per surgery	75%	50%; Aetna pays up to \$400 per surgery
Emergency Services (Copay waived if admitted)	80% Professional, 50% facility after \$100 copay	Paid as in-network	75% After \$100 copay	Paid as in-network
Urgent Care	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived	\$50 Copay; deductible waived
Prescription Drugs <sup>4</sup> Retail: per 30-day supply Mail Order: two times retail copay, up to 90-day supply	\$15/\$40/\$50	Not covered	\$20/\$40/\$70 After \$250 brand and non-formulary brand deductible	Not covered
Self-Administered Injectables/ Aetna Specialty CareRx <sup>SM</sup> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70%; Deductible waived	Not covered	70% After \$250 brand and non-formulary brand deductible	Not covered

# STANDARD MC PLANS

PLAN NAME	MC \$3,500 65/50 <sup>6</sup>		MC \$10,000 100/50 <sup>6</sup>	
PCP/Referrals Required	No	N/A	No	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	65%	50%	100%	50%
Calendar Year Deductible	\$3,500 Per member		\$10,000 Individual, \$10,000 family	
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$5,000 Per member	\$10,000 Per member	\$0 Individual, \$0 family	Unlimited
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Embedded Aggregate <sup>7</sup>	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician Office Visit*	\$35 Copay; deductible waived	50%	\$20 Copay; deductible waived	50%
Specialist Office Visit*	\$35 Copay; deductible waived	50%	100%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	\$20 Copay; deductible waived	Not covered
Walk-In Clinics	\$35 Copay; deductible waived	Not covered	\$20 Copay; deductible waived	Not covered
Outpatient Lab & X-Ray*	65%	50%	100% Coverage for the first \$300 per member, thereafter covered at 100% after deductible	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	65%	50%; Aetna pays up to \$800 per service	100%	50%; Aetna pays up to \$800 per service
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year, IN and OON combined)	65%	50%; Aetna pays up to \$25 per visit	100%	50%; Aetna pays up to \$25 per visit
Physical Exams — Adult	No charge	50%	No charge	50%
Well-Child Exams	No charge	50%	No charge	50%
Routine GYN	No charge	50%	No charge	50%
Inpatient Hospital	65%	50%; Aetna pays up to \$750 per day	100%	50%; Aetna pays up to \$750 per day
Outpatient Surgery OP Hospital Department	65%	50%; Aetna pays up to \$400 per surgery	100%	50%; Aetna pays up to \$400 per surgery
Outpatient Surgery Freestanding Facility	65%	50%; Aetna pays up to \$400 per surgery	100%	50%; Aetna pays up to \$400 per surgery
Emergency Services (Copay waived if admitted)	65% After \$100 copay	Paid as in-network	100%	Paid as in-network
Urgent Care	\$50 Copay; deductible waived	\$50 Copay; deductible waived	100%	100%
Prescription Drugs <sup>4</sup> Retail: per 30-day supply Mail Order: two times retail copay, up to 90-day supply	\$20/\$40/\$70 After \$250 brand and non-formulary brand deductible	Not covered	\$20/\$40/\$70; Deductible waived	Not covered
Self-Administered Injectables/ Aetna Specialty CareRx <sup>SM</sup> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70% After \$250 brand and non-formulary brand deductible	Not covered	70%; Deductible waived	Not covered

See page 23 for Footnotes.

## MC HSA HDHP PLANS

PLAN NAME	MC HSA Compatible HDHP \$2,000 80/50 <sup>e</sup>		MC HSA Compatible HDHP \$3,000 90/50 <sup>e</sup>		MC HSA Compatible HDHP \$3,500 80/50 <sup>e</sup>	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>PCP/Referrals Required</b>	No	N/A	No	N/A	No	N/A
<b>MEMBER BENEFITS</b>	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Coinsurance</b>	80%	50%	90%	50%	80%	50%
<b>Calendar Year Deductible</b>	\$2,000 Individual, \$4,000 family		\$3,000 Individual, \$6,000 family	\$3,000 Individual, \$6,000 family	\$3,500 Individual, \$7,000 family	
<b>Calendar Year Out-of-Pocket Maximum</b> (Deductible and certain payments do not apply)	\$3,500 Individual, \$7,000 family	\$7,000 Individual, \$14,000 family	\$2,500 Individual, \$5,000 family	\$5,000 Individual, \$10,000 family	\$2,000 Individual, \$4,000 family	\$4,000 Individual, \$8,000 family
<b>Deductible and Out-of-Pocket Maximum Accumulation</b>	True Integrated Family (TIF) <sup>g</sup>		True Integrated Family (TIF) <sup>g</sup>		True Integrated Family (TIF) <sup>g</sup>	
<b>Lifetime Maximum Benefit</b>	Unlimited		Unlimited		Unlimited	
<b>Primary Physician Office Visit*</b>	80%	50%	90%	50%	80%	50%
<b>Specialist Office Visit*</b>	80%	50%	90%	50%	80%	50%
<b>Primary and Specialist Physician E-Visit</b> (Register at www.relayhealth.com)	80%	Not covered	90%	Not covered	80%	Not covered
<b>Walk-In Clinics</b>	80%	Not covered	90%	Not covered	80%	Not covered
<b>Outpatient Lab &amp; X-Ray*</b>	80%	50%	90%	50%	80%	50%
<b>Outpatient Complex Imaging</b> (CAT, MRI, MRA/MRS and PET Scans; precertification required)	80%	50%; Aetna pays up to \$800 per service	90%	50%; Aetna pays up to \$800 per service	80%	50%; Aetna pays up to \$800 per service
<b>Outpatient Physical, Occupational and Chiropractic Therapy</b> (24 visits per calendar year, IN and OON combined)	80%	50%; Aetna pays up to \$25 per visit	90%	50%; Aetna pays up to \$25 per visit	80%	50%; Aetna pays up to \$25 per visit
<b>Physical Exams — Adult</b>	No charge	50%	No charge	50%	No charge	50%
<b>Well-Child Exams</b>	No charge	50%	No charge	50%	No charge	50%
<b>Routine GYN</b>	No charge	50%	No charge	50%	No charge	50%
<b>Inpatient Hospital</b>	80%	50%; Aetna pays up to \$750 per day	90%	50%; Aetna pays up to \$750 per day	80%	50%; Aetna pays up to \$750 per day
<b>Outpatient Surgery OP Hospital Department</b>	80%	50%; Aetna pays up to \$400 per surgery	90%	50%; Aetna pays up to \$400 per surgery	80%	50%; Aetna pays up to \$400 per surgery
<b>Outpatient Surgery Freestanding Facility</b>	80%	50%; Aetna pays up to \$400 per surgery	90%	50%; Aetna pays up to \$400 per surgery	80%	50%; Aetna pays up to \$400 per surgery
<b>Emergency Services</b>	80%	Paid as in-network	90%	Paid as in-network	80%	Paid as in-network
<b>Urgent Care</b>	80%	80%	90%	90%	80%	80%
<b>Prescription Drugs<sup>4</sup></b> <b>Retail:</b> per 30-day supply <b>Mail Order:</b> two times retail copay, up to 90-day supply	\$20/\$40/\$70 After integrated medical /Rx deductible	Not covered	\$20/\$40/\$70 After integrated medical /Rx deductible	Not covered	\$20/\$40/\$70 After integrated medical /Rx deductible	Not covered
<b>Self-Administered Injectables/ Aetna Specialty CareRx<sup>SM</sup></b> (Including retail and mail order; excludes insulin)	70% After integrated medical /Rx deductible	Not covered	70% After integrated medical /Rx deductible	Not covered	70% After integrated medical /Rx deductible	Not covered

# MC HRA HDHP PLANS

PLAN NAME	MC HRA HDHP \$3,000 80/50 <sup>6</sup>		MC HRA HDHP \$5,000 80/50 <sup>6</sup>	
PCP/Referrals Required	No	N/A	No	N/A
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	80%	50%	80%	50%
Calendar Year Deductible	\$3,000 Individual, \$6,000 family		\$5,000 Individual, \$10,000 family	
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$1,500 Individual, \$3,000 family	\$3,000 Individual, \$6,000 family	\$2,000 Individual, \$4,000 family	\$4,000 Individual, \$8,000 family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate <sup>7</sup>		Embedded Aggregate <sup>7</sup>	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician Office Visit*	\$20 Copay; deductible waived <sup>9</sup>	50%	\$20 Copay; deductible waived <sup>9</sup>	50%
Specialist Office Visit*	\$20 Copay; deductible waived <sup>9</sup>	50%	\$20 Copay; deductible waived <sup>9</sup>	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	\$10 Copay; deductible waived	Not covered
Walk-In Clinics	\$20 Copay; deductible waived <sup>9</sup>	Not covered	\$20 Copay; deductible waived <sup>9</sup>	Not covered
Outpatient Lab & X-Ray*	80%	50%	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	80%	50%; Aetna pays up to \$800 per service	80%	50%; Aetna pays up to \$800 per service
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year, IN and OON combined)	80%	50%; Aetna pays up to \$25 per visit	80%	50%; Aetna pays up to \$25 per visit
Physical Exams — Adult	No charge	50%	No charge	50%
Well-Child Exams	No charge	50%	No charge	50%
Routine GYN	No charge	50%	No charge	50%
Inpatient Hospital	80%	50%; Aetna pays up to \$750 per day	80%	50%; Aetna pays up to \$750 per day
Outpatient Surgery OP Hospital Department	80%	50%; Aetna pays up to \$400 per surgery	80%	50%; Aetna pays up to \$400 per surgery
Outpatient Surgery Freestanding Facility	80%	50%; Aetna pays up to \$400 per surgery	80%	50%; Aetna pays up to \$400 per surgery
Emergency Services	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	80%	80%	80%	80%
Prescription Drugs <sup>4</sup> Retail: per 30-day supply Mail Order: two times retail copay, up to 90-day supply	\$20/\$40/\$70 After integrated medical/Rx deductible	Not covered	\$20/\$40/\$70 After integrated medical/Rx deductible	Not covered
Self-Administered Injectables/ Aetna Specialty CareRx <sup>SM</sup> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70% After integrated medical /Rx deductible	Not covered	70% After integrated medical /Rx deductible	Not covered

See page 23 for Footnotes.

PPO/INDEMNITY PLANS			
PLAN NAME	PPO \$500 90/70 <sup>5</sup>		Indemnity <sup>5</sup>
PCP/Referrals Required	No	N/A	No
MEMBER BENEFITS	In-Network	Out-of-Network	Out-of-Network
Plan Coinsurance	90%	70%	80%
Calendar Year Deductible	\$500 Per member	\$500 Per member	\$500 Per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,000 Per member	\$8,000 Per member	\$3,500 Per member
Deductible and Coinsurance Maximum Accumulation	Two-member maximum		Two-member maximum
Lifetime Maximum Benefit	Unlimited		Unlimited
Primary Physician Office Visit*	\$15 Copay; deductible waived	70%	80%
Specialist Office Visit*	\$30 Copay; deductible waived	70%	80%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	\$10 Copay; deductible waived	Not covered	Not covered
Walk-In Clinics	\$15 Copay; deductible waived	Not covered	80%
Outpatient Lab & X-Ray*	No charge	70%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	90%	60%; Aetna pays up to \$800 per service	80%
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year, IN and OON combined)	90%	70%; Aetna pays up to \$25 per visit	80%
Physical Exams — Adult	No charge	70%	No charge
Well-Child Exams	No charge	70%	No charge
Routine GYN	No charge	70%	No charge
Inpatient Hospital	90% After \$250 copay per admission	70% After \$250 copay per admission	80% After \$250 copay per admission
Outpatient Surgery OP Hospital Department	80% After \$150 copay per surgery	60% After \$150 copay per surgery	70% After \$250 copay per surgery
Outpatient Surgery Freestanding Facility	90%	70% After \$150 copay per surgery	80%
Emergency Services (Copay waived if admitted)	90% After \$100 copay	Paid as in-network	80%
Urgent Care	\$50 Copay; deductible waived	\$50 Copay; deductible waived	80%
Prescription Drugs <sup>4</sup> Retail: per 30-day supply Mail Order: two times retail copay, up to 90-day supply	\$15/\$40/\$50	Not covered	\$10/\$25/\$50 After \$150 brand and brand non-formulary deductible
Self-Administered Injectables/ Aetna Specialty CareRx <sup>SM</sup> (Including retail and mail order; does not accumulate toward coinsurance maximum; excludes insulin)	70%; Deductible waived	Not covered	70%; Deductible waived

See page 23 for Footnotes.

## FOOTNOTES

***The federal health care reform legislation known as the Patient Protection and Affordable Care Act was signed into law on March 23, 2010. A number of new reforms are effective September 23, 2010, including coverage for dependents up to age 26, elimination of lifetime benefit dollar maximums, restriction of annual dollar maximums on essential health benefits, removal of cost sharing for preventive services and elimination of pre-existing condition exclusions for dependent children under 19 years of age. Your Aetna Avenue benefit program does comply with the new reform legislation.***

All services are subject to the deductible unless noted otherwise. The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance indicates what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums. Certain services may require prior certification.

Members or providers may be required to precertify or obtain approval for certain services such as non-emergency hospital care.

For a summary list of Limitations and Exclusions, refer to pages 52–53.

\*A copay, deductible and/or coinsurance for Lab/X-ray services related to preventive care screenings will be waived.

<sup>1</sup>For HMO plans, the three Rx Tiers are: Tier 1, Generic Formulary; Tier 2, Brand Formulary; Tier 3, Generic and Brand Non-Formulary.

<sup>2</sup>For the HMO Deductible and the HMO Coinsurance plans, "Participating Providers" refers to the HMO Deductible network. For the Vitalidad HMO plan, "Participating Providers" refers to the SIMNSA Network participating providers. For any questions or concerns about accessing and obtaining service from the SIMNSA Network, please call Member Services at 1-888-98-AETNA.

<sup>3</sup>Upon enrollment to a Vitalidad Plus plan, each member must select a primary care physician (PCP) either in California or Mexico. The selected PCP is responsible for coordinating the member's care. Members who select a California PCP may change to another California PCP at any time. Members who select a Mexico PCP may change to another Mexico PCP at any time. However, it is important to note that members are only allowed to change PCPs one time every 12 months when the new PCP is not located in the same country as the prior one. Refer to the Evidence of Coverage for additional information regarding PCP selection and changes.

<sup>4</sup>For Traditional plans, the four Rx Tiers are: Tier 1, Generic Formulary; Tier 2, Brand Formulary; Tier 3, Brand Non-Formulary; Tier 4, Self-Administered Injectables/Aetna Specialty CareRx<sup>SM</sup>.

<sup>5</sup>You may choose providers in our network (physicians and facilities), or you may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network provider. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the providers. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the provider bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums. For out-of-network physicians and other out-of-network providers, the recognized charge is what Aetna determines to be the usual charge level for the geographic area where you receive covered services. This is also known as the "reasonable" or "prevailing" charge. For out-of-network hospitals and other out-of-network facilities, the recognized charge is based on the Aetna Facility Fee Schedule. This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits, and you should contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

<sup>6</sup>You may choose providers in our network (physicians and facilities) or you may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network provider. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the provider. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the provider bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

For out-of-network physicians and other out-of-network providers, the recognized charge is based on the Aetna Market Fee Schedule (also referred to as Aetna Out-of-Network rates), which are Aetna's standard rates used to begin contract negotiations with providers who participate in our network. Since not all network providers contract at standard rates, our payment to an out-of-network provider may be based on rates lower than we pay to providers in our network. For out-of-network hospitals and other out-of-network facilities, Aetna pays a percentage as defined in your plan as the recognized charge. You may have to pay the difference between the out-of-network facility's bill and the amount that Aetna pays, plus any coinsurance and deductibles due under the plan.

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

<sup>7</sup>Each covered family member only needs to satisfy his or her individual deductible/out-of-pocket maximum/coinsurance maximum, not the entire family deductible/out-of-pocket maximum/coinsurance maximum.

<sup>8</sup>There is no individual deductible/out-of-pocket maximum/coinsurance maximum to satisfy within the family deductible/out-of-pocket maximum. Once the family deductible/out-of-pocket maximum is met, all family members will be considered as having met their deductible/out-of-pocket maximum for the remainder of the calendar year.

<sup>9</sup>The first four office visits per member per calendar year are paid with a copay; the deductible is waived for all types of visits combined (primary physician, specialist physician and walk-in clinics). Any visits over this limit are covered at the plan deductible and coinsurance.

Aetna Avenue

**DENTAL** OVERVIEW**AETNA DENTAL® PLANS**

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

*The Mouth Matters<sup>SM</sup>*

Research suggests that serious gum disease, known as periodontitis, may be associated with many health problems. This is especially true if serious gum disease continues without treatment.<sup>1,2</sup>

Now, here's the good news. Researchers are discovering that a healthy mouth may be important to your overall health.<sup>1,2</sup>

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

*The Dental Maintenance Organization (DMO®)*

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

*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.

<sup>1</sup> MayoClinic.com. "Oral health: A window to your overall health." Available online at [www.mayoclinic.com/health/dental/DE00001](http://www.mayoclinic.com/health/dental/DE00001). Accessed May 2010.

<sup>2</sup> R.C. Williams, A.H. Barnett, N. Claffey, M. Davis, R. Gadsby, M. Kellett, G.Y.H. Lip, and S. Thackray. "The potential impact of periodontal disease on general health: a consensus view." *Current Medical Research and Opinion*, Vol. 24, No. 6, 2008, 1635-1643.

\*DMI may not be available in all states.

### *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 Aetna 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 plans on a monthly basis. One blended rate is paid. Members may switch between the plans on a monthly basis by calling Member Services. Plan changes must be made by the 15th of the month to be effective the following month.

### *Dual Option\* plan*

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

### *Voluntary Dental option*

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

\*Dual Option does not apply to Voluntary Dental plans.

# AETNA SMALL GROUP DENTAL PLANS

Available with an Aetna Medical Plan to groups with 2–50 eligible employees Available without Medical plan (Dental standalone) to groups with 3–50 eligible employees	DMO Access <sup>4, 5</sup>	DMO Plus <sup>4</sup> (Plan 58)	Freedom-of-Choice Coinsurance Monthly selection between DMO and PPO	
	Plan 42	DMO Plan 58 Fixed copay	DMO Plan <sup>4</sup> 100/90/60	PPO Max <sup>7,8</sup> Plan 100/80/50
<b>Office Visit Copay</b>	\$10	\$5	\$5	N/A
<b>Annual Deductible Per Member</b> (Does not apply to Diagnostic & Preventive Services)	None	None	None	\$50; 3x Family maximum
<b>Annual Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	\$2,000
<b>DIAGNOSTIC SERVICES</b>				
<b>Oral Exams</b>				
<b>Periodic Oral Exam</b>	No charge	No charge	100%	100%
<b>Comprehensive Oral Exam</b>	No charge	No charge	100%	100%
<b>Problem-Focused Oral Exam</b>	No charge	No charge	100%	100%
<b>X-Rays</b>				
<b>Bitewing — Single Film</b>	No charge	No charge	100%	100%
<b>Complete Series</b>	No charge	No charge	100%	100%
<b>PREVENTIVE SERVICES</b>				
<b>Adult Cleaning</b>	No charge	No charge	100%	100%
<b>Child Cleaning</b>	No charge	No charge	100%	100%
<b>Sealants — Per Tooth</b>	\$10	\$5	100%	100%
<b>Fluoride Application — Child</b>	No charge	No charge	100%	100%
<b>Space Maintainers — Fixed</b>	\$100	\$60	100%	100%
<b>BASIC SERVICES</b>				
<b>Amalgam Filling — 2 Surfaces</b>	\$32	No charge	90%	80%
<b>Resin Filling — 2 Surfaces, Anterior</b>	\$55	No charge	90%	80%
<b>Oral Surgery</b>				
<b>Extraction — Exposed Root or Erupted Tooth</b>	\$30	No charge	90%	80%
<b>Extraction of Impacted Tooth — Soft Tissue</b>	\$80	\$46	90%	80%
<b>MAJOR SERVICES<sup>1</sup></b>				
<b>Complete Upper Denture</b>	\$500	\$275	60%	50%
<b>Partial Upper Denture (resin base)</b>	\$513	\$275	60%	50%
<b>Crown — Porcelain with Noble Metal<sup>2</sup></b>	\$488	\$210	60%	50%
<b>Pontic — Porcelain with Noble Metal<sup>2</sup></b>	\$488	\$210	60%	50%
<b>Inlay — Metallic (3 or more surfaces)</b>	\$463	\$180	60%	50%
<b>Oral Surgery</b>				
<b>Removal of Impacted Tooth — Partially Bony</b>	\$175 <sup>6</sup>	\$58	60%	50%
<b>ENDODONTIC SERVICES</b>				
<b>Bicuspid Root Canal Therapy</b>	\$195	\$85	90%	50%
<b>Molar Root Canal Therapy</b>	\$435 <sup>6</sup>	\$240	60%	50%
<b>PERIODONTIC SERVICES</b>				
<b>Scaling &amp; Root Planing — Per Quadrant</b>	\$65	\$55	90%	50%
<b>Osseous Surgery — Per Quadrant</b>	\$445 <sup>6</sup>	\$300	60%	50%
<b>ORTHODONTIC SERVICES<sup>1, 3</sup></b>				
<b>Orthodontic Lifetime Maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

See page 34 for Footnotes.

## AETNA SMALL GROUP DENTAL PLANS

Available with an Aetna Medical Plan to groups with 2–50 eligible employees Available without Medical plan (Dental standalone) to groups with 3–50 eligible employees	Freedom-of-Choice Plus Monthly selection between DMO and PPO		PPO \$1,000 Active <sup>7, 10</sup>	
	DMO Plan 58 <sup>4</sup> Fixed Copay	PPO Plan <sup>7, 10</sup> 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40
<b>Office Visit Copay</b>	\$5	N/A	N/A	N/A
<b>Annual Deductible per Member</b> (Does not apply to Diagnostic & Preventive Services)	None	\$50; 3x Family maximum	\$50; 3x Family maximum	\$50; 3x Family maximum
<b>Annual Maximum Benefit</b>	Unlimited	\$1,000	\$1,000	\$1,000
<b>DIAGNOSTIC SERVICES</b>				
<b>Oral Exams</b>				
<b>Periodic Oral Exam</b>	No charge	100%	100%	80%
<b>Comprehensive Oral Exam</b>	No charge	100%	100%	80%
<b>Problem-Focused Oral Exam</b>	No charge	100%	100%	80%
<b>X-Rays</b>				
<b>Bitewing — Single Film</b>	No charge	100%	100%	80%
<b>Complete Series</b>	No charge	100%	100%	80%
<b>PREVENTIVE SERVICES</b>				
<b>Adult Cleaning</b>	No charge	100%	100%	80%
<b>Child Cleaning</b>	No charge	100%	100%	80%
<b>Sealants — Per Tooth</b>	\$5	100%	100%	80%
<b>Fluoride Application — Child</b>	No charge	100%	100%	80%
<b>Space Maintainers — Fixed</b>	\$60	100%	100%	80%
<b>BASIC SERVICES</b>				
<b>Amalgam Filling — 2 Surfaces</b>	No charge	80%	80%	60%
<b>Resin Filling — 2 Surfaces, Anterior</b>	No charge	80%	80%	60%
<b>Oral Surgery<sup>9</sup></b>				
<b>Extraction — Exposed Root or Erupted Tooth</b>	No charge	80%	80%	60%
<b>Extraction of Impacted Tooth — Soft Tissue</b>	\$46	80%	80%	60%
<b>MAJOR SERVICES<sup>1</sup></b>				
<b>Complete Upper Denture</b>	\$275	50%	50%	40%
<b>Partial Upper Denture (resin base)</b>	\$275	50%	50%	40%
<b>Crown — Porcelain with Noble Metal</b>	\$210	50%	50%	40%
<b>Pontic — Porcelain with Noble Metal</b>	\$210	50%	50%	40%
<b>Inlay — Metallic (3 or more surfaces)</b>	\$180	50%	50%	40%
<b>Oral Surgery<sup>9</sup></b>				
<b>Removal of Impacted Tooth — Partially Bony</b>	\$58	50%	50%	40%
<b>ENDODONTIC SERVICES<sup>9</sup></b>				
<b>Bicuspid Root Canal Therapy</b>	\$85	80%	50%	40%
<b>Molar Root Canal Therapy</b>	\$240	50%	50%	40%
<b>PERIODONTIC SERVICES<sup>9</sup></b>				
<b>Scaling &amp; Root Planing — Per Quadrant</b>	\$55	80%	50%	40%
<b>Osseous Surgery — Per Quadrant</b>	\$300	50%	50%	40%
<b>ORTHODONTIC SERVICES<sup>1</sup></b>				
<b>Orthodontic Lifetime Maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

## AETNA SMALL GROUP DENTAL PLANS

	PPO \$1,500 <sup>7, 10</sup>		PPO \$1,500 Active <sup>7, 10</sup>		PPO \$2,000 <sup>7, 10</sup>
	PPO 1500 Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	PPO 2000 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	\$1,500	\$1,500	\$1,500	\$2,000	
<b>DIAGNOSTIC SERVICES</b>					
<b>Oral Exams</b>					
Periodic Oral Exam	100%	100%	80%	100%	
Comprehensive Oral Exam	100%	100%	80%	100%	
Problem-Focused Oral Exam	100%	100%	80%	100%	
<b>X-Rays</b>					
Bitewing — Single Film	100%	100%	80%	100%	
Complete Series	100%	100%	80%	100%	
<b>PREVENTIVE SERVICES</b>					
Adult Cleaning	100%	100%	80%	100%	
Child Cleaning	100%	100%	80%	100%	
Sealants — Per Tooth	100%	100%	80%	100%	
Fluoride Application — Child	100%	100%	80%	100%	
Space Maintainers — Fixed	100%	100%	80%	100%	
<b>BASIC SERVICES</b>					
Amalgam Filling — 2 Surfaces	80%	80%	60%	80%	
Resin Filling — 2 Surfaces, Anterior	80%	80%	60%	80%	
<b>Oral Surgery<sup>9</sup></b>					
Extraction — Exposed Root or Erupted Tooth	80%	80%	60%	80%	
Extraction of Impacted Tooth — Soft Tissue	80%	80%	60%	80%	
<b>MAJOR SERVICES<sup>1</sup></b>					
Complete Upper Denture	50%	50%	40%	50%	
Partial Upper Denture (resin base)	50%	50%	40%	50%	
Crown — Porcelain with Noble Metal	50%	50%	40%	50%	
Pontic — Porcelain with Noble Metal	50%	50%	40%	50%	
Inlay — Metallic (3 or more surfaces)	50%	50%	40%	50%	
<b>Oral Surgery<sup>9</sup></b>					
Removal of Impacted Tooth — Partially Bony	50%	50%	40%	50%	
<b>ENDODONTIC SERVICES<sup>9</sup></b>					
Bicuspid Root Canal Therapy	80%	80%	60%	80%	
Molar Root Canal Therapy	50%	50%	40%	50%	
<b>PERIODONTIC SERVICES<sup>9</sup></b>					
Scaling & Root Planing — Per Quadrant	80%	80%	60%	80%	
Osseous Surgery — Per Quadrant	50%	50%	40%	50%	
<b>ORTHODONTIC SERVICES<sup>1</sup></b>					
Orthodontic Lifetime Maximum	\$1,000	\$1,000	\$1,000	\$1,500	

## VOLUNTARY AETNA SMALL GROUP DENTAL PLANS<sup>11</sup>

Available with and without Aetna Medical Plan to groups with 3–50 eligible employees	DMO Access <sup>4, 5</sup>	DMO Plus <sup>4</sup> (Plan 58)
	Plan 42	DMO Plan 58 Fixed Copay
Office Visit Copay	\$15	\$10
Annual Deductible Per Member (Does not apply to Diagnostic & Preventive Services)	None	None
Annual Maximum Benefit	Unlimited	Unlimited
<b>DIAGNOSTIC SERVICES</b>		
<b>Oral Exams</b>		
Periodic Oral Exam	No charge	No charge
Comprehensive Oral Exam	No charge	No charge
Problem-Focused Oral Exam	No charge	No charge
<b>X-Rays</b>		
Bitewing — Single Film	No charge	No charge
Complete Series	No charge	No charge
<b>PREVENTIVE SERVICES</b>		
Adult Cleaning	No charge	No charge
Child Cleaning	No charge	No charge
Sealants — Per Tooth	\$10	\$5
Fluoride Application — Child	No charge	No charge
Space Maintainers — Fixed	\$100	\$60
<b>BASIC SERVICES</b>		
Amalgam Filling — 2 Surfaces	\$32	No charge
Resin Filling — 2 Surfaces, Anterior	\$55	No charge
<b>Oral Surgery</b>		
Extraction — Exposed Root or Erupted Tooth	\$30	No charge
Extraction of Impacted Tooth — Soft Tissue	\$80	\$46
<b>MAJOR SERVICES<sup>1</sup></b>		
Complete Upper Denture	\$500	\$275
Partial Upper Denture (resin base)	\$513	\$275
Crown — Porcelain with Noble Metal <sup>2</sup>	\$488	\$210
Pontic — Porcelain with Noble Metal <sup>2</sup>	\$488	\$210
Inlay — Metallic (3 or more surfaces)	\$463	\$180
<b>Oral Surgery</b>		
Removal of Impacted Tooth — Partially Bony	\$175 <sup>6</sup>	\$58
<b>ENDODONTIC SERVICES</b>		
Bicuspid Root Canal Therapy	\$195	\$85
Molar Root Canal Therapy	\$435 <sup>6</sup>	\$240
<b>PERIODONTIC SERVICES</b>		
Scaling & Root Planing — Per Quadrant	\$65	\$55
Osseous Surgery — Per Quadrant	\$445 <sup>6</sup>	\$300
ORTHODONTIC SERVICES <sup>1, 3</sup>	\$2,400 Copay	\$2,400 Copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply

# VOLUNTARY AETNA SMALL GROUP DENTAL PLANS<sup>11</sup>

	<b>Voluntary Freedom-of-Choice Coinsurance</b> Monthly selection between DMO and PPO Max	
	<b>DMO Plan<sup>4</sup></b> 100/90/60	<b>PPO Max Plan<sup>7,8</sup></b> 100/80/50
<b>Office Visit Copay</b>	\$10	N/A
<b>Annual Deductible Per Member</b> (Does not apply to Diagnostic & Preventive Services)	None	\$75; 3x Family maximum
<b>Annual Maximum Benefit</b>	Unlimited	\$2,000
<b>DIAGNOSTIC SERVICES</b>		
<b>Oral Exams</b>		
<b>Periodic Oral Exam</b>	100%	100%
<b>Comprehensive Oral Exam</b>	100%	100%
<b>Problem-Focused Oral Exam</b>	100%	100%
<b>X-Rays</b>		
<b>Bitewing — Single Film</b>	100%	100%
<b>Complete Series</b>	100%	100%
<b>PREVENTIVE SERVICES</b>		
<b>Adult Cleaning</b>	100%	100%
<b>Child Cleaning</b>	100%	100%
<b>Sealants — Per Tooth</b>	100%	100%
<b>Fluoride Application — Child</b>	100%	100%
<b>Space Maintainers — Fixed</b>	100%	100%
<b>BASIC SERVICES</b>		
<b>Amalgam Filling — 2 Surfaces</b>	90%	80%
<b>Resin Filling — 2 Surfaces, Anterior</b>	90%	80%
<b>Oral Surgery</b>		
<b>Extraction — Exposed Root or Erupted Tooth</b>	90%	80%
<b>Extraction of Impacted Tooth — Soft Tissue</b>	90%	80%
<b>MAJOR SERVICES<sup>1</sup></b>		
<b>Complete Upper Denture</b>	60%	50%
<b>Partial Upper Denture (resin base)</b>	60%	50%
<b>Crown — Porcelain with Noble Metal</b>	60%	50%
<b>Pontic — Porcelain with Noble Metal</b>	60%	50%
<b>Inlay — Metallic (3 or more surfaces)</b>	60%	50%
<b>Oral Surgery</b>		
<b>Removal of Impacted Tooth — Partially Bony</b>	60%	50%
<b>ENDODONTIC SERVICES</b>		
<b>Bicuspid Root Canal Therapy</b>	90%	50%
<b>Molar Root Canal Therapy</b>	60%	50%
<b>PERIODONTIC SERVICES</b>		
<b>Scaling &amp; Root Planing — Per Quadrant</b>	90%	50%
<b>Osseous Surgery — Per Quadrant</b>	60%	50%
<b>ORTHODONTIC SERVICES<sup>1,3</sup></b>	\$2,300 Copay	Not covered
<b>Orthodontic Lifetime Maximum</b>	Does not apply	Does not apply

See page 34 for Footnotes.

# VOLUNTARY AETNA SMALL GROUP DENTAL PLANS<sup>11</sup>

	PPO \$1,000 Active <sup>7, 10</sup>	
	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40
Office Visit Copay	N/A	N/A
Annual Deductible Per Member (Does not apply to Diagnostic & Preventive Services)	\$75; 3x Family maximum	\$75; 3x Family maximum
Annual Maximum Benefit	\$1,000	\$1,000
<b>DIAGNOSTIC SERVICES</b>		
<b>Oral Exams</b>		
Periodic Oral Exam	100%	80%
Comprehensive Oral Exam	100%	80%
Problem-Focused Oral Exam	100%	80%
<b>X-Rays</b>		
Bitewing — Single Film	100%	80%
Complete Series	100%	80%
<b>PREVENTIVE SERVICES</b>		
Adult Cleaning	100%	80%
Child Cleaning	100%	80%
Sealants — Per Tooth	100%	80%
Fluoride Application — Child	100%	80%
Space Maintainers — Fixed	100%	80%
<b>BASIC SERVICES</b>		
Amalgam Filling — 2 Surfaces	80%	60%
Resin Filling — 2 Surfaces, Anterior	80%	60%
<b>Oral Surgery</b>		
Extraction — Exposed Root or Erupted Tooth	80%	60%
Extraction of Impacted Tooth — Soft Tissue	80%	60%
<b>MAJOR SERVICES<sup>1</sup></b>		
Complete Upper Denture	50%	40%
Partial Upper Denture (resin base)	50%	40%
Crown — Porcelain with Noble Metal	50%	40%
Pontic — Porcelain with Noble Metal	50%	40%
Inlay — Metallic (3 or more surfaces)	50%	40%
<b>Oral Surgery</b>		
Removal of Impacted Tooth — Partially Bony	50%	40%
<b>ENDODONTIC SERVICES</b>		
Bicuspid Root Canal Therapy	50%	40%
Molar Root Canal Therapy	50%	40%
<b>PERIODONTIC SERVICES</b>		
Scaling & Root Planing — Per Quadrant	50%	40%
Osseous Surgery — Per Quadrant	50%	40%
<b>ORTHODONTIC SERVICES<sup>1, 3</sup></b>		
Orthodontic Lifetime Maximum	Does not apply	Does not apply

See page 34 for Footnotes.

VOLUNTARY AETNA SMALL GROUP DENTAL PLANS<sup>11</sup>

	PPO \$1,500 <sup>7, 10</sup>		PPO \$1,500 Active <sup>7, 10</sup>	
	PPO 1500 Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	
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	\$1,500	\$1,500	\$1,500	
<b>DIAGNOSTIC SERVICES</b>				
<b>Oral Exams</b>				
Periodic Oral Exam	100%	100%	80%	
Comprehensive Oral Exam	100%	100%	80%	
Problem-Focused Oral Exam	100%	100%	80%	
<b>X-Rays</b>				
Bitewing — Single Film	100%	100%	80%	
Complete Series	100%	100%	80%	
<b>PREVENTIVE SERVICES</b>				
Adult Cleaning	100%	100%	80%	
Child Cleaning	100%	100%	80%	
Sealants — Per Tooth	100%	100%	80%	
Fluoride Application — Child	100%	100%	80%	
Space Maintainers — Fixed	100%	100%	80%	
<b>BASIC SERVICES</b>				
Amalgam Filling — 2 Surfaces	80%	80%	60%	
Resin Filling — 2 Surfaces, Anterior	80%	80%	60%	
<b>Oral Surgery<sup>9</sup></b>				
Extraction — Exposed Root or Erupted Tooth	80%	80%	60%	
Extraction of Impacted Tooth — Soft Tissue	80%	80%	60%	
<b>MAJOR SERVICES<sup>1</sup></b>				
Complete Upper Denture	50%	50%	40%	
Partial Upper Denture (resin base)	50%	50%	40%	
Crown — Porcelain with Noble Metal <sup>2</sup>	50%	50%	40%	
Pontic — Porcelain with Noble Metal <sup>2</sup>	50%	50%	40%	
Inlay — Metallic (3 or more surfaces)	50%	50%	40%	
<b>Oral Surgery<sup>9</sup></b>				
Removal of Impacted Tooth — Partially Bony	50%	50%	40%	
<b>ENDODONTIC SERVICES<sup>9</sup></b>				
Bicuspid Root Canal Therapy	80%	80%	60%	
Molar Root Canal Therapy	50%	50%	40%	
<b>PERIODONTIC SERVICES<sup>9</sup></b>				
Scaling & Root Planing — Per Quadrant	80%	80%	60%	
Osseous Surgery — Per Quadrant	50%	50%	40%	
<b>ORTHODONTIC SERVICES<sup>1, 3</sup></b>				
Orthodontic Lifetime Maximum	\$1,000	\$1,000	\$1,000	

## OUT-OF-STATE PPO AETNA SMALL GROUP DENTAL PLANS<sup>8</sup>

	PPO \$1,000 <sup>7</sup>	PPO \$1,500 <sup>7</sup>	PPO \$2,000 <sup>7</sup>	Voluntary PPO \$1,000 <sup>7</sup>
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
<b>Office Visit Copay</b>	N/A	N/A	N/A	N/A
<b>Annual Deductible Per Member</b> (Does not apply to Diagnostic & Preventive Services)	\$50; 3x Family maximum	\$50; 3x Family maximum	\$50; 3x Family maximum	\$75; 3x Family maximum
<b>Annual Maximum Benefit</b>	\$1,000	\$1,500	\$2,000	\$1,000
<b>DIAGNOSTIC SERVICES</b>				
<b>Oral Exams</b>				
<b>Periodic Oral Exam</b>	100%	100%	100%	100%
<b>Comprehensive Oral Exam</b>	100%	100%	100%	100%
<b>Problem-Focused Oral Exam</b>	100%	100%	100%	100%
<b>X-Rays</b>				
<b>Bitewing — Single Film</b>	100%	100%	100%	100%
<b>Complete Series</b>	100%	100%	100%	100%
<b>PREVENTIVE SERVICES</b>				
<b>Adult Cleaning</b>	100%	100%	100%	100%
<b>Child Cleaning</b>	100%	100%	100%	100%
<b>Sealants — Per Tooth</b>	100%	100%	100%	100%
<b>Fluoride Application — With Cleaning</b>	100%	100%	100%	100%
<b>Space Maintainers</b>	100%	100%	100%	100%
<b>BASIC SERVICES</b>				
<b>Amalgam Filling — 2 Surfaces</b>	80%	80%	80%	80%
<b>Resin Filling — 2 Surfaces, Anterior</b>	80%	80%	80%	80%
<b>Oral Surgery</b>				
<b>Extraction — Exposed Root or Erupted Tooth</b>	80%	80%	80%	80%
<b>Extraction of Impacted Tooth — Soft Tissue</b>	80%	80%	80%	80%
<b>MAJOR SERVICES<sup>1</sup></b>				
<b>Complete Upper Denture</b>	50%	50%	50%	50%
<b>Partial Upper Denture (resin base)</b>	50%	50%	50%	50%
<b>Crown — Porcelain with Noble Metal</b>	50%	50%	50%	50%
<b>Pontic — Porcelain with Noble Metal</b>	50%	50%	50%	50%
<b>Inlay — Metallic (3 or more surfaces)</b>	50%	50%	50%	50%
<b>Oral Surgery</b>				
<b>Removal of Impacted Tooth — Partially Bony</b>	50%	50%	50%	50%
<b>ENDODONTIC SERVICES</b>				
<b>Bicuspid Root Canal Therapy</b>	50%	50%	50%	50%
<b>Molar Root Canal Therapy</b>	50%	50%	50%	50%
<b>PERIODONTIC SERVICES</b>				
<b>Scaling &amp; Root Planing — Per Quadrant</b>	50%	50%	50%	50%
<b>Osseous Surgery — Per Quadrant</b>	50%	50%	50%	50%
<b>ORTHODONTIC SERVICES<sup>1, 12</sup></b>				
<b>Orthodontic Lifetime Maximum</b>	\$1,000	\$1,000	\$1,000	\$1,000

**The above list of covered services is representative. Full list with limitations appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 52–53.**

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

<sup>1</sup>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 DMO Plus, Freedom-of-Choice Coinsurance, Freedom-of-Choice Plus, Voluntary DMO Access, Voluntary DMO Plus and Voluntary Freedom-of-Choice Coinsurance.

<sup>2</sup>There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures in DMO Access, DMO Plus, Voluntary DMO Access and Voluntary DMO Plus.

<sup>3</sup>Orthodontic coverage is available only to groups with 10 or more eligibles and for adults and dependent children.

<sup>4</sup>Fixed dollar amounts on the DMO in the DMO Access, DMO Plus, Freedom-of-Choice Coinsurance, Freedom-of-Choice Plus, Voluntary DMO Access, Voluntary DMO Plus and Voluntary Freedom-of-Choice Coinsurance are the member's responsibility.

<sup>5</sup>DMO Access and Voluntary DMO Access: Apart from the DMO network and DMO plan of benefits, members under this plan also have access to the Aetna Dental Access<sup>®</sup> network. This network provides access to providers who participate in the Aetna Dental Access network and have agreed to charge a negotiated discounted fee. Members can access this network for any service. However, the DMO benefits do not apply. In situations where the dentist participates in both the Aetna Dental Access network and the Aetna DMO network, DMO benefits take precedence over all other discounts, including discounts through the Aetna Dental Access network.

<sup>6</sup>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.

<sup>7</sup>Access to negotiated discounts: On all PPO, Voluntary PPO and PPO Max plans, including when part of Freedom-of-Choice, 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. Discounts are not insurance.

<sup>8</sup>Freedom-of-Choice Coinsurance, Voluntary Freedom-of-Choice Coinsurance and Out-of-State PPO plans: PPO Max non-preferred (out-of-network) coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

<sup>9</sup>Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Freedom-of-Choice Plus, PPO \$1,500, PPO \$1,500 Active, PPO \$2,000, Voluntary PPO \$1,500 and Voluntary PPO \$1,500 Active.

<sup>10</sup>Out-of-Network plan payments are limited by geographic area to the prevailing fees at the 80th percentile on the PPO in Freedom-of-Choice Plus, PPO \$1,000, PPO \$1,000 Active, PPO \$1,500, PPO \$1,500 Active, Voluntary PPO \$1,500, Voluntary PPO \$1,000 Active and Voluntary PPO \$1,500 Active and at the 90th percentile on the PPO \$2,000.

<sup>11</sup>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.

<sup>12</sup>Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

NOTES



NOTES

*Aetna Avenue***LIFE OVERVIEW**

Aetna Life Insurance Company (Aetna) Small Group life insurance or benefits plans include a range of flat-dollar insurance options 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 product for small groups.

**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*<sup>SM</sup> program.

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

***Giving you (and your employees) what you want***

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

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

***Accelerated death benefit —***

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

***Premium waiver provision —***

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

***Optional dependent life —***

This feature allows employees to add optional additional coverage for eligible spouses and children for employers with 10 or more employees.

***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.

## TERM LIFE PLAN OPTIONS

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

Available with an Aetna Medical plan to groups with 2–50 eligible employees.

Available with an Aetna Dental plan to groups with 10–50 eligible employees.

Available standalone (without Medical or Dental plans) to groups with 26–50 eligible employees.

### AD&D ULTRA®

AD&D Ultra is standardly included with our small group life insurance benefits 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 features at no additional cost to you, such as coverage for education or child-care expenses that make this protection even more valuable.

Benefits include:

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

For a summary list of Limitations and Exclusions, refer to pages 52–53.

# Aetna Avenue

## SMALL GROUP UNDERWRITING GUIDELINES

(Effective 5/1/2011)

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. 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.

<p><b>Affiliated, Associated or Multiple Companies</b></p>	<p>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:</p> <ul style="list-style-type: none"> <li>▪ One owner has controlling interest of all business to be included.</li> <li>▪ All businesses filed under one combined tax return <b>must</b> be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only two of the three businesses to be enrolled, the group will be considered a carve-out, will not be guaranteed issue and could be declined.</li> <li>▪ The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined <b>must have the minimum number of employees required by the state.</b></li> <li>▪ There are 50 or fewer employees in the combined employer groups.</li> <li>▪ A completed Common Ownership form is submitted.</li> <li>▪ 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.</li> <li>▪ Underwriting reserves the right to final underwriting review and may consider common ownership on a case-by-case underwriting exception.</li> <li>▪ Companies that are affiliated and that are eligible to file a combined income tax return for <b>purposes of state taxation</b> shall be considered one employer.</li> </ul> <p><b>Example:</b> 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.</p>
<p><b>Benefit Waiting Period</b></p>	<ul style="list-style-type: none"> <li>▪ Benefit waiting periods <b>must be consistently applied to all employees</b>, including newly hired key employees.</li> <li>▪ The benefit waiting period for future employees may be 0, 30, 60, 90, 120 or 180 days.</li> <li>▪ The eligibility date will be the first day of the <b>policy month</b> following the waiting period.</li> </ul> <p><b>Example:</b>                  Group A — effective date is July 1; employees will be issued an effective date of the 1st of the month following the chosen waiting period.                  Group B — effective date is July 15, employees will be issued an effective date of the 15th of the month following the chosen waiting period.</p> <ul style="list-style-type: none"> <li>▪ Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer.</li> <li>▪ 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 <b>all</b> employees.</li> <li>▪ Changes to the benefit waiting period may be requested 6 months after the original effective date.</li> <li>▪ Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date.</li> <li>▪ <b>No retroactive benefit waiting period changes will be allowed.</b></li> </ul>
<p><b>Cal-COBRA</b></p>	<ul style="list-style-type: none"> <li>▪ Premium for Cal-COBRA employees should be made at the time of the case submission. A separate premium check from the member should be included with the new business case submission.</li> <li>▪ However, if premium is not received, the group will be approved if all other requirements have been met.</li> </ul>
<p><b>Carve-Outs</b></p>	<ul style="list-style-type: none"> <li>▪ The general types of carve-outs that could be considered by Aetna include: California Branch Location and Management/Non-Management, Salary/Hourly, Union vs. Non-Union.</li> <li>▪ Aetna must enroll <b>and</b> maintain a minimum of eight employees who reside within Aetna's California Network Service Area.</li> <li>▪ 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.</li> <li>▪ Groups are not guaranteed issue.</li> </ul>
<p><b>Case Submission Dates</b></p>	<ul style="list-style-type: none"> <li>▪ Groups with 2 to 50 eligible employees must have all completed paperwork into Aetna Underwriting <b>no later than the end of the 5th business day after</b> the requested effective date.</li> <li>▪ If not received by this date, the effective date may be moved to the next available effective date.</li> </ul>
<p><b>Census Data</b></p>	<ul style="list-style-type: none"> <li>▪ Census data must be provided for all eligible employees, including COBRA-eligible and Cal-COBRA State Continuation employees.</li> <li>▪ Include the name, date of birth, date of hire, gender, dependent status and residence zip code (when multi-site/multi-state).</li> <li>▪ Retirees — See Employee Eligibility section.</li> <li>▪ COBRA/Cal-COBRA-eligible employees should be included on the census and noted as COBRA/Cal-COBRA.</li> </ul>

<p><b>Composite Rating</b></p>	<ul style="list-style-type: none"> <li>▪ Employers that enroll <b>25 California employees</b> may select tabular or composite rating on their initial effective or renewal date.</li> </ul> <p><b>Composite Rating for New Business:</b></p> <ul style="list-style-type: none"> <li>▪ Employer may offer a maximum of four plan options.</li> <li>▪ At least one person must enroll in each plan for it to be offered to new hires.</li> <li>▪ The composite rate for each plan will be determined based on the <u>census quoted</u>.</li> <li>▪ Upon final enrollment, the composite rate for each plan will be processed based upon the <u>enrolled employees</u>.</li> <li>▪ If the rates vary by more than 5%, the new business composite rates will be adjusted.</li> </ul> <p><b>Composite Rating for Renewing Business:</b></p> <ul style="list-style-type: none"> <li>▪ Renewal rates will be based on the <u>enrolled employees in each plan platform (HMO or MC/PPO)</u> at the time the renewal is processed.</li> <li>▪ Only the plans available after the initial enrollment will be rated for the renewal.</li> <li>▪ Employers must submit a request to underwriting to switch to composite rates at renewal.</li> <li>▪ If the employer currently has Pick-A-Plan in place, Medical underwriting is not required. However, the employer must select a maximum of four plans to be offered.</li> <li>▪ If the Employer wants to move to a richer plan or select the Pick-A-Plan option, they will be subject to underwriting.</li> </ul>
<p><b>Deductible Credit</b></p>	<ul style="list-style-type: none"> <li>▪ 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 either at the initial small group submission or with their first claim.</li> </ul>
<p><b>Definition of a Small Group Employer for the State of California</b></p>	<p>“Small employer” means any of the following:</p> <ul style="list-style-type: none"> <li>▪ Any person, proprietary or nonprofit firm, corporation, partnership, public agency or association that is actively engaged in business or service, that, on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, whichever is more favorable for eligibility, employed at least 2 but not more than 50 eligible employees, the majority of whom were employed within the state, that was not formed primarily for the purposes of obtaining health insurance and in which a bona-fide employer-employee relationship exists.             <ul style="list-style-type: none"> <li>– In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility.</li> <li>– In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation, shall be considered one employer. For the purpose of determining eligibility, the size of a small employer may be determined annually.</li> </ul> </li> <li>▪ Any guaranteed association that purchases health coverage for members of the association.</li> <li>▪ A California small employer subject to guaranteed issue (AB 1672) cannot be declined based on the medical conditions or claims experience; however, rates may be adjusted for known medical conditions (.90 RAF to 1.10 RAF).</li> </ul> <p><b>Newly formed businesses</b> may be considered guaranteed issue if the following are met:</p> <ul style="list-style-type: none"> <li>▪ Employer group meets all requirements of AB 1672, except for being in business 50% of the previous calendar quarter.</li> <li>▪ Employer submits a copy of the most recently filed DE 9C (Quarterly Wage and Tax Statement). If not available, up to a maximum of six weeks of consecutive weeks of payroll records, which include, for every eligible employee enrolling, taxes withheld, check number and wages earned.             <ul style="list-style-type: none"> <li>– If employer group does not have payroll records, see below.</li> </ul> </li> <li>▪ Sole Proprietor, Partnership or Limited Liability Partnership, Limited Liability Company and Corporations must submit the following:             <ul style="list-style-type: none"> <li>– <u>Sole Proprietor</u> — A copy of the Business License (not a professional license). A professional license, for example, is the certificate from the state that you are a licensed hair stylist, manicurist, real estate agent, etc.</li> <li>– <u>Partnership or Limited Liability Partnership</u> — A copy of the partnership agreement. For a Limited Partnership, Aetna can search the California Business Portal; however, this can not be used for a Partnership or Limited Liability Partnership.</li> <li>– <u>Limited Liability Company</u> — A copy of the Articles of Organization <u>and</u> the Operating Agreement, to include the signature page(s) of all officers. For Limited Liability Companies, Aetna can search the California Business Portal; however, all documents still need to be submitted.</li> <li>– <u>Corporations</u> — A copy of the Articles of Incorporation, to include the signature page(s) of all officers (must be followed up with a copy of the Statement of Information within 30 days of filing with the state).</li> </ul> </li> <li>▪ For Sole Proprietors, Partnership or Limited Liability Partnership, Limited Liability Company and Corporations, payroll is required.</li> <li>▪ Employer groups that cannot provide sufficient payroll and have not been in business for 50% of the previous calendar quarter, regardless of corporate structure, must provide the information below and may be declined coverage.             <ul style="list-style-type: none"> <li>– Employer groups that do not have six weeks of payroll must provide the information above as well as obtain a letter from a CPA that indicates the information below:                 <ul style="list-style-type: none"> <li>• A list of all employees, to include owners, partners and officers (full time and part time)</li> <li>• Number of hours worked per week for each employee</li> <li>• Weekly salary for each employee</li> <li>• Date of hire for each employee</li> <li>• Explanation of payroll record status</li> <li>• Date when Quarterly Wage and Tax Statement (DE 9C) will be filed</li> </ul> </li> </ul> </li> </ul>

<p><b>Dental</b></p>	<p><b>Open enrollments are prohibited.</b></p> <p><b>Coverage Waiting Period</b></p> <ul style="list-style-type: none"> <li>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 services for employees who were covered by the group's immediately preceding dental plan.             <ul style="list-style-type: none"> <li>To waive the waiting period for major services, the employer's immediately preceding group plan must have covered major services.</li> <li>To waive the waiting period for orthodontic services, the employer's immediately preceding group plan must have covered orthodontic services.</li> </ul> </li> </ul> <p><b>Example:</b> Prior major coverage but no orthodontic coverage. New plan has both major and orthodontic coverage. The waiting period is waived for major services but not for orthodontic services.</p> <p><b>Product Packaging</b></p> <ul style="list-style-type: none"> <li>DMO can be either sold standalone or packaged with any PPO option as a dual option.</li> <li>PPO can be sold standalone or packaged with the DMO as a dual option.</li> <li>Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold.</li> <li>Voluntary Dental plans cannot be sold or packaged with any other plan as a dual-option offering.</li> </ul> <p><b>Reinstatement</b></p> <p>For Voluntary Dental plan options: Members who were once enrolled, then terminated their coverage by discontinuing their contributions, may not re-enroll for a period of 24 months. All coverage rules apply from the new effective date, including, but not limited to, the coverage waiting period.</p> <p><b>Ineligible Industries</b></p> <p>Applies when Dental is sold standalone or packaged only with group insurance. This list does not apply if sold in combination with Medical.</p> <table border="1" data-bbox="386 590 1304 1050"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr> <td>0761-0783</td> <td>Seasonal Employees</td> <td>7631</td> <td>Watch, Clock &amp; Jewelry Repair</td> </tr> <tr> <td>3911-3915</td> <td>Jewelry Manufacturing</td> <td>7692-7699</td> <td>Miscellaneous Repair</td> </tr> <tr> <td>4111-4121</td> <td>Passenger Transportation</td> <td>7800-7999</td> <td>Amusement, Recreation, and Entertainment</td> </tr> <tr> <td>5271</td> <td>Mobile Home Dealers</td> <td>8000-8059</td> <td>Medical Groups</td> </tr> <tr> <td>5511-5599</td> <td>Auto Dealerships</td> <td>8071-8099</td> <td>Medical Groups</td> </tr> <tr> <td>5800-5899</td> <td>Restaurants</td> <td>8100-8199</td> <td>Legal</td> </tr> <tr> <td>6500-6799</td> <td>Real Estate</td> <td>8211-8299</td> <td>Schools, Libraries, Education</td> </tr> <tr> <td>7000-7099</td> <td>Hotels</td> <td>8300-8399</td> <td>Social Service</td> </tr> <tr> <td>7221</td> <td>Photo Studios</td> <td>8400-8499</td> <td>Museums, Art Galleries, Botanical Gardens</td> </tr> <tr> <td>7231-7241</td> <td>Beauty &amp; Barber Shops</td> <td>8600-8699</td> <td>Associations &amp; Trusts</td> </tr> <tr> <td>7251-7299</td> <td>Repairs, Cleaning, Personal Services</td> <td>8700-8799</td> <td>Engineering &amp; Management Services</td> </tr> <tr> <td>7319</td> <td>Advertising, Misc.</td> <td>8800-8899</td> <td>Service — Private Households</td> </tr> <tr> <td>7331-7338</td> <td>Direct Mailing, Secretarial Services</td> <td>8999</td> <td>Miscellaneous Services</td> </tr> <tr> <td>7361-7363</td> <td>Employment Agencies</td> <td>9721</td> <td>International Affairs</td> </tr> <tr> <td>7379</td> <td>Miscellaneous Computer Services</td> <td></td> <td></td> </tr> <tr> <td>7381-7382</td> <td>Security Systems, Armored Cars</td> <td></td> <td></td> </tr> <tr> <td>7384</td> <td>Photofinishing Labs</td> <td></td> <td></td> </tr> <tr> <td>7389</td> <td>Miscellaneous Business Services</td> <td></td> <td></td> </tr> </tbody> </table>	SIC Range	SIC Description	SIC Range	SIC Description	0761-0783	Seasonal Employees	7631	Watch, Clock & Jewelry Repair	3911-3915	Jewelry Manufacturing	7692-7699	Miscellaneous Repair	4111-4121	Passenger Transportation	7800-7999	Amusement, Recreation, and Entertainment	5271	Mobile Home Dealers	8000-8059	Medical Groups	5511-5599	Auto Dealerships	8071-8099	Medical Groups	5800-5899	Restaurants	8100-8199	Legal	6500-6799	Real Estate	8211-8299	Schools, Libraries, Education	7000-7099	Hotels	8300-8399	Social Service	7221	Photo Studios	8400-8499	Museums, Art Galleries, Botanical Gardens	7231-7241	Beauty & Barber Shops	8600-8699	Associations & Trusts	7251-7299	Repairs, Cleaning, Personal Services	8700-8799	Engineering & Management Services	7319	Advertising, Misc.	8800-8899	Service — Private Households	7331-7338	Direct Mailing, Secretarial Services	8999	Miscellaneous Services	7361-7363	Employment Agencies	9721	International Affairs	7379	Miscellaneous Computer Services			7381-7382	Security Systems, Armored Cars			7384	Photofinishing Labs			7389	Miscellaneous Business Services		
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<p><b>Dependent Eligibility</b></p>	<ul style="list-style-type: none"> <li>Eligible dependents include an employee's spouse/domestic partner. 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.</li> <li>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.</li> <li>Grandchildren are eligible if court ordered.</li> <li>For dependent Life, dependents are eligible from 14 days of age through their 19th birthday, or through their 23rd birthday, if in school.</li> <li>Dependents are not eligible for AD&amp;D or Disability coverage.</li> <li>For Medical and Dental, dependents must enroll in the same benefits as the employee (participation is not required).</li> <li>Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical plan. See product-specific Life/AD&amp;D and Disability guidelines under Product Specifications.</li> <li>Individuals cannot be covered as an employee and dependent under the same plan.</li> <li>Children eligible for coverage through both parents cannot be covered by both parents under the same plan.</li> </ul>																																																																												
<p><b>Effective Date</b></p>	<ul style="list-style-type: none"> <li>Groups with no prior coverage may request either the 1st or the 15th of the month effective date.</li> <li>The effective date requested by the employer may be up to 60 days in advance.</li> <li>When replacing an employer-sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period.             <ul style="list-style-type: none"> <li>For example, if the other plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.</li> </ul> </li> </ul>																																																																												
<p><b>Electronic Funds Transfer</b></p>	<ul style="list-style-type: none"> <li>Payment for the first month's premium at new business can be processed via an Electronic Funds Transfer.</li> <li>This does not apply to future premium payments.</li> </ul>																																																																												

<p><b>Employee Eligibility</b></p>	<p>An eligible employee means either of the following:</p> <ul style="list-style-type: none"> <li>▪ Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of at least 30 hours, in the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.</li> <li>▪ A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply:             <ul style="list-style-type: none"> <li>– The employee otherwise meets the definition of an eligible employee except for the number of hours worked.</li> <li>– The employer offers the employee health coverage under a health benefit plan.</li> <li>– All similarly situated individuals are offered coverage under the health benefit plan.</li> <li>– The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.</li> </ul> </li> </ul> <p><b>Retirees</b></p> <ul style="list-style-type: none"> <li>▪ Coverage is available for Medicare-eligible retirees and/or active Medicare-eligible in accordance with the Medicare-Retiree Underwriting Guidelines.</li> </ul> <p><b>COBRA /Cal-COBRA</b></p> <ul style="list-style-type: none"> <li>▪ COBRA/Cal-COBRA-eligible enrollees are required to be included on the census.</li> <li>▪ Health questions must be answered.</li> <li>▪ COBRA/Cal-COBRA qualifying event, length, start and end date must be provided.</li> </ul>
<p><b>Employer Contribution</b></p>	<p><b>Single Choice Medical</b></p> <ul style="list-style-type: none"> <li>▪ The employer must contribute at least 50% of the employee rate.</li> <li>▪ Coverage may be denied based upon inadequate contributions.</li> </ul> <p><b>Pick-A-Plan (Medical)</b></p> <ul style="list-style-type: none"> <li>▪ The employer must contribute 50% of the employee-only rate of whichever plan the employee selects; or</li> <li>▪ The employer may choose to offer a defined contribution of at least \$80 or the actual cost of the plan, whichever is less.</li> <li>▪ Coverage may be denied based upon inadequate contributions.</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ The employer must contribute at least 50% of the employee-only cost or 25% of the total plan.             <ul style="list-style-type: none"> <li>– For Voluntary Dental plans: Employer contribution can be from zero to 49% of the cost of the employee-only coverage.</li> </ul> </li> <li>▪ Pick-A-Plan is not available.</li> <li>▪ Coverage may be denied based upon inadequate contributions.</li> </ul> <p><b>Term Life</b></p> <ul style="list-style-type: none"> <li>▪ Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan.</li> <li>▪ Employers with 10–50 eligible lives: Employer must contribute at least 50% of the cost of the plan (excluding Optional Dependent Life).</li> <li>▪ Pick-A-Plan is not available.</li> <li>▪ Coverage may be denied based upon inadequate contributions.</li> </ul>
<p><b>Employer Eligibility</b></p>	<ul style="list-style-type: none"> <li>▪ All Aetna plans can be offered to sole proprietors, partnerships or corporations.</li> <li>▪ Employers (Companies/Organizations) must not be formed solely for the purpose of obtaining health coverage.</li> <li>▪ Non-guaranteed associations, Taft-Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employee/employer relationship exists are not eligible for Small Group coverage.</li> <li>▪ Dental and Life products have ineligible industries, which are listed separately under Product Specifications. The Dental-ineligible-industry list does not apply when Dental is sold in combination with Medical.</li> </ul>
<p><b>Employers Leaving an Aetna PEO</b></p>	<ul style="list-style-type: none"> <li>▪ Aetna currently provides coverage to several PEOs. Aetna's contract is with the PEO, not the individual client firms. When a small group is leaving the PEO that is insured with Aetna, we no longer need a letter of intent. 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, this is acceptable.</li> <li>▪ Groups leaving an Aetna PEO are not subject to guaranteed issue for up to 12 months from termination of the policy.</li> </ul>
<p><b>Employers Replacing Other Group Coverage</b></p>	<ul style="list-style-type: none"> <li>▪ A copy of the most recent billing statement that includes the employee listing must be submitted.</li> <li>▪ The employer should be told not to cancel any existing Medical coverage until they have been notified of approval from the Aetna Underwriting unit.</li> </ul>
<p><b>Holding Companies</b></p>	<ul style="list-style-type: none"> <li>▪ 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 that 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.</li> <li>▪ 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.             <ul style="list-style-type: none"> <li>– Example                 <ul style="list-style-type: none"> <li>• Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).</li> <li>• Bank A (the holding company) has no ownership; it is simply an umbrella company for the three Bank B locations.</li> <li>• Bank B has three locations and all under one TIN.</li> <li>• Bank A (the holding company) is under a separate TIN.</li> <li>• The holding company and banks have no ownership because the owners are all stockholders and bank employees or bank executives.</li> <li>• There are no articles of incorporation, only stock certificates.</li> <li>• 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.</li> <li>• Documentation needed: QWTS for Bank B, which should include all three locations.</li> </ul> </li> </ul> </li> </ul>

<p><b>Initial Premium Check</b></p>	<ul style="list-style-type: none"> <li>▪ The initial premium check should be in the amount of the first month's premium and drawn on a company check.</li> <li>▪ Premium checks for Cal-COBRA members should be on a separate check made payable to Aetna.</li> <li>▪ The initial premium check is not a binder check. Final premium will be determined upon underwriting review.</li> <li>▪ If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer.</li> </ul>																																																				
<p><b>Late Entrants</b></p>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ 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 canceled the coverage must wait until the next plan anniversary date to be eligible to be added.</li> </ul> <p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ An employee or dependent may enroll at any time; however, coverage is limited to preventive and diagnostic services for the first 12 months.</li> <li>▪ No coverage for most basic and major services for the first 12 months (24 months for orthodontics).</li> <li>▪ Late-entrant provision does not apply to enrollees less than age 5.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).</li> <li>▪ Life late-enrollee example: A group has \$50,000 Life with \$20,000 guaranteed issue limit. A 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.</li> </ul>																																																				
<p><b>Life — Basic Term</b></p>	<p>Open Enrollments are prohibited.</p> <p>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 three employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows:</p> <table border="1"> <thead> <tr> <th>Position/Job Class</th> <th>Basic Term Life Amount</th> </tr> </thead> <tbody> <tr> <td>Executives</td> <td>\$50,000</td> </tr> <tr> <td>Managers, supervisors</td> <td>\$20,000</td> </tr> <tr> <td>All other employees</td> <td>\$10,000</td> </tr> </tbody> </table> <p><b>Guaranteed Issue Coverage</b> Aetna provides certain amounts of Life insurance without requiring an employee to answer any medical questions. These insurance amounts are called "guaranteed issue." Employees wishing to obtain increased insurance amounts will be required to submit Evidence of Insurability, which means they must complete a medical questionnaire and may be required to submit to a medical exam. Depending on the customer's size, Life insurance amounts are guaranteed issue up to the maximums listed below:</p> <table border="1"> <thead> <tr> <th>Case Size</th> <th>Basic Term Life Amount</th> </tr> </thead> <tbody> <tr> <td>2–9 eligible lives</td> <td>\$20,000</td> </tr> <tr> <td>10–25 eligible lives</td> <td>\$75,000</td> </tr> <tr> <td>25–50 eligible lives</td> <td>\$100,000</td> </tr> </tbody> </table> <p><b>Evidence of Insurability (EOI)</b> 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) Coverage is requested outside of the employer's renewal period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).</p> <p><b>Actively at Work</b> 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.</p> <p><b>Continuity of Coverage (No Loss/No Gain)</b> The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers. If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.</p> <p><b>Ineligible Industries Life/AD&amp;D</b> — All industries are eligible except for standalone for groups of 26+.</p> <table border="1"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr> <td>1000–1499</td> <td>Mining</td> <td>7381</td> <td>Service — Detective</td> </tr> <tr> <td>2892–2899</td> <td>Explosives, Bombs &amp; Pyrotechnics</td> <td>7500–7599</td> <td>Auto Repair &amp; Service</td> </tr> <tr> <td>3291–3292</td> <td>Asbestos Products</td> <td>7800–7999</td> <td>Motion Picture, Amusement, Recreation</td> </tr> <tr> <td>3310–3329</td> <td>Primary Metal Industries</td> <td>8010–8043</td> <td>Medical Doctors/Clinics</td> </tr> <tr> <td>3480–3489</td> <td>Firearms/Ammunitions</td> <td>8600–8699</td> <td>Membership Associations</td> </tr> <tr> <td>5921</td> <td>Liquor Stores</td> <td>8800–8899</td> <td>Service — Private Household</td> </tr> <tr> <td>6211</td> <td>Security Brokers</td> <td>9999</td> <td>Non-Classified Establishment</td> </tr> <tr> <td>6531</td> <td>Real Estate — Agents</td> <td></td> <td></td> </tr> </tbody> </table>	Position/Job Class	Basic Term Life Amount	Executives	\$50,000	Managers, supervisors	\$20,000	All other employees	\$10,000	Case Size	Basic Term Life Amount	2–9 eligible lives	\$20,000	10–25 eligible lives	\$75,000	25–50 eligible lives	\$100,000	SIC Range	SIC Description	SIC Range	SIC Description	1000–1499	Mining	7381	Service — Detective	2892–2899	Explosives, Bombs & Pyrotechnics	7500–7599	Auto Repair & Service	3291–3292	Asbestos Products	7800–7999	Motion Picture, Amusement, Recreation	3310–3329	Primary Metal Industries	8010–8043	Medical Doctors/Clinics	3480–3489	Firearms/Ammunitions	8600–8699	Membership Associations	5921	Liquor Stores	8800–8899	Service — Private Household	6211	Security Brokers	9999	Non-Classified Establishment	6531	Real Estate — Agents		
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<p><b>Live/Work Guidelines</b></p>	<ul style="list-style-type: none"> <li>▪ Employees enrolled in Medical or Dental who reside in a Non-HMO (AVN/HMO HRA/HMO deductible) and/or DMO network code may enroll in an HMO/DMO product offered by their employer if they live within a <b>30-mile radius</b> of their work site that is within the HMO/DMO service area.</li> <li>▪ Vitalidad is available to California employers who have employees who work or live within the Vitalidad service area. (Imperial County is not within a Vitalidad service area.) Please see Vitalidad section.</li> <li>▪ Vitalidad Plus may be chosen in the areas where approved; however, to select SIMNSA as your primary care provider, you must live/work within the 50-mile radius as listed below. Please see Vitalidad Plus section.</li> <li>▪ Product availability for group benefit offerings are always determined by the zip code of the Employer.</li> <li>▪ If the employee resides at a distance farther than the 30-mile radius, exception requests should be directed to Underwriting for a feasibility determination.</li> <li>▪ Employees who are enrolling using the Live/Work guidelines should include their home address and zip code as well as the work-site address and zip code. All correspondence will be mailed to the employee's home address as listed on the application.</li> </ul>
<p><b>Medical</b></p>	<ul style="list-style-type: none"> <li>▪ All eligible employees, Cal-COBRA or COBRA enrollees applying for Medical coverage are required to complete the individual health questionnaire section of the employee enrollment form for groups of 2–50. Failure to do so may result in a maximum 1.10 RAF (risk adjustment factor) determination.</li> <li>▪ Eligible employees must complete the waiver section of the employee application for either the employee and/or their dependents when declining coverage. The health questionnaire does not need to be completed for those individuals who are declining Medical or Life at the guaranteed issue amount.</li> <li>▪ A group can be declined if more than 49% of the group's eligible employees are employed outside of the state of California on 50% of the business days in the last quarter of calendar year.</li> <li>▪ If the employee requests coverage above the guaranteed issue amount for Life, they will need to complete the individual health questionnaire.</li> <li>▪ Groups returning to Aetna within 12 months of termination are not subject to guaranteed issue and may be declined. Health &amp; Safety Code section 1357.09.</li> </ul> <p><b>Standard RAF Guidelines</b></p> <ul style="list-style-type: none"> <li>▪ Groups enrolling 2–4 employees will receive an automatic 1.10 RAF.</li> <li>▪ Groups enrolling 5–50 employees may qualify for a .90 RAF.</li> <li>▪ Please check with your Aetna Account Executive for information on Aetna's latest RAF promotion.</li> </ul>
<p><b>Option Sales Alongside Other Carriers</b></p>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ Standard participation of 75% must be met in order for a group to qualify for coverage for all plans except for Vitalidad Mexico con Aetna.</li> <li>▪ Accepting the greatest of 50% participation and a minimum of eight enrollees for group's offering coverage through another carrier's HMO.</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ Options sales alongside another Dental carrier are not allowed.</li> <li>▪ All Dental plans must be sold on a full replacement basis only.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ Not applicable.</li> </ul>
<p><b>Out of Area Within California</b></p>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ Employees residing outside of an Aetna network service area must enroll in the Aetna Indemnity plan.</li> <li>▪ Aetna Indemnity plan is only available if the employee resides outside of both the Aetna PPO network service area and the Aetna HMO network service area.</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ Employees residing outside of an Aetna network service area.</li> <li>▪ Employees who reside within California but outside of a DMO service area may be offered an in-state PPO plan.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ Not applicable.</li> </ul>
<p><b>Out-of-State Employees</b></p>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ Employees residing outside of California.</li> <li>▪ Employers must have at least 51% of their employees residing in California to be considered guaranteed issue.</li> <li>▪ Out-of-state employees who live/work in an out-of-state network area will receive California rates and products (inclusive of any required extraterritorial benefits).</li> <li>▪ Out-of-state employees who do not reside in an out-of-state network area will receive the California standard indemnity products (inclusive of any required extraterritorial benefits).</li> <li>▪ Out-of-state employees who reside in an area with an MC network must enroll in the California MC plan.</li> <li>▪ Out-of-state employees who reside in an area with a PPO-only network must enroll in the California PPO plan.</li> <li>▪ Out-of-state employees who reside in an indemnity-only network must enroll in the California indemnity plan.</li> <li>▪ HMO and EPO plans are not allowed outside of California.</li> </ul> <p><b>Network Availability for Out-of-State Employees</b></p> <ul style="list-style-type: none"> <li>▪ No MC plans are available in the following states: AK, HI, ID, IN, ME, MT, NE, PR, RI, SD and WY.</li> <li>▪ No PPO is available in the following states: AL, ID, MN, MT, ND, NM, RI, WI and WY.</li> <li>▪ No Indemnity or PPO products are available in HI or VT.</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ Out-of-state employees may only be offered one of the available four out-of-state Dental plans.</li> <li>▪ Maximum out-of-state employee percentage (and/or number of employees) will agree with the Medical guidelines for each state.</li> <li>▪ Orthodontic coverage is included for groups of 10 or more eligible employees.</li> <li>▪ Orthodontic coverage is only available for dependent children.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ Out-of-state employees are eligible for the Basic Term Life depending on the option selected by the employer.</li> </ul>

<p><b>Participation</b></p>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ <b>For non-contributory plans:</b> 100% participation is required. All employees, excluding those with coverage through another employer's plan, must enroll.</li> <li>▪ <b>Employers with 2–3 eligible employees:</b> 100% of eligible, excluding those with coverage through another employer's plan, must participate.</li> <li>▪ <b>Employers with 4–50 eligible employees:</b> 75% of eligible (rounded down), excluding those with coverage through another employer's plan, must participate. Example: 75% participation for a 5-life group is 3.75 applications — <b>our new calculation will round down</b>, so we will require 3 applications for participation to be met.</li> <li>▪ <b>Employers offering other carrier's HMO</b> must have at least 50% participation and a minimum of eight employees enrolling with Aetna.</li> <li>▪ <b>Employers offering the Vitalidad Mexico con Aetna are eligible for 65% participation</b> if at least one employee enrolls in a Vitalidad network area (see zip code listing under Vitalidad section).</li> <li>▪ 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%). Please provide group name and ID number on the waiver.</li> <li>▪ Individual coverage, including Medi-Cal, is not considered a valid waiver and will count toward the participation. Copies of ID cards may be requested for confirmation.</li> <li>▪ All employees waiving coverage must complete Section B and the waiver section of the application.</li> <li>▪ <b>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.</b></li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ <b>Employers paying 100% of the employee premium:</b> 100% participation is required. All employees, excluding those with other qualifying existing Dental coverage, must enroll.</li> <li>▪ <b>Groups with 2–3 eligible employees:</b> 100% participation is required, excluding those with other qualifying existing Dental coverage.</li> <li>▪ <b>Groups with 4–50 eligible employees:</b> 75% participation is required, excluding those with other qualifying Dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.</li> </ul> <p><b>Voluntary Dental</b></p> <ul style="list-style-type: none"> <li>▪ Not available for groups with less than three eligible employees.</li> <li>▪ At least 25% of the employees must participate, excluding employees with other qualifying coverage. Enrollees, excluding those with other qualifying existing Dental coverage or a minimum of three enrollees, whichever is greater, is required.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ <b>For non-contributory plans:</b> 100% participation is required.</li> <li>▪ <b>Groups with less than 10 eligible employees:</b> 100% participation is required.</li> <li>▪ <b>Groups with 10–50 eligible employees:</b> 75% participation is required if the plans are at least partially contributory.</li> </ul>
<p><b>PEOs</b> (Professional Employer Organizations)</p>	<ul style="list-style-type: none"> <li>▪ Groups must complete the PEO Questionnaire.</li> <li>▪ Groups coming from a PEO are excluded from the RAF promotion.</li> <li>▪ Groups coming from an Aetna PEO will be medically underwritten based upon the employee applications and a review of prior claims history.</li> <li>▪ Groups leaving an Aetna PEO are not guaranteed issue for 12 months from the date of termination.</li> </ul>
<p><b>Pick-A-Plan</b></p>	<p><b>New Business:</b></p> <ul style="list-style-type: none"> <li>▪ Employers may select Pick-A-Plan (all plans), which allows each employee and new hires to select any of our 30 plans.</li> <li>▪ If the employer <b>does not select Pick-A-Plan (all plans) the following will apply:</b> <ol style="list-style-type: none"> <li>a) If the employer <b>selects three or less plans</b>, underwriting will notify the broker/client that they are <b>not enrolled</b> in Pick-A-Plan via the underwriting requirements. New hires may only enroll in one of the three plans offered. If the employer wants to “upgrade” to a different plan or add another plan at renewal, they will be subject to underwriting approval. The employer will be given the option to enroll in Pick-A-Plan if they want to at enrollment only.</li> <li>b) If the employer <b>selects four or more plans</b>, underwriting will notify the broker/client that they are enrolled in Pick-A-Plan via the underwriting requirements. New hires may enroll in any of Aetna's plans. The employer is not subject to underwriting for adding new plans or changing their existing plan at renewal. Plan changes can only be made at renewal. If the employer doesn't want to enroll in Pick-A-Plan, a maximum of three plans may be offered.</li> </ol> </li> <li>▪ If an employer <b>selects Pick-A-Plan (all plans)</b> at the time of enrollment, the group/employee will not be subject to underwriting for future plan changes. No off-renewal plan changes will be allowed. New hires may choose from any of the Aetna plans offered.</li> <li>▪ Plan changes for employers and enrolled employees (except for qualified special enrollment events) can only be made at renewal.</li> <li>▪ Employees who choose to enroll in the richer plan are responsible for the difference in premium only if the employer is not paying the majority of the premium.</li> </ul> <p><b>Renewing Business</b></p> <ul style="list-style-type: none"> <li>▪ Employers who selected Pick-A-Plan (all plans) may add or change plans without medical underwriting.</li> <li>▪ Employers with employees enrolled in <b>four or more plans</b> may add or change plans without medical underwriting.</li> <li>▪ Employers with <b>three or less plans</b> must submit a request to add or upgrade to a different plan at renewal.</li> </ul> <p><b>Mid-Year Policy Benefit Changes</b></p> <ul style="list-style-type: none"> <li>▪ Groups that have elected Pick-A-Plan (all plans) will not be eligible for mid-year policy changes.</li> </ul> <p><b>Carve-Outs</b></p> <ul style="list-style-type: none"> <li>▪ Allowed (See Carve-Out section).</li> </ul>
<p><b>Plan Change Ancillary Additions</b> (Life or Dental)</p>	<ul style="list-style-type: none"> <li>▪ Employers may request plan changes up to the renewal date for changes that are to be effective on the renewal date.</li> <li>▪ Employers must request plan changes off of the renewal date at least two weeks prior to the desired effective date.</li> <li>▪ The future renewal date of the ancillary products will be the same as the Medical plan renewal date.</li> </ul>
<p><b>Plan Changes — Employees</b></p>	<ul style="list-style-type: none"> <li>▪ 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).</li> </ul>

<p><b>Plan Changes — Employer</b></p>	<ul style="list-style-type: none"> <li>▪ After the first 30 days of enrollment, employers may request a change in medical benefits six months after the original effective date.</li> <li>▪ Groups that have Pick-A-Plan (all plans) are not eligible for mid-year policy benefit changes.</li> <li>▪ Upgrades are only allowed once in a 12-month rolling period and are subject to medical underwriting.</li> <li>▪ Upgrades may be declined based upon underwriting review.</li> <li>▪ The requests for changes must be submitted to Aetna Small Group Underwriting 30 days prior to the requested effective date.</li> <li>▪ Late requests will be moved to the next applicable effective date pending underwriting approval.</li> <li>▪ During the first 30 days of coverage, the small employer shall have the option of changing coverage to a different benefit plan design offered by the same carrier. If a small employer notifies the carrier of the change within the first 15 days of the month, coverage under the new benefit plan design shall become effective no later than the first day of the following month; if a small employer notifies the carrier of the change after the 15th day of the month, coverage under the new benefit plan design shall become effective no later than the first day of the second month following notification.</li> </ul>
<p><b>Product Availability</b></p>	<p><b>Medical</b></p> <ul style="list-style-type: none"> <li>▪ Pick-A-Plan allows each employee the option to choose their Medical product from a wide selection of product offerings selected by the employer.</li> <li>▪ Employer may choose the Pick-A-Plan box, which provides all plans to all employees. If the employer does not want to offer all plans, they may choose just the plans they wish to allow their employees to enroll in.</li> <li>▪ Requests to add more products to the group's contract are subject to Medical underwriting, <i>if the group did not choose Pick-A-Plan (all plans) at their original effective date.</i></li> <li>▪ Carve-Outs: Allowed (See Carve-Out section).</li> <li>▪ Pick-A-Plan: Allowed (See Pick-A-Plan section).</li> </ul> <p><b>Dental</b></p> <ul style="list-style-type: none"> <li>▪ <b>Employers with three or more eligible:</b> Dental may be sold on a standalone basis or along with Medical on a bundled or unbundled basis.</li> <li>▪ <b>Employers with less than three eligible employees or two enrolled:</b> <ul style="list-style-type: none"> <li>– Dental must be sold with Medical and can not be sold on a standalone basis.</li> <li>– Voluntary Dental products are not available for groups with less than three eligible employees.</li> </ul> </li> <li>▪ If the employer selects both Medical and Dental coverages, they must be offered to all employees. <ul style="list-style-type: none"> <li>– Eligible employees do not have to enroll in both plans. Employees may enroll in Dental and not Medical and vice versa.</li> </ul> </li> <li>▪ Orthodontic coverage is included for groups with 10 or more eligible employees and is available for both adults and dependent children.</li> <li>▪ Carve-Outs: Not allowed.</li> <li>▪ Pick-A-Plan: Not available.</li> </ul> <p><b>Life</b></p> <ul style="list-style-type: none"> <li>▪ <b>Employers with 2–9 eligible employees:</b> Life must be sold with Medical and cannot be sold on a standalone basis.</li> <li>▪ <b>Employers with 10–25 eligible employees:</b> Basic Term Life is available packaged with either Medical or Dental.</li> <li>▪ <b>Employers with 26–50 eligible employees:</b> Basic Term Life is available either packaged with Medical or Dental or on a standalone basis.</li> <li>▪ Employees may elect Life coverage even if they do not elect Medical coverage or vice versa.</li> <li>▪ Employers with less than 10 eligible employees: Certain plan differences apply.</li> <li>▪ Carve-Outs: Not allowed.</li> <li>▪ Pick-A-Plan: Not available.</li> </ul>
<p><b>Rates — Tabular or Composite</b></p>	<p>The standard risk rates are based on the employer's zip code</p> <p><b>Tabular Rate Structure</b></p> <ul style="list-style-type: none"> <li>▪ Employers with Pick-A-Plan (all plans) will be tabular rated.</li> <li>▪ Employers with at least 25 California enrolling employees have the option of composite or tabular rates.</li> <li>▪ All rates are based upon the employer zip code.</li> </ul> <p><b>Composite Rate Structure</b></p> <ul style="list-style-type: none"> <li>▪ Employers with at least 25 California enrolling employees may elect composite rating.</li> <li>▪ Employers can offer a maximum of four Aetna Medical plans to their employees.</li> <li>▪ One employee must enroll into each plan and remain in a plan for it to be available at renewal.</li> <li>▪ New hires may only enroll into one of the four plans that are offered.</li> <li>▪ Employers can not change rating structure until renewal.</li> <li>▪ COBRA/Cal-COBRA employees are not counted as eligible.</li> <li>▪ Employers may elect tabular rating at renewal; however, plan change requests may be subject to underwriting approval.</li> <li>▪ Employers may elect Pick-A-Plan at renewal; however, this may be subject to underwriting approval.</li> </ul>
<p><b>Rate Guarantee</b></p>	<ul style="list-style-type: none"> <li>▪ Medical rates are guaranteed for one year (12 months).</li> <li>▪ 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.</li> <li>▪ Life rates are guaranteed for two years (24 months).</li> </ul>
<p><b>Renewal Benefit Changes</b></p>	<ul style="list-style-type: none"> <li>▪ Requests for plan changes to be effective on the renewal date must be submitted prior to the renewal date.</li> <li>▪ Requests for plan changes to be effective off of the renewal date must be submitted within 30 days of the requested effective date.</li> <li>▪ 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).</li> </ul>
<p><b>Self-Funding the Deductible/ Section 105 Plans</b></p>	<p>Please contact your Aetna sales representative for the latest information.</p>
<p><b>Signature Dates</b></p>	<ul style="list-style-type: none"> <li>▪ The Aetna employee application and all employee applications must be signed and dated prior to, and within, 90 days of the requested effective date.</li> <li>▪ All employee applications must be completed by the employee himself/herself.</li> </ul>

<p><b>Spin-Off Groups</b> (current Aetna customers leaving an Aetna group only)</p>	<p>Aetna will consider the group guaranteed issue with the following:</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Ownership documents showing that the spin-off company is a <b>newly formed separate entity</b>.</li> <li>▪ A minimum of two weeks' payroll. If the group that is spinning off has been in business longer than two weeks, payroll will be required for the amount of time in business up to a maximum of six consecutive weeks.</li> <li>▪ Medical claims will be requested and used along with the health information included on the employee application in order to provide an accurate RAF.</li> <li>▪ A group that is spinning off of another Aetna group is not eligible for current RAF promotions.</li> </ul>						
<p><b>Tax Documentation</b></p>	<ul style="list-style-type: none"> <li>▪ <b>For groups 21+ eligible:</b> Quarterly Wage and Tax Statement submission (DE 9C) <b>requirement waived</b> if the employee is on the prior carrier bill. For some groups (e.g., large groups moving to small). Quarterly Wage and Tax Statements will still be required to prove guaranteed issue AB1672.</li> <li>▪ When a company is Doing Business As (DBA), a copy of the Filed Assumed Name Certificate or Business Name Registration (fictitious name or DBA) should be provided, but may not be required.</li> <li>▪ Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status.</li> <li>▪ The employer must submit a copy of the most recently filed DE 9C, which must contain the names, salaries and withholdings for all employees of the employer group, along with a signature of the company representative.</li> <li>▪ In the event that a DE 9C is 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.</li> <li>▪ When a DE 9C or payroll records are submitted:             <ul style="list-style-type: none"> <li>– Employees who have terminated, work part-time or are newly hired should be noted accordingly on the document.</li> <li>– Any handwritten comments added to the document must be signed and dated by the employer.</li> <li>– For newly hired employees not listed on the document, the employer must provide at least two weeks of payroll (which includes hours worked, wages earned and taxes withheld) or a letter from the employer verifying the names of all employees and numbers of hours worked.</li> <li>– 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.</li> <li>– Other documentation may be requested by Underwriting upon receipt and review of sold case documents for final underwriting approval and installation.</li> <li>– Altered legal documentation will not be accepted.</li> <li>– Proprietors, Partners or Officers of the business who do not appear on the DE 9C or payroll must submit one of the following identified documents along with a completed and signed proof of eligibility form:</li> </ul> </li> </ul> <table border="1" data-bbox="389 846 1442 1339"> <tr> <td data-bbox="389 846 868 1003"> <p><b>Business Classification</b> <i>Franchise</i> <i>Limited Liability Company</i> <i>(operating as a Sole Proprietor)</i></p> </td> <td data-bbox="868 846 1442 1003"> <p><b>Documents</b> IRS Form 1040 along with Schedule C (Form 1040) IRS Form 1040 along with Schedule SE (Form 1040) IRS Form 1040 along with Schedule F (Form 1040) IRS 1040 along with Schedule K-1 (Form 1065) Any other documentation the owner would like to provide to determine eligibility</p> </td> </tr> <tr> <td data-bbox="389 1003 868 1140"> <p><b>Partner</b> <i>Partnership</i> <i>Limited Liability Partnership</i></p> </td> <td data-bbox="868 1003 1442 1140"> <p>IRS Form 1065 Schedule K-1 IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) Partnership agreement (including signature page) if established within two years — eligible partners must be listed on agreement Any other documentation the partners would like to provide to determine eligibility</p> </td> </tr> <tr> <td data-bbox="389 1140 868 1339"> <p><b>Corporate Officer</b> <i>Limited Liability Company</i> <i>(operating as C-Corp)</i> <i>C-Corporation</i> <i>Personal Service Corporation</i> <i>S-Corporation</i></p> </td> <td data-bbox="868 1140 1442 1339"> <p>IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) IRS Form 1120 W (C-Corp &amp; 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<p><b>1099 Employees</b></p>	<p>Aetna does not provide coverage to 1099 employees as of October 1, 2010.</p>						
<p><b>Townships and Municipalities</b></p>	<p><b>Townships</b> — A township is generally a small unit that has the status and powers of local government.</p> <p><b>Municipality</b> — 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.</p> <p><b>Underwriting Requirements</b></p> <ul style="list-style-type: none"> <li>▪ Quarterly Wage and Tax Statement (QWTS)</li> <li>▪ 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, but they may be paid via W2. In that case, obtain a copy of their prior year W2.</li> <li>▪ If elected officials are to be covered, request 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.</li> </ul>						

<p><b>Vitalidad Mexico con Aetna</b></p>	<p><b>Eligibility</b></p> <ul style="list-style-type: none"> <li>▪ Vitalidad is available to California employers who have employees who work or live within the Vitalidad service area. (Imperial County is not within a Vitalidad service area).</li> <li>▪ Participation of 65% for groups of 2–50 (excluding valid waivers) for those employers who have employees located in a Vitalidad service area with a minimum of one employee enrolling in Vitalidad.</li> <li>▪ The Vitalidad service area is defined as the Mexican cities of Tecate, Mexicali and Tijuana and includes the following U.S. zip codes that fall within a 50-mile radius:</li> </ul> <table border="1" data-bbox="381 283 1377 997"> <tr><td>91901</td><td>91943</td><td>92013</td><td>92052</td><td>92092</td><td>92121</td><td>92149</td><td>92175</td></tr> <tr><td>91902</td><td>91944</td><td>92014</td><td>92054</td><td>92093</td><td>92122</td><td>92150</td><td>92176</td></tr> <tr><td>91903</td><td>91945</td><td>92018</td><td>92056</td><td>92096</td><td>92123</td><td>92152</td><td>92177</td></tr> <tr><td>91905</td><td>91946</td><td>92019</td><td>92058</td><td>92101</td><td>92124</td><td>92153</td><td>92178</td></tr> <tr><td>91906</td><td>91947</td><td>92020</td><td>92064</td><td>92102</td><td>92126</td><td>92154</td><td>92179</td></tr> <tr><td>91908</td><td>91948</td><td>92021</td><td>92065</td><td>92103</td><td>92127</td><td>92155</td><td>92182</td></tr> <tr><td>91909</td><td>91950</td><td>92022</td><td>92066</td><td>92104</td><td>92128</td><td>92158</td><td>92184</td></tr> <tr><td>91910</td><td>91951</td><td>92023</td><td>92067</td><td>92105</td><td>92129</td><td>92159</td><td>92186</td></tr> <tr><td>91911</td><td>91962</td><td>92024</td><td>92069</td><td>92106</td><td>92130</td><td>92160</td><td>92187</td></tr> <tr><td>91912</td><td>91963</td><td>92025</td><td>92070</td><td>92107</td><td>92131</td><td>92161</td><td>92190</td></tr> <tr><td>91913</td><td>91976</td><td>92026</td><td>92071</td><td>92108</td><td>92132</td><td>92162</td><td>92191</td></tr> <tr><td>91914</td><td>91977</td><td>92027</td><td>92072</td><td>92109</td><td>92133</td><td>92163</td><td>92192</td></tr> <tr><td>91915</td><td>91978</td><td>92029</td><td>92074</td><td>92110</td><td>92134</td><td>92164</td><td>92193</td></tr> <tr><td>91916</td><td>91979</td><td>92030</td><td>92075</td><td>92111</td><td>92135</td><td>92165</td><td>92194</td></tr> <tr><td>91917</td><td>91980</td><td>92033</td><td>92078</td><td>92112</td><td>92136</td><td>92166</td><td>92195</td></tr> <tr><td>91921</td><td>91987</td><td>92036</td><td>92079</td><td>92113</td><td>92137</td><td>92167</td><td>92196</td></tr> <tr><td>91931</td><td>91990</td><td>92037</td><td>92081</td><td>92114</td><td>92138</td><td>92168</td><td>92197</td></tr> <tr><td>91932</td><td>92004</td><td>92038</td><td>92082</td><td>92115</td><td>92139</td><td>92169</td><td>92198</td></tr> <tr><td>91933</td><td>92007</td><td>92039</td><td>92083</td><td>92116</td><td>92140</td><td>92170</td><td>92199</td></tr> <tr><td>91934</td><td>92008</td><td>92040</td><td>92084</td><td>92117</td><td>92142</td><td>92171</td><td></td></tr> <tr><td>91935</td><td>92009</td><td>92046</td><td>92085</td><td>92118</td><td>92143</td><td>92172</td><td></td></tr> <tr><td>91941</td><td>92010</td><td>92049</td><td>92090</td><td>92119</td><td>92145</td><td>92173</td><td></td></tr> <tr><td>91942</td><td>92011</td><td>92051</td><td>92091</td><td>92120</td><td>92147</td><td>92174</td><td></td></tr> </table>	91901	91943	92013	92052	92092	92121	92149	92175	91902	91944	92014	92054	92093	92122	92150	92176	91903	91945	92018	92056	92096	92123	92152	92177	91905	91946	92019	92058	92101	92124	92153	92178	91906	91947	92020	92064	92102	92126	92154	92179	91908	91948	92021	92065	92103	92127	92155	92182	91909	91950	92022	92066	92104	92128	92158	92184	91910	91951	92023	92067	92105	92129	92159	92186	91911	91962	92024	92069	92106	92130	92160	92187	91912	91963	92025	92070	92107	92131	92161	92190	91913	91976	92026	92071	92108	92132	92162	92191	91914	91977	92027	92072	92109	92133	92163	92192	91915	91978	92029	92074	92110	92134	92164	92193	91916	91979	92030	92075	92111	92135	92165	92194	91917	91980	92033	92078	92112	92136	92166	92195	91921	91987	92036	92079	92113	92137	92167	92196	91931	91990	92037	92081	92114	92138	92168	92197	91932	92004	92038	92082	92115	92139	92169	92198	91933	92007	92039	92083	92116	92140	92170	92199	91934	92008	92040	92084	92117	92142	92171		91935	92009	92046	92085	92118	92143	92172		91941	92010	92049	92090	92119	92145	92173		91942	92011	92051	92091	92120	92147	92174	
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<p><b>Vitalidad Plus California con Aetna</b></p>	<ul style="list-style-type: none"> <li>▪ Vitalidad Plus may be chosen in the areas where approved; however, to select SIMNSA as your primary care provider, you must live/work within the 50-mile radius as listed above.</li> </ul>																																																																																																																																																																																								

## 2010/2011 PRODUCT MAPPING SUMMARY

Plan Name	2010/2011 Plan Name	HMO 10	HMO 20	HMO 30	HMO 40	HMO 50	HMO Deductible	HMO Coinsurance	Vitalidad HMO 10	Vitalidad Plus 10/5	Vitalidad Plus 30/10	AVN HMO 10/20	AVN HMO 20/30	AVN HMO 30/40
HMO HRA 750	HMO 30	U	U		D	D	D	D	D	D	D	D	D	D
HMO HRA 1500	HMO 30	U	U		D	D	D	D	D	D	D	D	D	D
HMO 10	HMO 10		D	D	D	D	D	D	D	D	D	D	D	D
HMO 15	HMO 20	U		D	D	D	D	D	D	D	D	D	D	D
HMO 20	HMO 20	U		D	D	D	D	D	D	D	D	D	D	D
HMO 30	HMO 30	U	U		D	D	D	D	D	D	D	D	D	D
HMO 40	HMO 40	U	U	U		D	D	D	D	D	D	D	D	D
HMO 50	HMO 50	U	U	U	U		D	D	D	D	D	D	D	D
HMO Deductible	HMO Deductible	U	U	D	D	D		D	D	D	D	D	D	D
HMO Coinsurance	HMO Coinsurance	U	U	D	D	D	U		D	D	D	D	D	D
Vitalidad HMO 5	Vitalidad HMO 10	U	U	U	D	D	D	D		U	U	D	D	D
Vitalidad HMO 10	Vitalidad HMO 10	U	U	U	D	D	D	D		U	U	D	D	D
Vitalidad Plus 20/5	Vitalidad Plus 10/5	U	U	D	D	D	D	D	D		D	D	D	D
Vitalidad Plus 40/10	Vitalidad Plus 30/10	U	U	D	D	D	D	D	D	U		D	D	D
AVN HMO 10	AVN HMO 10/20	U	D	D	D	D	D	D	D	D	D		D	D
AVN HMO 20	AVN HMO 20/30	U	D	D	D	D	D	D	D	D	D	U		D
AVN HMO 30	AVN HMO 30/40	U	U	D	D	D	D	D	D	D	D	U	U	
AVN HMO 40	AVN HMO 40/50	U	U	D	D	D	D	D	D	D	D	U	U	U
MC 250 90/70	MC 250 90/70	D	D	D	D	D	D	D	D	D	D	D	D	D
MC 250 80/60	MC 250 80/60	D	D	D	D	D	D	D	D	D	D	D	D	D
MC 500 80/60	MC 500 80/60	D	D	D	D	D	D	D	D	D	D	D	D	D
EPO 80/EPO 500	MC 750 80/50/50	U	U	D	D	D	D	D	D	D	D	D	D	D
MC 750 80/50/50	MC 750 80/50/50	D	D	D	D	D	D	D	D	D	D	U	U	D
MC 1000 70/50	MC 1000 70/50	D	D	D	D	D	D	D	D	D	D	U	U	D
MC 1000 80/50/50	MC 1000 80/50/50	D	D	D	D	D	D	D	D	D	D	U	U	D
MC 2000 80/50/50	MC 2000 80/50/50	D	D	D	D	D	D	D	D	D	D	U	U	D
MC 2500 75/50	MC 2500 75/50	U	U	D	D	D	D	D	D	D	D	U	U	D
MC Basic	MC 2500 75/50	U	U	D	D	D	D	D	D	D	D	U	U	D
MC 3500 65/50	MC 3500 65/50	U	U	D	D	D	D	D	D	D	D	U	U	D
MC 10,000 100/50	MC 10,000 100/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HSA 2000 80/50	MC HSA 2000 80/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HSA 3000 100/50	MC HSA 3000 90/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HSA 2300/2500 80/50	MC HSA 2000 80/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HSA 3300 80/50	MC HSA 3500 80/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HRA 3000 80/50	MC HRA 3000 80/50	U	U	U	D	D	D	D	D	D	D	U	U	D
MC HRA 5000 80/50	MC HRA 5000 80/50	U	U	U	D	D	D	D	D	D	D	U	U	D
PPO 500 90/70	PPO 500 90/70	D	D	D	D	D	D	D	D	D	D	D	D	D
PPO 750 80/60	PPO 500 90/70	D	D	D	D	D	D	D	D	D	D	D	D	D

D = Buy down (no medical underwriting required)  
 U = Buy up (medical underwriting required and may be declined)



## LIMITATIONS AND EXCLUSIONS

### MEDICAL

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

### AETNA HMO, DEDUCTIBLE HMO, COINSURANCE HMO, AETNA VALUE NETWORK<sup>SM</sup> HMO, VITALIDAD HMO & VITALIDAD PLUS HMO

- All medical and hospital services not specifically covered, or which are limited or excluded by the plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary, routine patient care costs for members participating in a cancer clinical trial)
- Hearing aids
- Home births

- Immunizations for travel or work\*
- Implantable drugs and certain injectable drugs, including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies, such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in the plan documents
- Non-medically necessary services or supplies
- Orthotics, except as specified in the plan
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents

\*California members are covered for all indicated or medically necessary immunizations.

## AETNA MC, 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
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies, such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in the plan documents
- Non-medically necessary services or supplies
- Orthotics, as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special duty nursing
- Those for or related to treatment of obesity or for diet or weight control

### *Pre-existing conditions exclusion provision*

These plans impose a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to everyone. A pre-existing conditions exclusion means that if an individual 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 six months.

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

If an individual had less than six months of group or three months of individual (including Medicare, Medicaid and Medi-Cal) creditable coverage immediately before the date he or she enrolled, the plan's pre-existing conditions exclusion period will be reduced by the number of days of that prior coverage.

If the individual had no prior creditable coverage within the six months for group or three months for individual prior to his or her enrollment date (either because he or she had no prior coverage or because there was more than a six months of group or three months of individual gap from the date the individual's 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 plan's exclusion period based on your creditable coverage, individuals should provide us a copy of any Certificates of Creditable Coverage they have. Please contact Aetna Member Services at **1-888-802-3862** for PPO and **1-888-702-3862** for HMO for assistance in obtaining a Certificate of Creditable Coverage from prior carrier or if there are 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

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

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

Specific service limitations

- DMO plans: Oral exams (four per year)\*\*
- PPO plans: Oral exams (two routine and two problem-focused per year)

- All plans:
  - Bitewing X-rays (one set per year)\*
  - Complete series X-rays (one set every three years)\*\*
  - Cleanings (two per year)\*
  - Fluoride (one treatment per year; children under 16)\*\*
  - Sealants (one treatment per tooth, every three years on permanent molars; children under 16)\*
  - Scaling and root planing (four quadrants every two years)
  - Osseous surgery (one per quadrant every three years)
- All other limitations and exclusions in the plan documents

### *Pre-existing conditions exclusion provision*

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

\*The frequency limits for preventive services do not apply to DMO plans if needed more frequently due to medical necessity.

## AD&D ULTRA

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

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

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

## SUBMISSION DETAILS AND GUIDELINES

For more information about Aetna's Small Business Solutions, please contact your local Aetna Account Executive 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**

E-mail Address:

**ASGBLCA@Aetna.com**

Overnight Mailing Address:

Aetna Small Group  
Underwriting  
1385 E. Shaw Avenue  
Fresno, CA 93710

Mailing Address:

Aetna Small Group  
Underwriting  
P.O. Box 24004  
Fresno, CA 93779-4004

Effective dates may be the first or fifteenth of the month only. If purchasing a group Medicare plan, only the first of the month effective date is available for the entire group's submission.

All required paperwork must be received by Aetna by the fifth business day after the requested effective date.

### EMPLOYER INFORMATION

#### *Employer Application*

Complete all pages of the application

- Employer signature must be of an officer 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/Cal-COBRA form for any employees currently eligible or enrolled on COBRA/Cal-COBRA.
- Applications will not be accepted more than 90 days from the date signed.
- No altered applications (a new application will be required).
- Statement of Understanding must be completed for all group submissions.

#### *Employer Medicare Application*

- Complete and sign if any employees are electing an Aetna Medicare plan.
- Only first of the month effective dates are available for the entire group's submission.

#### *DE 9C or other applicable tax documents*

- Part-time, terminated, seasonal or temporary employees must be indicated on the wage and tax report.
- For seasonal industries, such as farming or fruit processing, 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 DE 9C. 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 DE 9C, 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 DE 9C, submit a minimum of two weeks' payroll indicating compensation and taxes withheld.

*Premium check made payable to Aetna Health of California Inc.*

- A premium check on company stock for 100% of the first month's Medical, Dental and Life premiums payable to "Aetna Health of California Inc."

OR

- A completed ACH form for electronic payment submission of first month's premium.

*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 Employer 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.

*Medicare information (in addition to items under Employer Information section)*

- Effective date of all plans must be the first of the month.
- Group Medicare enrollment forms.
- Employee Medicare enrollment forms.
- Illustrative rates circled for plan selection.

*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.
- To avoid potential delays in getting your client approved and enrolled, make sure your new case submissions are complete.

# AETNA AVE

*Aetna Avenue® — Your Destination for Small Business Solutions®*

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



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