A world of information right at your fingertips

Small Business Solutions

FOR BUSINESSES WITH 2 TO 50 ELIGIBLE EMPLOYEES

Medical, dental and life

An Employer Guide to Small Business Solutions

California
Effective April 1, 2009

Note: Some RX copay options are pending regulatory approval.

Aetna®

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Choice. Simplicity. Affordability. With Aetna, it's yours.

In the world of small business, there's nothing more critical to a company's success than the health and well-being of its employees. At Aetna, we are committed to putting the member at the center of everything we do — with a new generation of consumer-friendly health care benefits, insurance and related programs designed to give employees the product choices, tools and information they need to lead healthier, more productive lives.

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Health/Dental benefits and health/dental insurance are offered and/or underwritten by Aetna Health of California Inc. and/or Aetna Dental of California Inc. and Aetna Life Insurance Company. Life insurance policies are offered and underwritten by Aetna Life Insurance Company (Aetna).

Aetna offers its Pick-A-Plan portfolio option to California small businesses (2 – 50 eligible employees)

Pick-A-Plan is Aetna Small Group's suite of plans designed specifically with the small employer in mind. These plans provide choice, flexibility and simplicity.

What is the Pick-A-Plan option?

Pick-A-Plan allows employers with two or more enrolled employees to offer just one, two or all plans from Aetna's medical product portfolio to build a customized benefits package for their group.

By offering Pick-A-Plan at initial enrollment, current employees can switch to any plan at the employer's anniversary, without medical underwriting.

If employers didn't select Pick-A-Plan at the initial enrollment with Aetna, employees may have to go through medical review to determine if they qualify for a new plan. If Pick-A-Plan is in place, all new hires will be able to select any plan at the time of enrollment.

Aetna medical plans* explained

Aetna has 14 HMO plans in California.

Aetna's HMO health benefits plans feature:

- Lower out-of-pocket costs
- No claim forms
- Emergency care coverage — anywhere, anytime, 24 hours a day
- Fixed out-of pocket costs for covered services
- No deductible for prescription drugs
- No lifetime dollar maximums
- Direct access to some specialists like Ob/Gyn
- Members coordinate care through a primary care physician (PCP)
- Each covered member of the family may choose his or her own PCP
- Four HMO plan types to choose from (HMO, Value Network HMO, Deductible HMO and HealthFund HMO HRA)
- Vitalidad México con Aetna provides health benefits coverage for those who prefer medical care in Mexico

HMO plan

Health benefits plans are available with copayments ranging from $10 – $40 for physician visits. Members have access to Aetna's full HMO network. Members begin by selecting any PCP from Aetna's participating network of HMO providers. All of the health care professionals meet Aetna's stringent credentialing requirements and have demonstrated their ability to provide quality health care services.

Aetna Value Network℠ HMO plan

Four health benefits plans are available within the Aetna Value Network which is comprised of a subset of Aetna's full HMO network. Aetna Value Network plans offer the same benefits of Aetna's HMO plan, with a premium savings of a select network of providers. See page 9 for a listing of counties where the Aetna Value Network is available.

Aetna Deductible HMO $1000

Aetna's Deductible HMO health benefits plan utilizes the same network as the Aetna HealthFund HMO HRA network (see page 8 for network availability). The Deductible HMO provides additional savings by applying a deductible for certain medical services. This plan allows for such services as primary and specialist care, basic X-ray/lab and prescription drugs to remain at a copayment and not subject to the deductible.

Aetna HealthFund® HMO HRA

The Aetna HealthFund HMO HRA combines the features of a conventional HMO with those of new consumer-directed health plans — including a fund to help members pay for eligible medical expenses. Through this combination, our plan puts the power of consumerism to work for your clients. The Aetna HealthFund HMO includes two parts that work together: an HMO plan and a Health Reimbursement Arrangement (HRA) fund.

Members pay copays, with no deductible applied, for certain services. Copays are not eligible for reimbursements from the member's HRA fund. Copay services include:

- Primary care physician visits;
- Specialist physician visits;
- Urgent care facilities visits; and
- Diagnostic lab and X-ray services.

Deductibles are eligible for reimbursement from the member's HRA fund. Members will need to meet the deductible for the following services:

- Emergency care;
- Inpatient hospital care; and
- Outpatient surgery, home health care, and durable medical equipment.

*HMO, Aetna HealthFund HMO HRA, HMO Deductible, Aetna Value Network HMO, and Vitalidad México con Aetna plans are provided or administered by Aetna Health of California Inc. EPO, MC, PPO and Indemnity are underwritten or administered by Aetna Life Insurance Company. Not all products are available in all California zip codes. For employees residing outside a California service area, an indemnity plan may be offered.

Aetna will offer the in-state portfolio and rating structure to out-of-state employees that live in an out-of-state network area. Out-of-state employees that do not live in an out-of-state network area will be eligible for an in-state indemnity plan. To confirm network availability, call 1-877-249-2472, option 6.

The HealthFund: At the start of each plan year, Aetna will establish a fund which will help members pay eligible out-of-pocket health care expenses that are subject to the HMO deductible. If an employee's fund is spent before the entire HMO deductible is met, the employee will pay the remaining deductible amount. Once the deductible is satisfied, the employee will then pay a copay or coinsurance amount until the HMO plan's out-of-pocket maximum is met. If a member doesn't use the entire fund in a given plan year, the remaining amount is added to next year's fund balance.

Vitalidad México con Aetna℠

Members who prefer to obtain medical care in Mexico and live or work within 50 miles of Tijuana, Mexicali and Tecate (see underwriting guidelines on page 45 for a list of zip codes) are eligible to enroll in a Vitalidad HMO health benefits plan. The 50-mile radius applies to employees and their dependents whose primary residence is either California or Mexico. Employers can be located in any one of several California counties where Aetna currently offers an HMO plan (excluding Imperial County). All care must be accessed through our Vitalidad network except for urgent or emergency care.

EPO (Open Access) plan

The Aetna EPO (Open Access) health insurance plan provides health care benefits through Aetna's wide selection of physicians and health care providers. Members are not required to select a PCP or obtain referrals for specialty care.

- Coverage is limited to network providers.
- No claim forms.
- No PCP selection required.

Managed Choice® (MC) plan

The Aetna MC health insurance plan gives members the freedom to choose any recognized provider or hospital — no referrals are necessary.

- No PCP selection required.
- No referrals required.
- Members can choose any provider from Aetna's network for a covered service.
- Members may visit any out-of-network recognized provider for a covered service.
- For certain plans, members pay an office visit copayment each time they go to a participating specialist or non-specialist physician.

PPO plan

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

- Large provider network.
- No claim forms in-network.
- If members choose a provider from Aetna's network of participating physicians and hospitals, out-of-pocket costs will be lower.
- Deductibles and coinsurance apply.

Consumer-directed health plans

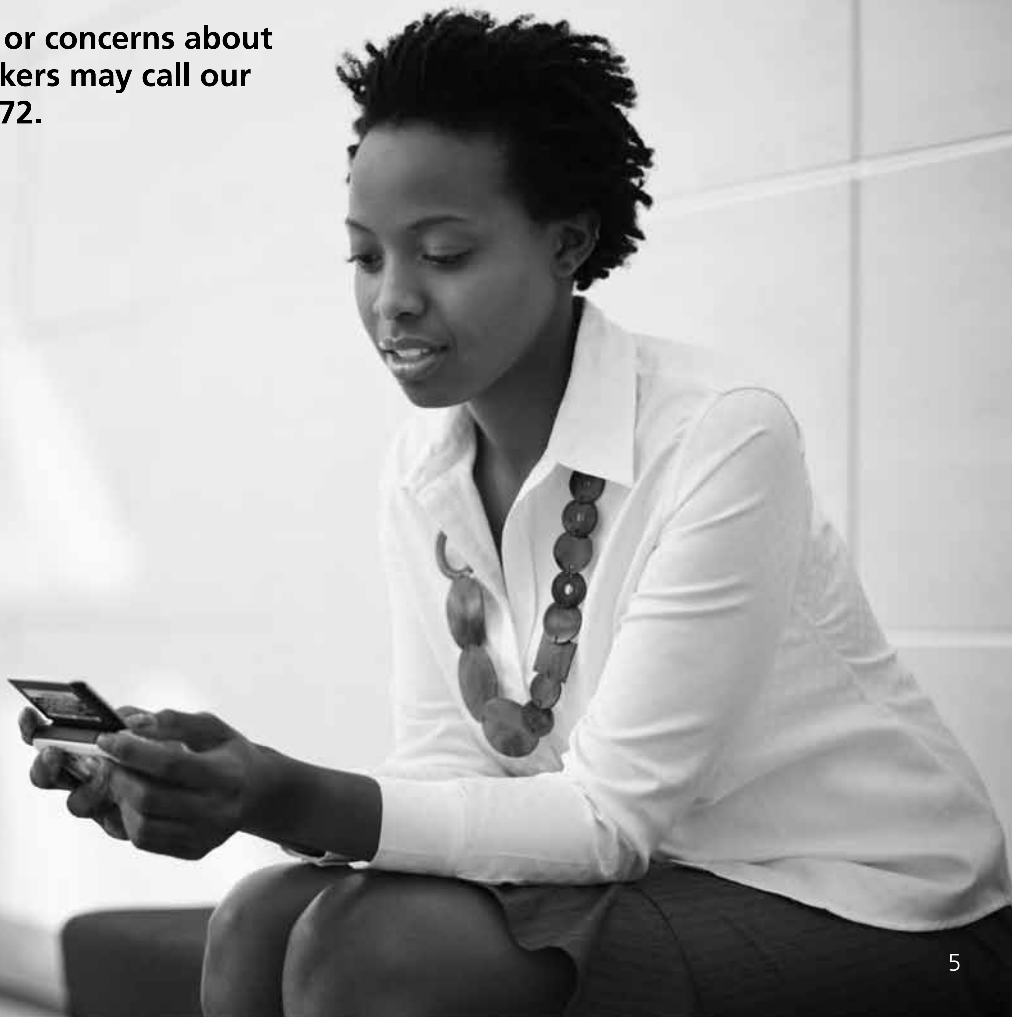
Consumer-directed health plans are high-deductible health plans (HDHP) designed to give individuals greater flexibility and control when purchasing care. Aetna's HDHP's are paired with account-based funds that include health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending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

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

An explanation of coinsurance maximums, out-of-pocket maximums		
MC/EPO/HRA HDHP/PPO	HSA HDHP	HMO/AVN HMO/HMO HRA/Vitalidad HMO/HMO Deductible $1,000
Amounts over allowable charges, copays, failure to precertify penalty, payments for non-SMI mental disorders, substance abuse, Rx (including self-injectables), infertility and DME do not apply towards Coinsurance Maximum and continue to be payable after the maximum is reached.	Amounts over allowable charges and failure to precertify penalty do not apply towards 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		
HMO HRA	HMO/AVN HMO/HMO Deductible/ Vitalidad HMO/MC HSA HDHP/MC HRA HDHP	MC/EPO/PPO
True Integrated Family	Embedded Aggregate	Two-Member Maximum
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.	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.	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.

For any questions about these plans, or concerns about accessing and obtaining services, brokers may call our Broker Support Team at 1-877-249-2472.



A way to manage health and health care expenses

Annual HSA contributions for 2010 are $3,050 per individual/$6,150 per family. Maximums will be adjusted for the cost of living in future years.

An innovative array of products and services for today's employees and employers

While reducing costs is a major objective, consumerism focuses on helping consumers make better choices about their health care. It's about asking questions and learning about options and alternatives. It transforms the once passive "user" of health care to an informed, active, engaged "consumer" of health care. Aetna remains committed to this important new direction in health benefits. The Aetna HealthFund family of consumer-directed health care products and services offers flexibility, choice and convenience for employers and employees.

Health Savings Account (HSA)

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

Health Reimbursement Arrangement (HRA)

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

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

COBRA Administration

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

Section 125 Cafeteria Plans and Section 132 Transit Reimbursement Accounts

Employers can help their employees save money while saving themselves money as well. Employees can reduce their taxable income, and employers can pay less in payroll taxes. There are three ways to save:

Premium Only Plans (POP)

Employees can pay for their portion of the group health insurance expenses on a pretax basis. First year POP fees waived with the purchase of a minimum of $20K in Life.

Flexible Savings Account (FSA)

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

Transit Reimbursement Account (TRA)

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

Administrative fees

Aetna has programs and services available to help administer HSAs, HRAs FSAs and COBRA. To learn more, contact the Broker Support Team at 1-877-249-2472, option 6.

FEE DESCRIPTION	FEE
HSA	
Initial Set-Up	$0
Monthly Fees	$0
POP	
Initial Set-Up*	$150
Renewal	$75
HRA and FSA**	
Initial Set-Up*	
2 – 25 Employees	$350
26 – 50 Employees	$450
51 – 100 Employees	$550
Renewal Fee	50% of the initial set-up fee
Monthly Fees†	$5.00 per participant
Additional Set-Up Fee *for "stacked" plans (those electing an Aetna HRA and FSA simultaneously)*	$150
Participation Fee *for "stacked" participants*	$9.75 per participant
Minimum Fees	
0 – 25 Employees	$10 per month minimum
26 – 299 Employees	$50 per month minimum
TRA	
Annual Fee	$350
Transit Monthly Fees	$4.25 per participant
Parking Monthly Fees	$3.15 per participant
COBRA (Federal)	
Annual Fee, 20-50 employees	$50
Monthly Fee	$0.85 per employee

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

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

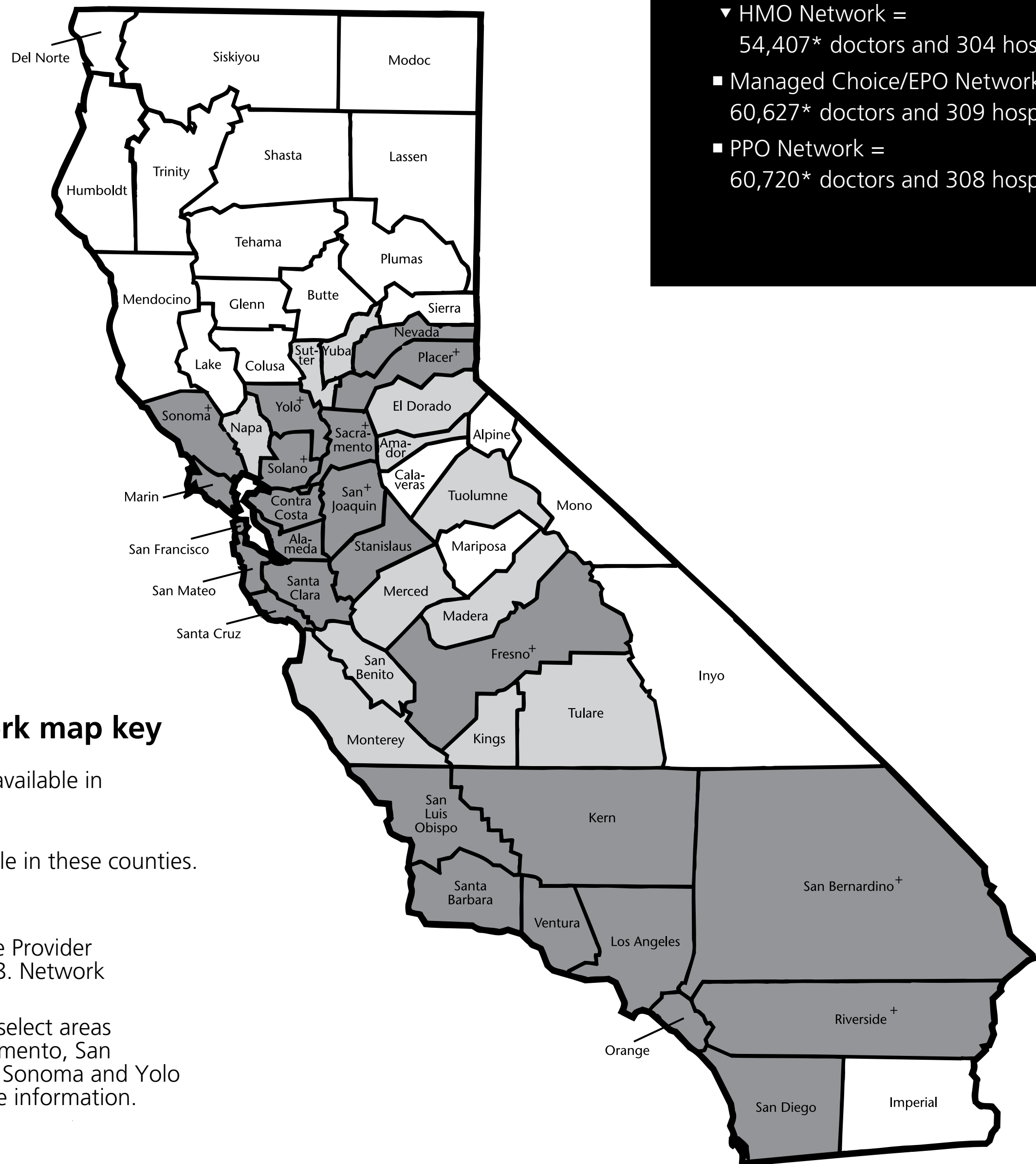
†For HRA, if the employer opts out of Streamline, the fee is increased $1.50 per participant.

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

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

Medical provider network

(HealthFund® HMO HRA/HMO Deductible plan/ HMO/EPO/MC/PPO plans)



Large physician network*

California provider network has more than 60,000 physicians and 300 hospitals.

- HMO Network = 54,407* doctors and 304 hospitals
- Managed Choice/EPO Network = 60,627* doctors and 309 hospitals
- PPO Network = 60,720* doctors and 308 hospitals

Medical provider network map key

- HMO/EPO/MC/PPO plans are available in these counties.
- EPO/MC/PPO plans are available in these counties.

*According to the Aetna Enterprise Provider Database as of November 1, 2008. Network subject to change.

+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 following IPAs are not available to HealthFund HMO HRA or HMO Deductible members:

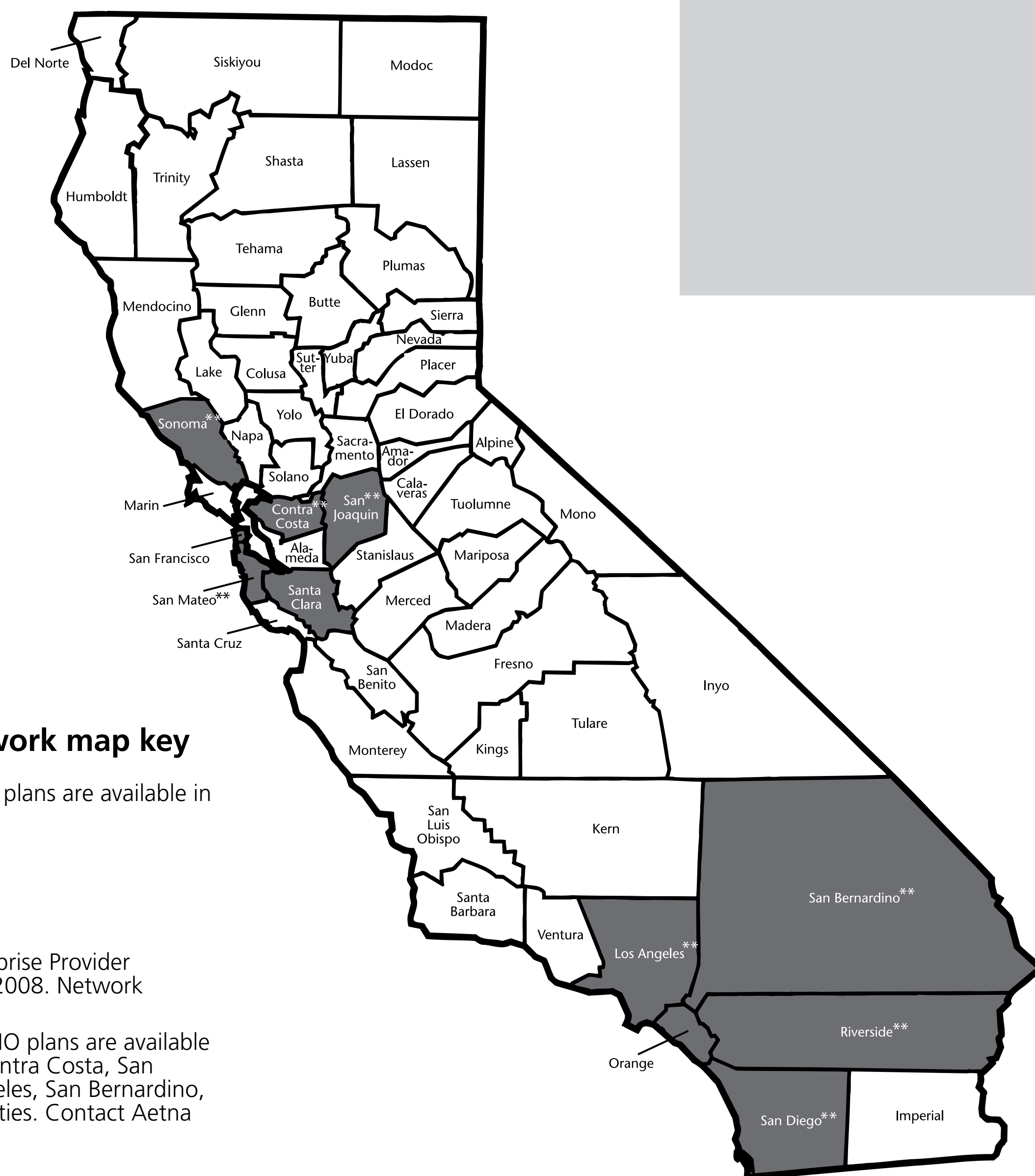
County	IPA
Kern	Independence Medical Group
Los Angeles	All Care Medical Group
Los Angeles	Axminister
Los Angeles	Cedars-Sinai Health Associates
Los Angeles	Cedars-Sinai Medical Care Foundation
Los Angeles	Family Care Specialists IPA, A Medical Group
Los Angeles	Physicians' Healthways Medical Group
Los Angeles	Prudent Medical Care
Los Angeles	Torrance Hospital IPA Medical Group
Orange	Mission Hospital Affiliated Physicians
Orange	St. Joseph Heritage Medical Group
Orange	St. Joseph Hospital Affiliated Physicians
Orange	St. Jude Affiliated Physicians
Orange	St. Jude Heritage Medical Group
Riverside	Riverside Physicians Network
San Diego	Primary Care Associates Medical Group
San Diego	Scripps Clinic Medical Group
San Diego	Scripps Medical Foundation — Mercy Medical Group
San Diego	Scripps Penn Elm
San Diego	Sharp Mission Park Medical Group

Medical provider network

(Aetna Value Network℠ HMO plans)

Physician network*

- Aetna Value Network = 24,526* doctors and 304 hospitals



Medical provider network map key

■ Aetna Value Network HMO plans are available in these counties.

*According to the Aetna Enterprise Provider Database as of November 1, 2008. 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 following Counties, including all zip codes, are included in the Aetna Value Network:

San Francisco
Santa Clara
Orange

The following Counties are included in the Aetna Value Network with the exception of the following zip codes.

Contra Costa County with the following zip code exceptions:

Crockett (94525)
El Cerrito (94530)
El Sobrante (94803, 94820)
Hercules (94547)
Pinole (94564)
Port Costa (94569)
Richmond (94801, 94802, 94804, 94805, 94807, 94808, 94850, 94875)
Rodeo (94572)
San Pablo (94806)

San Joaquin County — all zip codes currently filed for Commercial HMO with the following zip code exceptions:

Clements (95227)
Escalon (95320)
Farmington (95230)
Lodi (95241)
Ripon (95366)
Stockton (95267, 95269, 95296, 95297)
Tracy (95377, 95378, 95391)

Sonoma County — all zip codes currently filed for Commercial HMO with the following zip code exceptions:

Annapolis (95412)
Bodega (94922)
Bodega Bay (94923)
Cloverdale (95425)
Cotati (94931)
Cazadero (95421)
Duncans Mills (95430)
Eldridge (95431)
Geyserville (95441)
Graton (95444)
Guerneville (95446)
Healdsburg (95448)
Jenner (95450)
Kenwood (95452)
Petaluma (94953, 94955, 94999)
Rohnert Park (94926, 94927)
Santa Rosa (95402, 95403, 95406, 95409)
The Sea Ranch (95497)
Rio Nido, Sebastopol (95471-73)
Sonoma (95476)
Stewarts Point (95480)
Valley Ford (94972)
Villa Grande (95486)
Vineburg (95487)
Windsor (95492)

Los Angeles County — with the following zip code exceptions:

Avalon (90704)
Littlerock (93543)
Llano (93544)
Pearblossom (93553)

Riverside County — with the following zip code exceptions:

Anza (92539)
Aguanga (92536)
Mecca (92254)
Thermal (92274)
White Water (92282)

San Bernardino County — with the following zip code exceptions:

Amboy (92304)
Cadiz (92319)
Daggett (92327)
Fawnskin (92333)
Fort Irwin (92310)
Helendale (92342)
Hinkley (92347)
Joshua Tree (92252)
Landers (92285)
Lucerne Valley (92356)
Ludlow (92338)
Morongo Valley (92256)
Newberry Springs (92365)
Phelan (92329)
Pioneertown (92268)
Red Mountain (93558)
Sugarloaf (92386)
Trona (93562 & 93592)
Twentynine Palms (92277, 92278)
Yermo (92398)
Yucca Valley (92284, 92286)

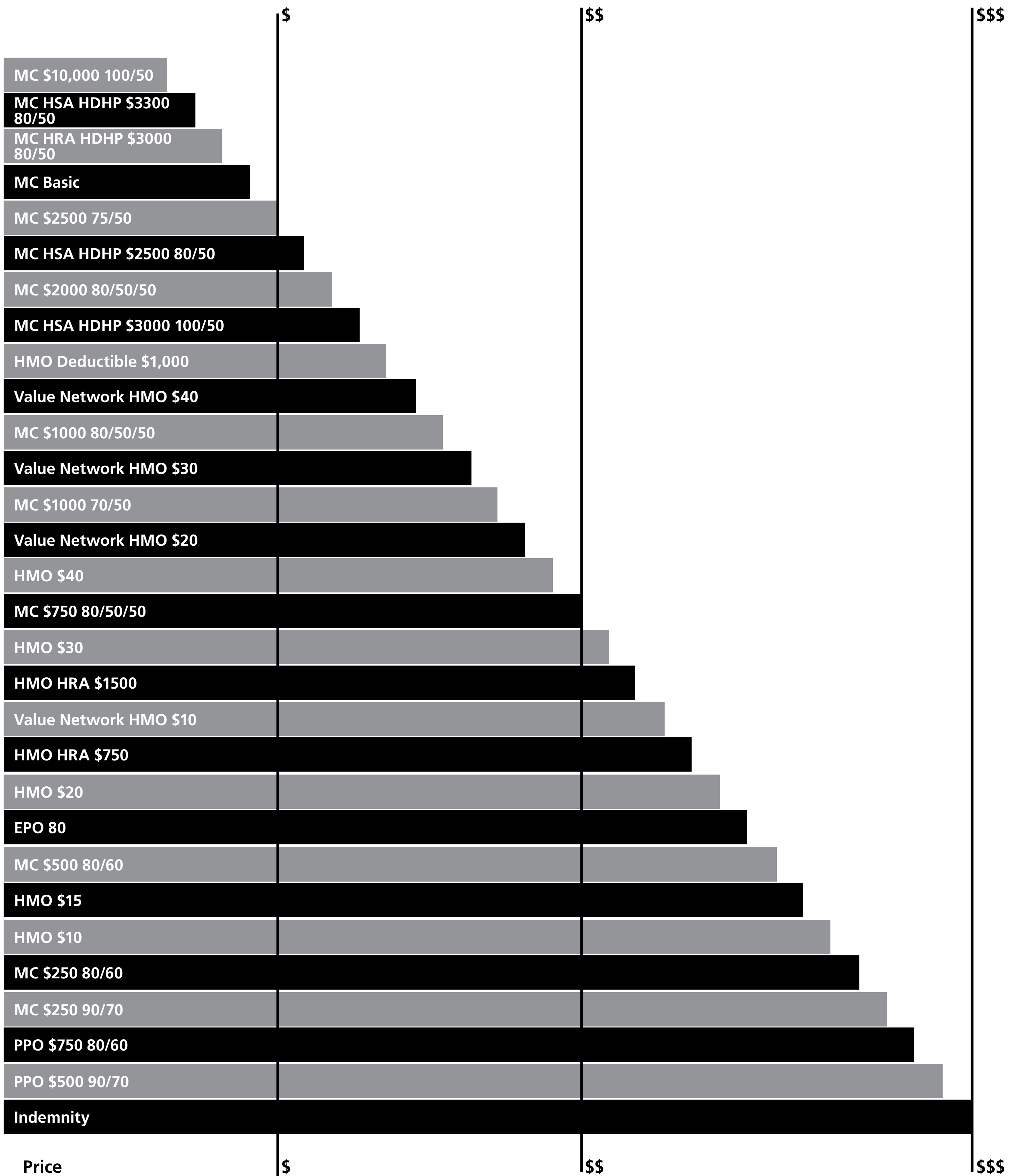
San Diego County — with the following zip code exceptions:

Borrego Springs (92004)
Boulevard (91905)
Camp Pendleton (92055)
Campo (91906)
Guatay (91931)
Jacumba (91934)
Mount Laguna (91948)
Palomar Mountain (92060)
Pine Valley (91962)
Potrero (91963 & 91990)
Ranchita (92066)
Tecate (91980 & 91987)
Young America (91991-91995)
Warner Springs (92086)

San Mateo County — with the following zip code exceptions:

Pescadero (94060)

Plan type and value by price*



*Average prices may vary by county.

PLAN NAME	HealthFund HMO HRA $750	HealthFund HMO HRA $1,500
PCP/Referrals Required	Yes	Yes
MEMBER BENEFITS	In-Network	In-Network
HRA Fund Amount	$250 Employee / $500 Family	$500 Employee / $1,000 Family
Fund Administration	The Fund will be used to pay for member responsibility for services that are subject to the deductible. Once the deductible is met, assuming the Fund has been exhausted, the underlying medical plan provides coverage. If a Fund balance still exists, the Fund will pay the member's responsibility until the out-of-pocket maximum has been reached or the Fund has been exhausted, whichever comes first.	
Fund Rollover	Any remaining fund amount at the end of the plan year is rolled over into next year's fund amount.	
Eligible Fund Expenses	The Fund pays expenses subject to deductible. Expenses not payable under the Fund are any plan limits, any non-covered expenses, services covered at 100% and physician services copays.	
Plan Year Deductible (Applies to Out-of-Pocket-Maximum)	$750 Individual / $1,500 Family	$1,500 Individual / $3,000 Family
	The Family Deductible can be met by a combination of family members or by a single individual within the family. The Deductible applies to all applicable covered services except primary care and specialist physician office visits, preventive care services, diagnostic and X-ray, urgent care services and prescriptions drugs. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the Plan Year. There is no Individual Deductible to satisfy within the Family Deductible.	
Plan Year Out-of-Pocket Maximum (Includes deductible)	$2,000 Individual / $4,000 Family	$3,500 Individual / $7,000 Family
	Only those out-of-pocket expenses resulting from the application of deductible and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once the Family Out-of-Pocket is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the Plan Year. There is no Individual Out-of-Pocket Maximum to satisfy within the Family Out-of-Pocket Maximum.	
Lifetime Maximum Benefit	Unlimited	Unlimited
Primary Physician Office Visit	$25 copay; deductible waived	$40 copay; deductible waived
Specialist Office Visit	$25 copay; deductible waived	$40 copay; deductible waived
Chiropractic Services (20 visits per Plan year)	$15 copay; deductible waived	$15 copay; deductible waived
Outpatient Lab & X-ray	$25 copay; deductible waived	$40 copay; deductible waived
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	$100 copay; deductible waived	$100 copay; deductible waived
Physical Exams – Adult	$25 copay; deductible waived	$40 copay; deductible waived
Well-Child Exams	$25 copay; deductible waived	$40 copay; deductible waived
Routine GYN	$25 copay; deductible waived	$40 copay; deductible waived
Inpatient Hospital	$250 copay; after deductible	$500 copay; after deductible
Outpatient Surgery OP Hospital Department	$200 copay; after deductible	$250 copay; after deductible
Outpatient Surgery Freestanding Facility	$100 copay; after deductible	$125 copay; after deductible
Emergency Services (Copay waived if admitted)	$100 copay; after deductible	$100 copay; after deductible
Urgent Care	$50 copay; deductible waived	$50 copay; deductible waived
Prescription Drugs* Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$20 / $40 / $60; deductible waived	$20 / $40 / $60; deductible waived
Self-Injectable Drugs	Covered Under Medical	Covered Under Medical

*For HMO, the three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Generic and Brand Non-Formulary.

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

Member 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 48-49.

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

*For HMO, the three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Generic and Brand Non-Formulary.

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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 48-49.

PLAN NAME	Value Network HMO $10	Value Network HMO $20	Value Network HMO $30	Value Network HMO $40
PCP/Referrals Required	Yes	Yes	Yes	Yes
MEMBER BENEFITS	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Plan Coinsurance	N/A	N/A	N/A	N/A
Calendar Year Deductible	None	None	None	None
Calendar Year Copay Maximum (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
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Primary Physician Office Visit	$10 copay	$20 copay	$30 copay	$40 copay
Specialist Office Visit	$10 copay	$20 copay	$30 copay	$40 copay
Chiropractic Services (20 visits per calendar year)	$15 copay	$15 copay	$15 copay	$15 copay
Outpatient Lab & X-ray	$10 copay	$20 copay	$30 copay	$40 copay
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	$10 copay	$20 copay	$30 copay	$40 copay
Outpatient Physical, Occupational (20 visits per calendar year)	$10 copay	$20 copay	$30 copay	$40 copay
Physical Exams – Adult	$10 copay	$20 copay	$30 copay	$40 copay
Well-Child Exams	$10 copay	$20 copay	$30 copay	$40 copay
Routine GYN	$10 copay	$20 copay	$30 copay	$40 copay
Inpatient Hospital	$100 copay per day up to 3-days per admit	$400 copay per day up to 3-days per admit	$600 copay per day up to 3-days per admit	$800 copay per day up to 3-days per admit
Outpatient Surgery OP Hospital Department	$100 copay	$200 copay	$300 copay	$400 copay
Outpatient Surgery Freestanding Facility	No Charge	$100 copay	$150 copay	$200 copay
Emergency Services (Copay waived if admitted)	$100 copay	$100 copay	$100 copay	$100 copay
Urgent Care	$50 copay	$50 copay	$50 copay	$50 copay
Prescription Drugs* Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$20 / $40 / $60	$20 / $40 / $60	$20 / $40 / $60	$20 / $40 / $60
Self-Injectable Drugs	Covered Under Medical	Covered Under Medical	Covered Under Medical	Covered Under Medical

*For HMO, the three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Generic and Brand Non-Formulary.
Some benefits are subject to age and frequency schedules, limitations or visit maximums.
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 48-49.

PLAN NAME	Vitalidad HMO $5	Vitalidad HMO $10
PCP/Referrals Required	Yes	Yes
MEMBER BENEFITS	In-Network	In-Network
Calendar Year Deductible	None	None
Calendar year Copay Maximum (Certain payments do not apply)	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family
Lifetime Maximum Benefit	Unlimited	Unlimited
Primary Physician Office Visit	$5 copay	$10 copay
Specialist Office Visit	$5 copay	$10 copay
Routine Physical Exams	No charge	No charge
Well-Child Exams	No charge	No charge
Routine GYN	No charge	No charge
Outpatient Lab & X-ray	No charge	No charge
Inpatient Hospital	No charge	$100 copay per day up to 7-days per admit
Outpatient Surgery	No charge	No charge
Emergency Services (In SIMNSA Network)	$10 copay	$20 copay
Emergency Services (Out of SIMNSA Network)	$100 copay	$100 copay
Ambulance (In SIMNSA Network)	No charge	No charge
Ambulance (Out of SIMNSA Network)	$50 copay	$50 copay
Urgent Care (In SIMNSA Network)	$10 copay	$20 copay
Urgent Care (Out of SIMNSA Network)	$35 copay	$35 copay
Prescription Drugs (In SIMNSA Network)	$5 Generic and Brand	$10 Generic and Brand
Prescription Drugs (Out of SIMNSA Network / Closed Formulary) Closed Formulary is based on medications related to an Emergency Room or Urgent Care visit.	$5 Generic / $15 Brand	$10 Generic / $20 Brand
Mail Order Prescription Drugs	Not Covered	Not Covered

For this 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**.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

The dollar amount copayments indicate what the member is required to pay.

For a summary list of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	EPO 80 (Open Access)
PCP/Referrals Required	No
MEMBER BENEFITS	In-Network
Plan Coinsurance	80%
Calendar Year Deductible	None
Calendar Year Coinsurance Maximum (Certain payments do not apply)	$4,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum
Lifetime Maximum Benefit	$5,000,000
Primary Physician Office Visit	$20 copay
Specialist Office Visit	$40 copay
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	$10 copay
Walk-In Clinics	$20 copay
Outpatient Lab & X-ray	No charge
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	80%
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year)	$40 copay
Physical Exams – Adult	$20 copay
Well-Child Exams	$20 copay
Routine GYN	$20 copay
Inpatient Hospital	80%
Outpatient Surgery Facility OP Hospital Department	$300 copay
Outpatient Surgery Facility Freestanding Surgical Facility	$100 copay
Outpatient Surgery Professional Charges	80%
Emergency Services (Copay waived if admitted)	80% after $100 copay
Urgent Care	$50 copay
Prescription Drugs* Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$15 / $40 / $50
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%

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

The dollar amount copayments indicate what the member is required to pay and the percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC $250 90/70*		MC $250 80/60*	
PCP/Referrals Required	No	NA	No	NA
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	90%	70%	80%	60%
Calendar Year Deductible	$250 per member	$250 per member	$250 per member	$250 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	$3,000 per member	$6,000 per member	$3,500per member	$7,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	$5,000,000		$5,000,000	
Primary Physician Office Visit	$15 copay; deductible waived	70%	$20 copay; deductible waived	60%
Specialist Office Visit	$15 copay; deductible waived	70%	$20 copay; deductible waived	60%
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	$15 copay; deductible waived	Not Covered	$20 copay; deductible waived	Not Covered
Outpatient Lab & X-ray	No Charge	70%	No Charge	60%
Outpatient Complex Imaging (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
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%	60%; Aetna pays up to $25 per visit
Physical Exams – Adult	$15 copay; deductible waived	70%	$20 copay; deductible waived	60%
Well-Child Exams	$15 copay; deductible waived	70%	$20 copay; deductible waived	60%
Routine GYN	$15 copay; deductible waived	70%	$20 copay; deductible waived	60%
Inpatient Hospital	90%	70% after $250 copay per admission	80%	60% after $250 copay per admission
Outpatient Surgery OP Hospital Department	80%	60% after $150 copay per surgery	70%	50% after $150 copay per surgery
Outpatient Surgery Freestanding Facility	90%; deductible waived	70% after $150 copay per surgery	80%; deductible waived	60% after $150 copay per surgery
Emergency Services (Copay waived if admitted)	90% after $100 copay	Paid as in-network	80% 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** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$10 / $25 / $50	Not Covered	$15 / $40 / $50	Not Covered
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%; deductible waived	Not Covered	70%; deductible waived	Not Covered

*Payment for out-of-network professional care is determined based upon the lowest of the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in the plan documents as "reasonable". Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC $500 80/60*		MC $1,000 70/50*	
PCP/Referrals Required	No	NA	No	NA
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	$5,000,000		$5,000,000	
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	$35 copay; deductible waived	60%	$25 copay; deductible waived	50%
Well-Child Exams	$35 copay; deductible waived	60%	$25 copay; deductible waived	50%
Routine GYN	$35 copay; deductible waived	60%	$25 copay; deductible waived	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** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$15 / $40 / $50	Not Covered	$15 / $40 / $50	Not Covered
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%; deductible waived	Not Covered	70%; deductible waived	Not Covered

*Payment for out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC $750 80/50/50*		MC $1,000 80/50/50*		MC $2,000 80/50/50*	
PCP/Referrals Required	No	NA	No	NA	No	NA
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	80% Professional 50% Facility	50%	80% Professional 50% Facility	50%	80% Professional 50% Facility	50%
Calendar Year Deductible	$750 per member		$1,000 per member	$1,000 per member	$2,000 per member	$2,000 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	$5,000 per member	$10,000 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum		Two-Member Maximum	
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%
Specialist Office Visit	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%	$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	$10 copay; deductible waived	Not Covered
Walk-In Clinics	$25 copay; deductible waived	Not Covered	$25 copay; deductible waived	Not Covered	$25 copay; deductible waived	Not Covered
Outpatient Lab & X-ray	No Charge	50%	No Charge	50%	No Charge	50%
Outpatient Complex Imaging (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	50%	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	80%	50%; Aetna pays up to $25 per visit
Physical Exams – Adult	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%
Well-Child Exams	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%
Routine GYN	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%	$25 copay; deductible waived	50%
Inpatient Hospital	80% Professional 50% Facility	50%; Aetna pays up to $750 per day	80% Professional 50% Facility	50%; Aetna pays up to $750 per day	80% Professional 50% Facility	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	70% Professional 50% Facility	50%; Aetna pays up to $400 per surgery	70% Professional 50% Facility	50%; Aetna pays up to $400 per surgery
Outpatient Surgery Freestanding Facility	80% Professional 50% Facility	50%; Aetna pays up to $400 per surgery	80% Professional 50% Facility	50%; Aetna pays up to $400 per surgery	80% Professional 50% Facility	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	80% Professional 50% Facility after $100 copay	Paid as in-network	80% Professional 50% Facility 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	$50 copay; deductible waived	$50 copay; deductible waived
Prescription Drugs** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$15 / $40 / $50	Not Covered	$15 / $40 / $50	Not Covered	$15 / $40 / $50	Not Covered
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%; deductible waived	Not Covered	70%; deductible waived	Not Covered	70%; deductible waived	Not Covered

*Payment for out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC $2,500 75/50*		MC Basic*		MC $10,000 100/50*	
PCP/Referrals Required	No	NA	No	NA	No	NA
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	75%	50%	80%	50%	100%	50%
Calendar Year Deductible	$2,500 per member		$2,000 per member	$2,000 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	$3,000 per member	$5,000 per member	$0 Individual $0 Family	Unlimited
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum		Embedded Aggregate	
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	$25 copay; deductible waived	50%	$20 copay; deductible waived**	Not Covered	$15 copay; deductible waived	50%
Specialist Office Visit	$25 copay; deductible waived	50%	$20 copay; deductible waived**	Not Covered	100%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	$10 copay; deductible waived	Not Covered	Not Covered	Not Covered	$15 copay; deductible waived	Not Covered
Walk-In Clinics	$25 copay; deductible waived	Not Covered	Not Covered	Not Covered	$15 copay; deductible waived	Not Covered
Outpatient Lab & X-ray	75%	50%	$20 copay; deductible waived; limited to $300 per member per calendar year	Not Covered	$15 copay; deductible waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	75%	50%; Aetna pays up to $800 per service	Not Covered	Not Covered	100%	50%; Aetna pays up to $800 per service
Outpatient Physical, Occupational and Chiropractic Therapy (24 visits per calendar year IN and OON combined)	75%	50%; Aetna pays up to $25 per visit	$20 copay; deductible waived**	Not Covered	100%	50%; Aetna pays up to $25 per visit
Physical Exams – Adult	$25 copay; deductible waived	50%	$20 copay; deductible waived**	Not Covered	$15 copay; deductible waived	50%
Well-Child Exams	$25 copay; deductible waived	50%	$20 copay; deductible waived**	Not Covered	$15 copay; deductible waived	50%
Routine GYN	$25 copay; deductible waived	50%	$20 copay; deductible waived**	Not Covered	$15 copay; deductible waived	50%
Inpatient Hospital	75%	50%; Aetna pays up to $750 per day	80%	50%; Aetna pays up to $750 per day	100%	50%; Aetna pays up to $750 per day
Outpatient Surgery OP Hospital Department	75%	50%; Aetna pays up to $400 per surgery	70% after $150 copay per surgery	50%; Aetna pays up to $400 per surgery	100%	50%; Aetna pays up to $400 per surgery
Outpatient Surgery Freestanding Facility	75%	50%; Aetna pays up to $400 per surgery	80%	50%; Aetna pays up to $400 per surgery	100%	50%; Aetna pays up to $400 per surgery
Emergency Services (Copay waived if admitted)	75% after $100 copay	Paid as in-network	80% after $100 copay	Paid as in-network	100%	Paid as in-network
Urgent Care	$50 copay; deductible waived	$50 copay; deductible waived	Not Covered	Not Covered	100%	100%
Prescription Drugs*** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$20 / $40 / $70	Not Covered	$15 Generic / 50% Brand; Limited to $1,000 per member per calendar year	Not Covered	$20 / $40 / $70; deductible waived	Not Covered
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%; deductible waived	Not Covered	Not Covered	Not Covered	70%; deductible waived	Not Covered

*Payment for out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

**This plan provides limited benefits only and does not constitute a comprehensive insurance plan. As such, it may not cover all of the expenses associated with your health care needs. Office visits are limited to three per member per calendar year for all types of office visits combined (primary physician, specialist physician, preventive care, chiropractic, PT/OT/ST, mental health). Routine lab and x-rays provided by the provider during a covered office visit and billed with the office visit is included in the office visit copay. Preventive care (routine physicals, routine child exams, mammograms and routine GYN) are included in the three office visit benefit. If the member chooses not to use any/all of his or her three office visits for preventive care, preventive care is still covered at the plan coinsurance after the deductible.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC HSA Compatible HDHP $3,000 100/50*		MC HSA Compatible HDHP $2,500 80/50*		MC HSA Compatible HDHP $3,300 80/50*	
PCP/Referrals Required	No	NA	No	NA	No	NA
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Coinsurance	100%	50%	80%	50%	80%	50%
Calendar Year Deductible	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family	$2,500 Individual $5,000 Family		$3,300 Individual $6,600 Family	
Calendar Year Out of Pocket Maximum (Deductible and certain payments do not apply)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	$1,700 Individual $3,400 Family	$2,700 Individual $5,400 Family	$1,700 Individual $3,400 Family	$2,700 Individual $5,400 Family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate		Embedded Aggregate		Embedded Aggregate	
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000	
Primary Physician Office Visit	100%	50%	80%	50%	80%	50%
Specialist Office Visit	100%	50%	80%	50%	80%	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	100%	Not Covered	80%	Not Covered	80%	Not Covered
Walk-In Clinics	100%	Not Covered	80%	Not Covered	80%	Not Covered
Outpatient Lab & X-ray	100%	50%	80%	50%	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	100%	50%; Aetna pays up to $800 per service	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)	100%	50%; Aetna pays up to $25 per visit	80%	50%; Aetna pays up to $25 per visit	80%	50%; Aetna pays up to $25 per visit
Physical Exams – Adult	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%
Well-Child Exams	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%
Routine GYN	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%	$15 copay; deductible waived	50%
Inpatient Hospital	100%	50%; Aetna pays up to $750 per day	80%	50%; Aetna pays up to $750 per day	80%	50%; Aetna pays up to $750 per day
Outpatient Surgery OP Hospital Department	100%	50%; Aetna pays up to $400 per surgery	70% after $150	50%; Aetna pays up to $400 per surgery	70% after $150	50%; Aetna pays up to $400 per surgery
Outpatient Surgery Freestanding Facility	100%	50%; Aetna pays up to $400 per surgery	80%	50%; Aetna pays up to $400 per surgery	80%	50%; Aetna pays up to $400 per surgery
Emergency Services (Copay waived if admitted)	100%	Paid as in-network	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	100%	50%	80%	50%	80%	50%
Prescription Drugs** Retail: per 30-day supply Mail Order: two times retail copay, 31 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
Self-Injectable Drugs (Including retail and mail order)	70% after Integrated Medical / Rx Deductible	Not Covered	70% after Integrated Medical / Rx Deductible	Not Covered	70% after Integrated Medical / Rx Deductible	Not Covered

*Payment for out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	MC HRA HDHP $3,000 80/50*	
PCP/Referrals Required	No	NA
MEMBER BENEFITS	In-Network	Out-of-Network
Plan Coinsurance	80%	50%
Calendar Year Deductible	$3,000 Individual $6,000 Family	
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Deductible and Coinsurance Maximum Accumulation	Embedded Aggregate	
Lifetime Maximum Benefit	$5,000,000	
Primary Physician Office Visit	$20 copay; deductible waived**	50%
Specialist Office Visit	$20 copay; deductible waived**	50%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	$10 copay; deductible waived	Not Covered
Walk-In Clinics	$20 copay; deductible waived**	Not Covered
Outpatient Lab & X-ray	80%	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans; precertification required)	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
Physical Exams – Adult	$20 copay; deductible waived**	50%
Well-Child Exams	$20 copay; deductible waived**	50%
Routine GYN	$20 copay; deductible waived**	50%
Inpatient Hospital	80%	50%; Aetna pays up to $750 per day
Outpatient Surgery OP Hospital Department	80%	50%; Aetna pays up to $400 per surgery
Outpatient Surgery Freestanding Facility	80%	50%; Aetna pays up to $400 per surgery
Emergency Services (Copay waived if admitted)	80%	Paid as in-network
Urgent Care	80%	80%
Prescription Drugs*** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$20 / $40 / $70 after Integrated Medical / Rx Deductible	Not Covered
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70% after Integrated Medical / Rx Deductible	Not Covered

*Payment for out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

**The first four office visits per member per calendar year are paid with a copay for all types of visits combined (primary physician, specialist physician and preventive care). Any visit over this limit are covered at plan deductible and coinsurance.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

PLAN NAME	PPO $500 90/70*		PPO $750 80/60**		Indemnity*
PCP/Referrals Required	No	NA	No	NA	No
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Plan Coinsurance	90%	70%	80%	60%	80%
Calendar Year Deductible	$500 per member	$500 per member	$750 per member		$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	$4,000 per member	$8,000 per member	$4,500 per member	$9,000 per member	$3,500 per member
Deductible and Coinsurance Maximum Accumulation	Two-Member Maximum		Two-Member Maximum		Two-Member Maximum
Lifetime Maximum Benefit	$5,000,000		$5,000,000		$5,000,000
Primary Physician Office Visit	$15 copay; deductible waived	70%	$25 copay; deductible waived	60%	80%
Specialist Office Visit	$30 copay; deductible waived	70%	$50 copay; deductible waived	60%	80%
Primary and Specialist Physician E-Visit (Register at www.relayhealth.com)	$10 copay; deductible waived	Not Covered	$10 copay; deductible waived	Not Covered	Not Covered
Walk-In Clinics	$15 copay; deductible waived	Not Covered	$25 copay; deductible waived	Not Covered	80%
Outpatient Lab & X-ray	No Charge	70%	No Charge	60%	80%
Outpatient Complex Imaging (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	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%	60%; Aetna pays up to $25 per visit	80%
Physical Exams – Adult	$15 copay; deductible waived	70%	$25 copay; deductible waived	60%	80%
Well-Child Exams	$15 copay; deductible waived	70%	$25 copay; deductible waived	60%	80%
Routine GYN	$15 copay; deductible waived	70%	$25 copay; deductible waived	60%	80%
Inpatient Hospital	90% after $250 copay per admission	70% after $250 copay per admission	80%	60% after $250 copay per admission; Aetna pays up to $750 per day	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 $150 copay	50% after $150 copay per surgery; Aetna pays up to $400 per surgery	70% after $250 copay per surgery
Outpatient Surgery Freestanding Facility	90%	70% after $150 copay per surgery	80%	60% after $150 copay per surgery; Aetna pays up to $400 per surgery	80%
Emergency Services (Copay waived if admitted)	90% after $100 copay	Paid as in-network	80% after $100 copay	Paid as in-network	80%
Urgent Care	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	$50 copay; deductible waived	80%
Prescription Drugs*** Retail: per 30-day supply Mail Order: two times retail copay, 31 to 90 day supply	$15 / $40 / $50	Not Covered	$15 / $40 / $50	Not Covered	$10 / $25 / $50 after $150 brand and brand non-formulary deductible
Self-Injectable Drugs (Including retail and mail order) Does not accumulate toward Coinsurance Maximum (Excludes insulin)	70%; deductible waived	Not Covered	70%; deductible waived	Not Covered	70%; deductible waived

*Payment for out-of-network professional care is determined based upon the lowest of the provider's usual charge for furnishing it or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in the plan documents as "reasonable". Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule.

**Payment for out-of-network care is determined based upon the negotiated charge that would apply is such services or supplies were received from an In-Network (or Preferred provider). These charges are referred to in your plan documents as "recognized" charges.

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

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 amounts indicate what Aetna is required to pay.

Some benefits are subject to age and frequency schedules, limitations or visit maximums.

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

For a summary of Limitations and Exclusions, refer to pages 48-49.

Aetna dental benefits and insurance plans

With a variety of plan options to choose from, employers will now be able to offer employees a dental plan to meet their needs, with rates that will give them a reason to smile. Choose from the dental plan that works best from among eight plan options consisting of various DMO and PPO plan designs and packages.

The Mouth Matters℠

More than 164 million work hours are lost each year due to dental diseases and visits.[1] Research also shows that more than 90 percent of all medical illnesses are detectable in the mouth and that 75 percent of people over the age of 35 have periodontal (gum) disease.[2] Untreated oral diseases can have a big impact on the quality of life. This means that a dentist may be the first health care provider to diagnose a health problem. Aetna is proud to offer our Aetna Dental/Medical Integration℠ (DMI) program at no additional charge to plan sponsors that have both medical and dental coverages with Aetna. Our DMI program focuses on those who are pregnant or have diabetes, coronary artery disease (heart disease) or cerebrovascular disease (stroke) and have not had a recent dental visit. Using a variety of outreach methods, 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. Call your Aetna account representative for more details.

Dental Maintenance Organization (DMO®) benefits plan

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 can 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) dental insurance plan

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

PPO Max dental insurance plan

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

Freedom-of-Choice plan design

Get maximum flexibility with our two-in-one dental plan design. The Freedom-of-Choice plan design provides the administrative ease of one plan, yet members get to choose between the DMO benefits and PPO insurance plans on a monthly basis. 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 design

In the Dual Option plan design, the DMO must be packaged with any one of the PPO plans. Employees can choose between the DMO and PPO offerings at annual enrollment. Please note, this Dual Option is not available for Voluntary plan designs.

Voluntary Dental options

The Voluntary Dental options provide 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.

Dental waiting period

A dental waiting period may be waived based on the employer's prior group coverage; this does not apply to Voluntary plans.

[1]U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion; Resource Library Fact Sheet "Oral Health for Adults," December 2006.

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

DMI may not be available in all states.

CALIFORNIA 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	DMO Plus (Plan 58)	Freedom-of-Choice Basic Monthly selection between DMO and PPO	
	Plan 42[2]	Fixed Copay DMO Plan 58[2]	Fixed Copay DMO Plan 53[2]	PPO Plan 100/60/40
Office Visit Copay	$10	$5	$5	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	None	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited	$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	Per schedule	No Charge	No Charge	100%
Comprehensive oral exam	Per schedule	No Charge	No Charge	100%
Problem-focused oral exam	Per schedule	No Charge	No Charge	100%
X-rays				
Bitewing — single film	Per schedule	No Charge	No Charge	100%
Complete series	Per schedule	No Charge	No Charge	100%
Preventive Services				
Adult Cleaning	Per schedule	No Charge	$8	100%
Child Cleaning	Per schedule	No Charge	$7	100%
Sealants — per tooth	Per schedule	$5	$8	100%
Fluoride application — child	Per schedule	No Charge	No Charge	100%
Space maintainers — fixed	Per schedule	$60	$65	100%
Basic Services				
Amalgam filling — 2 surfaces	Per schedule	No Charge	$24	60%
Resin filling — 2 surfaces, anterior	Per schedule	No Charge	$35	60%
Oral Surgery				
Extraction — exposed root or erupted tooth	Per schedule	No Charge	$15	60%
Extraction of impacted tooth — soft tissue	Per schedule	$46	$60	60%
Major Services[1]				
Complete upper denture	Per schedule	$275	$300	40%
Partial upper denture (resin base)	Per schedule	$275	$300	40%
Crown — Porcelain with noble metal[3]	Per schedule	$210	$260	40%
Pontic — Porcelain with noble metal[3]	Per schedule	$210	$260	40%
Inlay — Metallic (3 or more surfaces)	Per schedule	$180	$220	40%
Oral Surgery				
Removal of impacted tooth — partially bony	Per schedule	$58	$72	40%
Endodontic Services				
Bicuspid root canal therapy	Per schedule	$85	$140	40%
Molar root canal therapy	Per schedule	$240	$260	40%
Periodontic Services				
Scaling & root planing — per quadrant	Per schedule	$55	$55	40%
Osseous surgery — per quadrant	Per schedule	$300	$325	40%
Orthodontic Services[1]	$2300 copay	$2300 copay	$2300 copay2	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

[1]Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.

[2]Fixed dollar amounts on the DMO in DMO Plus and the Freedom-of-Choice Basic & Freedom-of-Choice Plus are member responsibility.

[3]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures; DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.

Access to negotiated discounts: On all the PPO plans including when part of Freedom-of-Choice, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the on the PPO in Freedom-of-Choice Plus, PPO $1500, PPO $1500 Active and PPO $2000.

Out-of-Network plan payments are limited by geographic area on the PPO in Freedom-of-Choice Basic, Freedom-of-Choice Plus, PPO $1000, PPO $1500 and PPO $1500 Active to the prevailing fees at the 80th percentile and the 90th percentile on the PPO $2000.

DMO Access & DMO Plus can be offered with any one of the PPO plans in PPO Plans in a Dual Option package.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 49.

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

CALIFORNIA 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 $1000 Active	
	Fixed Copay DMO Plan 58[2]	PPO Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40
Office Visit Copay	$5	N/A	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	$1,000	$1,000	$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	No Charge	100%	100%	80%
Comprehensive oral exam	No Charge	100%	100%	80%
Problem-focused oral exam	No Charge	100%	100%	80%
X-rays				
Bitewing — single film	No Charge	100%	100%	80%
Complete series	No Charge	100%	100%	80%
Preventive Services				
Adult Cleaning	No Charge	100%	100%	80%
Child Cleaning	No Charge	100%	100%	80%
Sealants — per tooth	$5	100%	100%	80%
Fluoride application — child	No Charge	100%	100%	80%
Space maintainers — fixed	$60	100%	100%	80%
Basic Services				
Amalgam filling — 2 surfaces	No Charge	80%	80%	60%
Resin filling — 2 surfaces, anterior	No Charge	80%	80%	60%
Oral Surgery				
Extraction — exposed root or erupted tooth	No Charge	80%	80%	60%
Extraction of impacted tooth — soft tissue	$46	80%	80%	60%
Major Services[1]				
Complete upper denture	$275	50%	50%	40%
Partial upper denture (resin base)	$275	50%	50%	40%
Crown — Porcelain with noble metal[3]	$210	50%	50%	40%
Pontic — Porcelain with noble metal[3]	$210	50%	50%	40%
Inlay — Metallic (3 or more surfaces)	$180	50%	50%	40%
Oral Surgery				
Removal of impacted tooth — partially bony	$58	50%	50%	40%
Endodontic Services				
Bicuspid root canal therapy	$85	80%	50%	40%
Molar root canal therapy	$240	50%	50%	40%
Periodontic Services				
Scaling & root planing — per quadrant	$55	80%	50%	40%
Osseous surgery — per quadrant	$300	50%	50%	40%
Orthodontic Services[1]	$2300 copay	Not covered	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

[1]Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.
[2]Fixed dollar amounts on the DMO in DMO Plus and the Freedom-of-Choice Basic & Freedom-of-Choice Plus are member responsibility.
[3]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures; DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.
Access to negotiated discounts: On all the PPO plans including when part of Freedom-of-Choice, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the on the PPO in Freedom-of-Choice Plus, PPO $1500, PPO $1500 Active and PPO $2000.
Out-of-Network plan payments are limited by geographic area on the PPO in Freedom-of-Choice Basic, Freedom-of-Choice Plus, PPO $1000, PPO $1500 and PPO $1500 Active to the prevailing fees at the 80th percentile and the 90th percentile on the PPO $2000.
DMO Access & DMO Plus can be offered with any one of the PPO plans in PPO Plans in a Dual Option package.
Orthodontic coverage is available only to groups with 10 or more eligibles and for adults and dependent children.
Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 49.

CALIFORNIA 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

	PPO $1500	PPO $1500 Active		PPO $2000
	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
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing — single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
Preventive Services				
Adult Cleaning	100%	100%	80%	100%
Child Cleaning	100%	100%	80%	100%
Sealants — per tooth	100%	100%	80%	100%
Fluoride application — child	100%	100%	80%	100%
Space maintainers — fixed	100%	100%	80%	100%
Basic Services				
Amalgam filling — 2 surfaces	80%	80%	60%	80%
Resin filling — 2 surfaces, anterior	80%	80%	60%	80%
Oral Surgery				
Extraction — exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth — soft tissue	80%	80%	60%	80%
Major Services[1]				
Complete upper denture	50%	50%	40%	50%
Partial upper denture (resin base)	50%	50%	40%	50%
Crown — Porcelain with noble metal[3]	50%	50%	40%	50%
Pontic — Porcelain with noble metal[3]	50%	50%	40%	50%
Inlay — Metallic (3 or more surfaces)	50%	50%	40%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	50%	50%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	80%	80%	60%	80%
Molar root canal therapy	50%	50%	40%	50%
Periodontic Services				
Scaling & root planing — per quadrant	80%	80%	60%	80%
Osseous surgery — per quadrant	50%	50%	40%	50%
Orthodontic Services[1]	50%	50%	40%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,500

[1]Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.
[2]Fixed dollar amounts on the DMO in DMO Plus and the Freedom-of-Choice Basic & Freedom-of-Choice Plus are member responsibility.
[3]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures; DMO Plus and Freedom-of-Choice Basic & Freedom-of-Choice Plus.
Access to negotiated discounts: On all the PPO plans including when part of Freedom-of-Choice, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the on the PPO in Freedom-of-Choice Plus, PPO $1500, PPO $1500 Active and PPO $2000.
Out-of-Network plan payments are limited by geographic area on the PPO in Freedom-of-Choice Basic, Freedom-of-Choice Plus, PPO $1000, PPO $1500 and PPO $1500 Active to the prevailing fees at the 80th percentile and the 90th percentile on the PPO $2000.
DMO Access & DMO Plus can be offered with any one of the PPO plans in PPO Plans in a Dual Option package.
Orthodontic coverage is available only to groups with 10 or more eligibles and for adults and dependent children.
Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 49.

CALIFORNIA VOLUNTARY AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 3 - 50 Eligible Employees
Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees

	DMO Access	DMO Plus (Plan 58)	PPO $1000 Active	
	Plan 42[2]	Fixed Copay DMO Plan 58[2]	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40
Office Visit Copay	$15	$10	N/A	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	$1,000	$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	Per schedule	No Charge	100%	80%
Comprehensive oral exam	Per schedule	No Charge	100%	80%
Problem-focused oral exam	Per schedule	No Charge	100%	80%
X-rays				
Bitewing — single film	Per schedule	No Charge	100%	80%
Complete series	Per schedule	No Charge	100%	80%
Preventive Services				
Adult Cleaning	Per schedule	No Charge	100%	80%
Child Cleaning	Per schedule	No Charge	100%	80%
Sealants — per tooth	Per schedule	$5	100%	80%
Fluoride application — child	Per schedule	No Charge	100%	80%
Space maintainers — fixed	Per schedule	$60	100%	80%
Basic Services				
Amalgam filling — 2 surfaces	Per schedule	No Charge	80%	60%
Resin filling — 2 surfaces, anterior	Per schedule	No Charge	80%	60%
Oral Surgery				
Extraction — exposed root or erupted tooth	Per schedule	No Charge	80%	60%
Extraction of impacted tooth — soft tissue	Per schedule	$46	80%	60%
Major Services[1]				
Complete upper denture	Per schedule	$275	50%	40%
Partial upper denture (resin base)	Per schedule	$275	50%	40%
Crown — Porcelain with noble metal[3]	Per schedule	$210	50%	40%
Pontic — Porcelain with noble metal[3]	Per schedule	$210	50%	40%
Inlay — Metallic (3 or more surfaces)	Per schedule	$180	50%	40%
Oral Surgery				
Removal of impacted tooth — partially bony	Per schedule	$58	50%	40%
Endodontic Services				
Bicuspid root canal therapy	Per schedule	$85	50%	40%
Molar root canal therapy	Per schedule	$240	50%	40%
Periodontic Services				
Scaling & root planing — per quadrant	Per schedule	$55	50%	40%
Osseous surgery — per quadrant	Per schedule	$300	50%	40%
Orthodontic Services[1]	$2400 copay	$2400 copay	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

[1]Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary DMO Plus.
[2]Fixed dollar amounts on the DMO in Voluntary DMO Plus are member responsibility.
[3]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures in Voluntary DMO Plus.
Access to negotiated discounts: On all the Voluntary PPO plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Voluntary PPO $1500, Voluntary PPO $1500 Active.
Orthodontic coverage is available only to groups with 10 or more eligibles and for adults and dependent children.
If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.
Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 49.

CALIFORNIA VOLUNTARY AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 3 - 50 Eligible Employees

Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees

	PPO $1500	PPO $1500 Active	
	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
Diagnostic Services			
Oral Exams			
Periodic oral exam	100%	100%	80%
Comprehensive oral exam	100%	100%	80%
Problem-focused oral exam	100%	100%	80%
X-rays			
Bitewing — single film	100%	100%	80%
Complete series	100%	100%	80%
Preventive Services			
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%
Basic Services			
Amalgam filling — 2 surfaces	80%	80%	60%
Resin filling — 2 surfaces, anterior	80%	80%	60%
Oral Surgery			
Extraction — exposed root or erupted tooth	80%	80%	60%
Extraction of impacted tooth — soft tissue	80%	80%	60%
Major Services[1]			
Complete upper denture	50%	50%	40%
Partial upper denture (resin base)	50%	50%	40%
Crown — Porcelain with noble metal[3]	50%	50%	40%
Pontic — Porcelain with noble metal[3]	50%	50%	40%
Inlay — Metallic (3 or more surfaces)	50%	50%	40%
Oral Surgery			
Removal of impacted tooth — partially bony	50%	50%	40%
Endodontic Services			
Bicuspid root canal therapy	80%	80%	60%
Molar root canal therapy	50%	50%	40%
Periodontic Services			
Scaling & root planing — per quadrant	80%	80%	60%
Osseous surgery — per quadrant	50%	50%	40%
Orthodontic Services[1]	50%	50%	40%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000

[1]Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary DMO Plus.
[2]Fixed dollar amounts on the DMO in Voluntary DMO Plus are member responsibility.
[3]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures in Voluntary DMO Plus.
Access to negotiated discounts: On all the Voluntary PPO plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO in Voluntary PPO $1500, Voluntary PPO $1500 Active.
Orthodontic coverage is available only to groups with 10 or more eligibles and for adults and dependent children.
If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.
Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 49.

OUT-OF-STATE PLAN DESIGNS

Available with an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees
Available without an Aetna Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees

MEMBER BENEFITS	PPO 1,000[++]	PPO 1,500[++]	PPO 2,000[++]	Voluntary PPO 1000[++]
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible Per Member (Does not apply to Diagnostic & Preventive Services)	$50; 3x Family Max	$50; 3x Family Max	$50; 3x Family Max	$75; 3x Family Max
Annual Maximum Benefit	$1,000	$1,500	$2,000	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing — single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
PREVENTIVE SERVICES				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants — per tooth	100%	100%	100%	100%
Fluoride application — with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces permanent	80%	80%	80%	80%
Resin filling — 2 surfaces permanent	80%	80%	80%	80%
Oral Surgery				
Simple extraction	80%	80%	80%	80%
Extraction of impacted tooth — soft tissue	80%	80%	80%	80%
MAJOR SERVICES*				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown — Porcelain with noble metal	50%	50%	50%	50%
Pontic — Porcelain with noble metal	50%	50%	50%	50%
Inlay — Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing — per quadrant	50%	50%	50%	50%
Osseous surgery — per quadrant	50%	50%	50%	50%
ORTHODONTIC SERVICES*+	50%	50%	50%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,000

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. PPO Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

[+]Orthodontic coverage on all Out-of-State Dental plans is for dependent children only and is only available to groups with 10 or more eligibles. Out-of-State PPO Dental is for out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Montana, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont and Wyoming. Out-of-state employees in these states will receive the Indemnity Dental Plan. The list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate.

[++]Plans can be either Indemnity or Max plans. Talk with your Account Executive for more information.

Access to negotiated discounts: On all the PPO plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

OOS Voluntary: 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.

For a summary list of Limitations and Exclusions, refer to page 49.

Aetna Life Insurance

Small Business decision makers can choose from affordable life insurance solutions to meet their employees' needs. We also provide extra value through a variety of services for their employees.

Life insurance

We know that life insurance is an important part of the benefits package offered by employers. 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.

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

Giving employers (and their employees) what they want

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

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

- **Accelerated death benefit —** Also called the "living benefit," the accelerated death benefit provides payment to terminally ill employees or spouses. This payment can be up to 75 percent of the life insurance benefit.
- **Premium waiver provision —** Employee coverage may stay in effect up to age 65 without premium payments if an employee becomes permanently and totally disabled while insured due to an illness or injury prior to age 60.
- **Optional dependent life —** This feature allows employees to add optional additional coverage for eligible spouses and children for employers with 10 or more employees. This employee-paid benefit enables employees to cover their spouses and dependent children.

AD&D Ultra®

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

Benefits include:

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

NOTE: For a summary list of Limitations and Exclusions, refer to page 49.

TERM LIFE BENEFITS

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 without an Aetna Medical or Dental (Life Standalone) to Groups with 26-50 Eligible Employees		
	2-9 Employees	**10-50 Employees**
Basic Life Schedule	Flat $10,000, $15,000, $20,000, $50,000	Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000
Class Schedules	Not Available	Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class
Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60
Age Reduction Schedule	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Guaranteed Issue	$20,000	10-25: $75,000; 26-50: $100,000
Participation Requirements	100%	100% on noncontributory plans; 75% on contributory plans
Contribution Requirements	100% Employer Contribution	Minimum 50% Employer Contribution (excluding Optional Dependent Term)
AD&D ULTRA®		
AD&D Schedule	Automatically Included; Same as Life plan	Automatically Included; Same as Life plan
Additional Features	Passenger restraint & airbag, education (for dependent and/or spouse), Child Care, Repatriation, Coma, Total Disability, 365-day covered loss	Passenger restraint & airbag, education (for depend and/or spouse), Child Care, Repatriation, Coma, Total Disability, 365-day covered loss
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	$5,000
Child Amount	Not Available	$2,000

Life products are underwritten by Aetna Life Insurance Company.

LIFE RATES (BILLED AS SHOWN)

All rates for Optional Dependent Term Life (for all age brackets) on the Basic Term Life are: $2.93 monthly per employee.

Life rates are guaranteed for two (2) years from the effective date.

Life is available with: Medical for 2-50, Dental for 10-50, Standalone for 26-50.

AGE LAST BIRTHDAY	COMBINED BASIC LIFE & AD&D RATE (per $1,000 of coverage)
0 -19	0.14
20-24	0.15
25-29	0.15
30-34	0.16
35-39	0.18
40-44	0.24
45-49	0.34
50-54	0.52
55-59	0.85
60-64	1.01
65-69	1.64
70-74	2.81
75-79	4.93
80-84	8.74
85+	15.42

There are no ineligible industries for Basic Term Life Insurance when written with Medical.

Rates are subject to change.

Health care on the Web

Through Aetna's website (www.aetna.com) members have access to health information, resources and services designed to help them better manage their health.

Aetna Navigator — The power to help members manage their health

It's easy and convenient for Aetna members to manage their health benefits. Anytime — day or night — wherever they have Internet access, members can log in to Aetna Navigator, Aetna's secure member website. Members who register on the site can check the status of their claims, contact Aetna Member Services, estimate the costs of health care services and much more!

Aetna Navigator is a valuable online resource for personalized benefits and health information. Once registered for Aetna Navigator, members can:

- Review who is covered under their plan.
- Check claim status and view Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services to better plan their expenses.
- Research the price of a drug and learn if there are less costly alternatives.*
- Find health care professionals and facilities that participate in their plan.
- Request member ID cards.
- Print temporary member identification needed for a health care visit.
- View credible health information and news and more!

Aetna Navigator is ready 24/7! Aetna members can go to **www.aetna.com** and select Aetna Navigator. If they haven't already, encourage them to register today by clicking on the Register Now! link.

Aetna Transparency Initiative — Tools to help members make informed decisions

Our suite of interactive Web-based cost tools is designed to help members estimate the costs of health care services so they can plan for and take better charge of their health care expenses. Members can compare costs on:

- Prescription drugs* — cost of generic versus brand-name drugs and more.
- Surgical and scope procedures — such as arthroscopy and colonoscopy.
- Office visits — such as routine physicals and emergency room visits.
- Diagnostic tests and vaccines — such as lab tests, X-rays, MRI and other tests.
- Diseases and conditions — for services associated with specific diseases and conditions such as asthma, diabetes, pregnancy, heart disease and high blood pressure.

Aetna Enroll℠ — Secure. Easy. Efficient.

Aetna Enroll allows plan sponsors, administrators and brokers to manage benefits through an easy-to-use application and gives employees the ability to view and make changes to their benefits. However, group administrators and/or brokers can maintain total control of any information sent to Aetna.

Advantages for members and plan sponsors include:

- Faster, more accurate enrollment administration
- Improved intra-company communication
- All data is secure and confidential
- High level of control — employee changes must be approved by the broker or plan administrator prior to Aetna receiving the changes
- Easy-to-use reports
- Better understanding of benefits
- More secure than paper
- Easier to submit changes to Human Resources or the broker
- Simplified decision-making

DocFind®

Finding a participating doctor has never been easier with our DocFind online provider directory. Members can search for participating physicians, hospitals, pharmacies, dentists and eyewear providers. Searches for provider information are now even easier with consolidated screens — enter all search criteria on one page instead of several, and with fewer "clicks." Search criteria or sort results can easily be changed from the summary page. Members can now easily access Navigator's registration page, or can quickly log in to Navigator to obtain provider demographic, cost and quality information.

*If offered by their plan.

DocFind also allows members to search by zip code, miles willing to travel, city and state or county and state. Narrow the search by specialty, hospital affiliation and/or languages spoken — all with a few clicks of a mouse.

When members find the provider they want, we can also help them get there with a map and driving directions. Best of all, DocFind is updated regularly and is available 24 hours a day, 7 days a week. To request a paper directory, contact Aetna.

Aetna InteliHealth® website

Our award-winning* health information website, **www.intelihealth.com**, is a premier provider of online consumer-based health, wellness and disease-specific information. In addition, members can search a drug database and register for condition-specific e-mails.

Aetna Voice Advantage®

The system enables employees to conduct many tasks by phone, such as checking claims, changing doctors and requesting ID cards.

Personal Health Record — Help employees make history!

Staying aware of all the health information available today can be overwhelming. But engaging employees in their own health is easier with our Personal Health Record because it:

- Creates a more complete picture of health — Claims information is prefilled and automatically updates. Employees can find their health history at any time. They can even add more information, such as over-the-counter medications and family health history, and print a summary to share with their doctors.
- Stays current with medical guidelines and technology — Our patented CareEngine® system compares current evidence-based information with all available member data. This helps identify gaps in care and gives employees a better chance to stay healthy.

Plan for Your Health℠

Plan for Your Health is a public education campaign focused on helping consumers understand the connection between health benefits and financial planning — particularly for women. The campaign's website, **PlanforYourHealth.com**, makes it easy for consumers to access credible tools and information, empowering them to make better health benefits and financial decisions to meet their present and future needs.
The site includes:

- Useful tips on navigating health benefits in relation to overall financial well-being.
- Tools to figure out how important life changes will affect health benefits options.
- Information on choosing the best health benefits options for women and their families.

A convenient solution for care on the go

Walk-in Clinics**

Walk-in Clinics are convenient alternatives to the doctor's office. You might be surprised by the full spectrum of services available at a Walk-in Clinic, many of which are staffed by physician assistants and nurse practitioners. They offer:

- Treatment for minor burns, stings or bites, sprains, strains and cuts
- Care for earaches, flu and cold symptoms, sinus infections and allergies
- Physicals and pediatric and gynecologic services
- Flu shots and other vaccinations
- X-ray and lab services

Urgent Care Centers**

For care that is not minor, such as fractures, sprains or other urgent injuries, we contract with urgent care centers to offer an economical alternative to visiting an emergency room. Urgent care sites are staffed with physicians to handle urgent medical needs, whereas walk-in clinics are staffed by nurse practitioners to care for minor ailments. And just like walk-in clinics, some urgent care centers offer evening and weekend hours with no appointments needed.

Follow these simple steps to locate a nearby Walk-in Clinic or Urgent Care Center:

Step 1

Start your search in DocFind.

Step 2

Complete all the category selections — note there are required fields to complete.

- Decide how you'd like to search for a provider — by zip code, city, or county
- Under **PROVIDER CATEGORY**, select **Facilities (such as lab, walk-in clinics and X-ray)**
- Under **PROVIDER TYPE**, select **Walk-In Clinics or Urgent Care Facilities**
- Finally, under **PLAN**, select the plan

Step 3

Click START SEARCH for a listing of all the Walk-in Clinics in the geographical area you selected.

*Including WWW Health Award, Forbes Best of the Web, and eHealth Leadership Award, among others.

**California HMO members must contact their medical group or Primary Care Physician for Walk-in Clinic and Urgent Care Center use.

Special programs

Our special programs offer a wealth of features that complement our standard medical and dental coverage. Read on to discover the many ways we can help employers and their employees stay healthy.

Aetna Health Connections℠ disease management — Our newly redesigned capabilities offer support for over 30 conditions as well as integrated care for members with multiple conditions. The program includes cutting-edge technology that helps improve patient safety, doctor communication and more.

Informed Health® Line — Members have access to a broad range of health information — 24 hours a day, 7 days a week — over the telephone. With the Informed Health Line, members can speak directly with a registered nurse anytime, 24/7, about a wide variety of health and wellness topics. Members can also listen to our Audio Health Library, which features thousands of health topics in English and Spanish. Callers can easily transfer to a registered nurse at any time during their call.

National Medical Excellence Program® — When Aetna members face difficult or life-threatening situations such as organ transplants, Aetna's National Medical Excellence Program (NME) coordinates care and provides access to covered treatment through our Institutes of Excellence™ network. The program also coordinates specialized treatment for members with certain rare or complicated conditions and assists members who are admitted to the hospital for emergency medical care when they are traveling temporarily outside of the United States.

Except for emergency medical care as described previously, services under this program must be preauthorized. A listing of facilities in our Institutes of Excellence network can be found in DocFind at **www.aetna.com.**

National Advantage™ Program — Members can lower their out-of-pocket expenses for covered medical benefits by using National Advantage Program (NAP) health care professionals and facilities. NAP offers access to contracted rates for many medical claims that currently are paid at billed charges under indemnity plans, the out-of-network portion of managed care plans or for emergency/medically necessary services not provided within the network.

Aetna Women's Health℠ programs — Focus specifically on the health care needs of women. Programs include:

- Our Beginning Right® maternity program, which offers information and services to expectant mothers including care coordination by obstetrical nurses experienced in preterm labor education, breastfeeding support and more. We want to make sure expectant mothers have the information needed to make informed decisions about health care while pregnant or planning a pregnancy.
- Our Breast Health Education Center, which offers information and services dedicated to breast health, including our Breast Cancer Case Management Program, confidential genetic testing for breast and ovarian cancer, our Breast Health website and more.

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

- Choice — They'll find a range of resources to help them balance their personal and professional lives.
- Easy access — Small Group EAP can be reached anytime, through a single call to a toll-free number or on the Web at **www.aetnaeap.com.**
- Professional assistance — Our workplace-trained specialists provide confidential phone support, assessing needs and recommending an appropriate course of action. Employees and their household members receive three phone consultations per member in a calendar year.

Employers can also take advantage of EAP Resources:

- Management and Human Resources assistance. Employers get unlimited phone consultations with workplace-trained clinicians who can provide help in dealing with complex employee issues that may arise.
- Online tools. Employers can also get online tools and materials to encourage employees to use the EAP by visiting **www.aetnaeap.com** (enter your company ID: 4BALANCE and select the "Promotional Materials" link).

*Aetna Employee Assistance Program is offered through Behavioral Health, LLC.

Underwriting guidelines

California (effective 4/1/09)

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.

Affiliated, Associated or Multiple Companies	Employers who have more than one business with different Tax Identification Numbers (TINs) may be eligible to enroll as one group if the following are met: ■ One owner has controlling interest of all business to be included; **or** ■ The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and ■ All businesses filed under one combined tax return **must** be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only 2 of the 3 businesses to be enrolled, the group will be considered a carve out, will not be Guarantee Issue, and could be declined. ■ The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined **must have the minimum number of employees required by the state**. ■ There are 50 or fewer employees in the combined employer groups. ■ A completed Common Ownership form is submitted. ■ Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups. ■ Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception. **Example:** One owner has controlling interest of all companies to be included: Company 1 – Jim owns 75% and Jack owns 25% Company 2 – Jim owns 55% and Jack owns 45% Both companies can be written as one group since Jim has controlling interest in both.
Benefit Waiting Period	■ Benefit waiting periods **must be consistently applied to all employees**, including newly hired key employees. ■ The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days. ■ The eligibility date will be the first day of the **policy month** following the waiting period. Example: Group A — effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period. Group B — effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period. ■ Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer. ■ 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 <u>all</u> employees. ■ Changes to the benefit waiting period may be requested 6 months after the original effective date. ■ Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date. ■ **No retroactive benefit waiting period changes will be allowed.**
Cal-COBRA	■ Premium for Cal-COBRA employees should be made at the time of the case submission. However, if premium is not received, the group will be approved if all other requirements have been met. ■ If the premium for the Cal-COBRA application is not submitted at the time of the case approval, the following will occur: > HMO — the member will be enrolled and a letter advising of the premium due will be sent to the Cal-COBRA employee at their home address. The Cal-COBRA employee will not appear active until the premium is received by Aetna. > PPO and MC members — one outreach call will be made to the member advising them that their application has been received and a premium check is needed in order for them to be enrolled onto the plan. Once this outreach call has been completed the application will be forwarded to our CAL-COBRA team for processing. The Cal-COBRA employee will not appear active until the premium is received by Aetna.
Carve Outs	■ The general types of carve outs that could be considered by Aetna include: California Branch Location and Management/ Non-Management, Salary, Union vs. Non-Union. ■ Aetna must enroll **and** maintain a minimum of 8 employees who reside within Aetna's California Network Service Area. ■ Employers may request to carve out a specific class of employees for coverage, subject to underwriting approval which can be declined, even if the standard participation requirements are met. ■ Union vs. Non-Union carve outs will be considered Guarantee Issue when proof of coverage is provided on the Union Employees. Acceptable proof of prior coverage is a copy of the health care billing statement for the previous month.
Case Submission Dates	■ Groups with 2 to 50 eligible employees must have all completed paperwork into Aetna Underwriting **no later than the end of the 5th business day after** the requested effective date. ■ If not received by this date, the effective date will be moved to the next available effective date.
Census Data	■ Census data must be provided for all eligible employees, including COBRA eligible and Cal-Cobra State Continuation employees. ■ Include the name, date of birth, date of hire, gender, dependent status, and residence zip code (when multi-site/multi-state) ■ Retirees – See Employee Eligibility section. ■ COBRA/Cal-Cobra eligible employees should be included on the census and noted as COBRA/Cal-COBRA.

Composite Rating	■ Employers **that enroll 25 California employees** may select tabular or composite rating on their initial effective or renewal date. **Composite Rating for New Business:** ■ Employer may offer a maximum of four plan options. ■ At least 1 person must enroll in each plan for it to be offered to new hires. ■ The composite rate for each plan will be determined based on the **census quoted**. ■ Upon final enrollment, the composite rate for each plan will be processed based upon the **enrolled employees**. ■ If the rates vary by more than 5%, the new business composite rates will be adjusted. **Composite Rating for Renewing Business:** ■ Renewal rates will be based on the **enrolled employees in each plan platform (HMO or EPO/MC/PPO)** at the time the renewal is processed. ■ Only the plans available after the initial enrollment will be rated for the renewal. ■ Employers must submit a request to underwriting to switch to composite rates at renewal. ■ 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. ■ If the employer wants to move to a richer plan or select the Pick-A-Plan option they will be subject to underwriting.
Deductible Credit	■ Employees who are eligible and want to receive credit for deductible paid to prior Company should submit a copy of the Explanation of Benefits to Aetna. They may do this at either at the initial small group submission or with their first claim.
Definition of a Small Group Employer	"Small employer" means either of the following: ■ 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. > 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. > 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. ■ Any guaranteed association that purchases health coverage for members of the association. ■ A California small employer subject to Guarantee 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). **Newly formed businesses** that have been in business for at least 6 weeks may be considered guarantee issue if the following are met: ■ Employer Groups meet all requirements of AB 1672, except for being in business 50% of the previous calendar quarter. ■ Submits a copy of the most recently filed DE 6 (Quarterly Wage and Tax Statement). If not available, up to a maximum of 6 weeks of consecutive weeks of payroll records which include, for every eligible employee enrolling, taxes withheld, check number and wages earned. > If Employer Group does not have payroll records, see below. ■ Sole Proprietor, Partnership or Limited Liability Partnership, Limited Liability Company and Corporations must submit the following: > Sole Proprietor – A copy of the Business License (not a professional license). A professional license for example is the certificate form the state that you are a licensed hair stylist, manicurist, real estate agent, etc. > Partnership or Limited Liability Partnership – A copy of the partnership agreement. For a Limited Partnership, we can search the California Business Portal; however this can not be used for a Partnership or Limited Liability Partnership. > Limited Liability Company – A copy of the Articles of Organization **and** the Operating Agreement to include the signature page(s) of all officers. For Limited Liability Company's we can search the California Business Portal, however all documents still need to be submitted. > Corporations – A copy of the Articles of Incorporation to include the signature page(s) of all offices (must be followed up with a copy of the Statement of Information within 30 days of filing with the state). ■ 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. Employer groups that do not have 6 weeks of payroll must provide the information above as well as obtain a letter from a CPA that indicates the information below: > A list of all employees, to include owners, partners, officers (full time and part time) > Number of hours worked per week for each employee > Weekly salary for each employee > Date of hire for each employee > Explanation of payroll record status > Date when Quarterly Wage and Tax Statement (DE 6) will be filed?

Dental

Open enrollments are prohibited.

Coverage Waiting Period

- For Major and Orthodontic services, employees must be enrolled members of the plan for one year (not applicable to DMO). Waiting Period is waived separately for Major and Orthodontic for employees who were covered by the group's immediately preceding dental plan.
  - > To waive the Waiting Period for Major services, the group's immediately preceding group plan must have covered Major Services.
  - > To waive the Waiting Period for Orthodontic services, the group's immediately preceding group plan must have covered Orthodontic services.

  Example: 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.

Product Packaging

- DMO can be either sold standalone or packaged with any PPO Option as a Dual Option.
- PPO can be sold standalone or packaged with the DMO as a Dual Option.
- Freedom-of Choice cannot be packaged with any other option. **It must be the only plan sold.**
- Voluntary Dental plans **cannot** be sold or packaged with any other plan as Dual Option offering.

Reinstatement

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.

Ineligible Industries

Applies when Dental is sold standalone or packaged only with Group insurance. This list does not apply if sold in combination with the Medical.

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		

Dependent Eligibility

- Eligible dependents include an employee's spouse/domestic partner, unmarried children up to the limiting age of the plan, and physically or mentally disabled Dependent Child, regardless of age, if they were covered under their Employer's group plan on the day before the effective date of this plan.
- For a disabled Dependent Child both the Handicapped Child Attending Physician's Statement and the Request for Continuation of Medical Coverage for Handicapped Child must be completed and turned in at the time of new case submission before the child may be approved and enrolled.
- Effective 1/1/09, If a plan/policy provides coverage for a dependent child who is over 18 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution, the following apply:
  - > Any break in the school calendar will not disqualify the dependent child from coverage.
  - > If the dependent child takes a medical leave of absence, and the nature of the dependent child's injury, illness, or condition would render the dependent child incapable of self-sustaining employment, the provisions related to disabled dependent coverage applies if the dependent child is chiefly dependent on the subscriber/policyholder for support and maintenance.
  - > If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not meet the requirements for continuation of coverage as a disabled dependent the following applies:
    - Coverage must not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate in the plan/policy, whichever comes first.
    - The period of coverage begins on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first.
    - Any break in the school calendar does not disqualify the dependent child from coverage.
    - Documentation or certification of the medical necessity for a leave of absence from school must be submitted:
      - > at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable: or
      - > 30 days after the start date of the medical leave of absence from school.
- Aetna maintains a more liberal view of same sex or opposite sex domestic partnerships. Upon request, Aetna will honor the state of California's legal definition in lieu of Aetna's liberal interpretation.
- The limiting age for Medical and Dental is standard to age 19, to age 24 for full time students.
- The limiting age for Life is standard from live birth to age 21, to age 23 for full-time students.
- 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.
- For dependent life, dependents are eligible from 14 days to age 19, or to age 23 if in school.
- Dependents are not eligible for AD&D.
- Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan.

Effective Date

- Groups with no prior coverage may request either the 1st or the 15th of the month effective dates.
- The effective date requested by the employer may be up to 60 days in advance.
- When replacing an employer-sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period.
  - > 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.

Electronic Funds Transfer	■ Payment for the first month's premium at new business can be processed via an Electronic Funds Transfer. ■ This does not apply to future premium payments.
Employee Eligibility	An eligible employee means either of the following: ■ 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. ■ 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: > The employee otherwise meets the definition of an eligible employee except for the number of hours worked. > The employer offers the employee health coverage under a health benefit plan. > All similarly situated individuals are offered coverage under the health benefit plan. > The employee must have worked at least 20 hours per normal work week for at least 50 percent 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, to, payroll records and employee wage and tax filings. ■ For employees reported on the IRS 1099 forms, see the 1099 employee section. ■ Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa. **Retirees** ■ Coverage is available for Medicare-eligible retirees and/or active Medicare-eligible in accordance with the Medicare-Retiree Underwriting Guidelines. **COBRA /Cal-COBRA** ■ COBRA/Cal-COBRA eligible enrollees are required to be included on the census. ■ Health questions must be answered. ■ COBRA/Cal-COBRA qualifying event, length, start and end date must be provided.
Employer Contribution	**Single Choice Medical** ■ The employer must contribute at least 50% of the employee rate. ■ Coverage may be denied based upon inadequate contributions. **Pick-A-Plan (Medical)** ■ The employer must contribute 50% of the employee only rate of whichever plan the employee selects. ■ The employer may choose to offer a Defined Contribution of at least $80 or the actual cost of the plan, whichever is less. ■ Coverage may be denied based upon inadequate contributions. **Dental** ■ The employer must contribute at least 50% of the employee-only cost or 25% of the total plan. ■ For Voluntary Dental plans: Employer contribution can be from zero to 49% of the cost of the employee only coverage. ■ Pick-A-Plan is not available. ■ Coverage may be denied based upon inadequate contributions. **Term Life** ■ Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan. ■ Employers with 10 to 50 eligible lives: Employer must contribute at least 50% of the cost of the plan (excluding Optional Dependent Life). ■ Pick-A-Plan is not available. ■ Coverage may be denied based upon inadequate contributions.
Employer Eligibility	■ All Aetna plans can be offered to sole proprietors, partnerships or corporations. ■ Employers (Companies/Organizations) must not be formed solely for the purpose of obtaining health coverage. ■ 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. ■ 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.
Employers leaving an Aetna PEO	■ Employers leaving a PEO that is not currently insured with Aetna will be required to complete the Aetna PEO form. Underwriting will determine eligibility based upon this completed form. ■ Employers leaving a PEO that is currently insured with Aetna do not need to complete the Aetna PEO form. A statement signed by the employer will be sufficient. ■ The PEO Form will only be requested from an Aetna PEO client when the employer is still receiving services from the Aetna PEO.
Employers Replacing Other Group Coverage	■ A copy of the most recent billing statement that includes the employee listing must be submitted. ■ The employer should be told **not to cancel any existing medical coverage** until they have been notified of approval from the Aetna Underwriting unit.
Holding Companies	■ **Holding company** — A holding company is a company that owns part, all, or a majority of other companies' outstanding stock. It usually refers to a company which does not produce goods or services itself; rather its only purpose is owning shares of other companies. Holding companies allow the reduction of risk for the owners and can allow the ownership and control of a number of different companies. ■ **Parent Company** – A parent company is a holding company that owns enough voting stock in another firm (subsidiary) to control management and operations by influencing or electing its board of directors. A parent company could simply be a company that wholly owns another company. **Example** ■ Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank). ■ Bank A (the holding company) has no ownership; it is simply an umbrella company for the 3 Bank B locations. ■ Bank B has 3 locations and all under one TIN. ■ Bank A (the holding company) is under a separate TIN ■ The holding company and banks have no ownership because the owners are all stockholders and bank employees or bank executives. ■ There are no articles of incorporation only stock certificates. ■ Bank B is the only group enrolling. Bank A is listed as an associated company with no employees and the group is not to be enrolled. ■ Documentation needed: QWTS for Bank B which should include all 3 locations.

Initial Premium Check	■ The initial premium check should be in the amount of the first month's premium and drawn on a company check. ■ The initial premium check is not a binder check. Final premium will be determined upon underwriting review. ■ If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer.
Late Entrants	■ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. ■ Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below. ■ Voluntary cancellation of coverage is **NOT** a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added. **Medical** ■ Late applicants without a qualifying event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll. **Dental** ■ An employee or dependent may enroll at any time; however, coverage is limited to Preventive and Diagnostic Services for the first 12 months. ■ No coverage for most Basic and Major Services for the first 12 months (24 months for Orthodontics). ■ Late entrant provision does not apply to enrollees less than age 5. **Life** ■ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. ■ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI). ■ Life late enrollee example: Group has $50,000 life with $20,000 guarantee issue limit. Late enrollee enrolling for $50,000 would not automatically get the $20,000. Since the applicant is late they must medically qualify for the entire $50,000.
Life — Basic Term	**Open Enrollments are prohibited.** **Job Classifications (Position) Schedules** Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to 3 separate classes are allowed (with a minimum requirement of 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than 5 times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows: Position/Job Class — Basic Term Life Amount Executives — $50,000 Managers, Supervisors — $20,000 All Other Employees — $10,000 **Guaranteed Issue Coverage** Aetna provides certain amounts of life insurance without requiring an employee to answer any medical questions. These insurance amounts are called "Guarantee 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: Case Size — Basic Term Life Amount 2-9 Eligible lives — $20,000 10-25 Eligible lives — $75,000 25-50 Eligible lives — $100,000 **Evidence of Insurability (EOI)** EOI is required when one or more of the following conditions exist: 1) Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit. 2) New coverage is requested during the renewal period. 3) 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.) **Actively at Work** Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day. **Continuity of Coverage (No Loss/No Gain)** The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers. If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable. **Ineligible Industries Life/AD&D** — All industries are eligible except for standalone for groups of 26+.

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	Fire Arms/Ammunitions	8600-8699	Membership Associations
5921	Liquor Stores	8800-8899	Service – Private Household
6211	Security Brokers	9999	Non Classified Establishment
6531	Real Estate – Agents		

Live/Work Guidelines	■ Employees enrolled in Medical or Dental who reside in a Non-HMO (AVN/HMO/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 **30 miles radius** of their work site that is within the HMO/DMO Service Area. ■ Product availability for group benefit offerings are always determined by the zip code of the Employer. ■ If the employee resides at a distance further than the 30 mile radius, exception requests should be directed to Underwriting for a feasibility determination. ■ Employees 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.
Medical	■ 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 to 50. Failure to do so may result in a maximum 1.10 RAF (risk adjustment factor) determination. ■ Eligible employees must complete the waiver section of the employee application for either the employee and/or their dependents when declining coverage. The health questionnaire does not need to be completed for those individuals who are declining Medical or Life at the Guarantee Issue amount. ■ 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 or calendar year. ■ If the employee is requesting coverage above the Guarantee Issue amount for life they will need to complete the individual health questionnaire. **Standard RAF Guidelines** ■ Groups enrolling 2 to 4 employees will receive an automatic 1.10 RAF. ■ Groups enrolling 5 to 50 employees may qualify for a .90 RAF. ■ Please check with your Aetna Account Executive for information on Aetna's latest RAF promotion.
Option Sales Alongside other Carriers	**Medical** ■ 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. ■ Accepting the greatest of 50% participation and a minimum of 8 enrollees for group's offering coverage through another carrier's HMO. **Dental** ■ Options sales alongside another Dental carrier are not allowed. ■ All Dental plans must be sold on a full replacement basis only. **Life** ■ Not applicable
Out of Area Within California	**Medical** ■ Employees residing outside of an Aetna Network Service Area. Must enroll in the Aetna Indemnity Plan. ■ 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. **Dental** ■ Employees residing outside of an Aetna Network Service Area. ■ Employees who reside within California but outside of a DMO service area may be offered an In-State PPO plan. **Life** ■ Not Applicable
Out-of-State Employees	**Medical** ■ Employees residing outside of California. ■ Employers must have at least 51% of their employees residing in California to be considered Guarantee Issue. ■ Out-of-State employees that live/work in an out-of-state network area will receive California rates and products (inclusive of any required extraterritorial benefits). ■ Out-of-State employees that do not reside in an out-of-state network area will receive the California Standard Indemnity products (inclusive of extraterritorial benefits). ■ Out-of-State employees who reside in an area with an MC network must enroll in the California MC plan. ■ Out-of-State employees who reside in an area with a PPO only network must enroll in the California PPO plan. ■ Out-of-State employees who reside in an Indemnity only network must enroll in the California Indemnity plan. ■ HMO and EPO plans are not allowed outside of California. **Network Availability for Out-of-State** ■ No MC plans are available in the following states: AK, HI, ID, IN, ME, MT, NE, PR, RI, SD, and WY. ■ No PPO is available in the following states: AL, ID, MN, MT, ND, NM, RI, WI, and WY. ■ No Indemnity or PPO products are available in HI or VT. **Dental** ■ Out-of-State employees may only be offered one of the available 4 Out of State Dental plans. ■ Maximum out-of-state employee percentage (and/or number of employees) will agree with the Medical guidelines for each state. ■ Orthodontic coverage is included for groups of 10 or more eligible employees. ■ Orthodontic coverage is only available for dependent children. **Life** ■ Out-of-State employees are eligible for the Basic Term Life depending on the option selected by the Employer.

Participation	**Medical** ■ **For Non-Contributory plans,** 100% participation is required. All employees, excluding those with coverage through another employer's plan, must enroll. ■ **Employers with 2 to 3 eligible employees:** 100% of eligible, excluding those with coverage through another employer's plan, must participate. ■ **Employers with 4 to 50 eligible employees:** 75% of eligible (rounded), excluding those with coverage through another employer's plan, must participate. ■ **Employer's offering other Carrier's HMO** must have at least 50% participation and a minimum of 8 employees enrolling with Aetna. ■ **Employer's offering the Vitalidad Mexico com Aetna are eligible for 65%** participation if at least 1 employee enrolls in a Vitalidad network area (see zip code listing under Vitalidad Section). ■ Employees waiving due to 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%). ■ Individual coverage is not considered a valid waiver and will count towards the participation. Copies of ID cards may be requested for confirmation. ■ All employees waiving coverage must complete Section B and the waiver section of the application. ■ **If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement.** **Dental** ■ **Employers paying 100% of the employee premium:** 100% participation is required. All employees, excluding those with other qualifying existing Dental coverage, must enroll. ■ **Groups with 2 to 3 eligible employees:** 100% participation is required, excluding those with other qualifying existing Dental coverage. ■ **Groups with 4 to 50 eligible employees:** 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. **Voluntary Dental** ■ Not available for groups with less than 3 eligible employees. ■ 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 3 enrollees whichever is greater is required. Waivers are required. **Life** ■ **For Non-Contributory plans,** 100% participation is required. ■ **Groups with less than 10 eligible employees,** 100% participation is required. ■ **Groups with 10 to 50 eligible employees,** 75% participation is required if the plans are at least partially contributory.
Partially Self-Funded Deductible Plans/ Section 105 Plans	Employers offering partially self-funding or insuring of the deductible must enroll in one of Aetna's designated plans, be it in a wraparound, addition, or companion capacity. ■ Employers offering partially self-funding or insuring of the deductible, may select either our HMO Deductible or MC HRA HDHP plans. ■ Groups that partially self-fund or insure the deductible, and have all employees enrolling in a HMO Deductible or MC HRA HDHP plan, are not eligible for Pick-A-Plan (all plans).
PEOs (Professional Employer Organizations)	A Professional Employer Organization (PEO) (also known as an Employee Leasing Firm) is a company that provides outsourcing of human resources and payroll functions to small and mid-sized firms. Services include recruitment and training of employees, purchasing and administering worker's compensation programs, managing employment regulation compliance and worksite safety programs and providing employee benefits as well as handling payroll and employment related taxes. Generally these employees are not considered to be employees of the client companies, but of the PEO in order to obtain coverage via the leasing firm and not from the employer to whom they are being leased. Employers who participate in PEOs are generally not eligible to purchase small group coverage from insurance carriers. However, in some instances the employer is eligible to contract for insurance separate from the PEO. In order to obtain coverage from Aetna an employer who is currently using a PEO should complete the PEO Questionnaire. **PEO Questionnaire for Small Group** The guidelines on whether to accept or decline based on the questionnaire answers are as follows: 1. Are you currently a client of a PEO (Professional Employer Organization)? Yes or No If yes, accept; If no, accept 2. Is group coverage available to you as a client of the PEO? Yes or No If yes, decline; If no, accept 3. Is the group considered a Co-Employer with the PEO? If yes, accept; If no, decline 4. By enrolling for coverage as a small employer I am not in violation of any contract with the PEO. Agree or Disagree If agree, accept; If disagree, decline

Pick-A-Plan	**New Business:** ■ Employers may select Pick-A-Plan (all plans) which allows each employee and new hires to select any of our 28 plans. ■ If the employer <u>does not select Pick-A-Plan (all plans) the following will apply</u>: > a) If the employer <u>selects 3 or less plans</u>, underwriting will notify the broker/client that they are <u>not enrolled</u> in Pick-A-Plan via the underwriting requirements. New hires may only enroll in one of the 3 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.* > b) If the employer <u>selects 4 or more plans</u>, 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 3 plans may be offered.* ■ If an employer **selects Pick-A-Plan (all plans)** 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. ■ Plan changes for employers and enrolled employees (except for qualified Special Enrollment event) can only be made at renewal. ■ 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. **Renewing Business** ■ Employers who selected Pick-A-Plan (all plans) may add or change plans without medical underwriting. ■ Employers with employees enrolled in <u>4 or more plans</u> may add or change plans without medical underwriting. ■ Employers with <u>3 or less plans</u> must submit a request to add or upgrade to a different plan at renewal. **Mid-Policy Benefit Changes** ■ Groups that have elected Pick-A-Plan (all plans) will not be eligible for mid year policy changes. **Carve Outs** ■ Allowed (See Carve Out section) **1099 Employees** ■ Allowed (See 1099 Employee Section)
Plan Change Ancillary Additions (Life or Dental)	■ Employers may request Plan Changes up to the renewal date for changes that are to be effective on the renewal date. ■ Employers must request Plan Changes off of the renewal date at least 2 weeks prior to the desired effective date. ■ The future renewal date of the ancillary products will be the same as the medical plan renewal date.
Plan Changes — Employees	■ Employees are not eligible to change plans until the group's open enrollment period which is upon their annual renewal (except for qualified Special Enrollment events).
Plan Changes — Employer	■ After the first 30 days of enrollment, Employers may request a change in medical benefits 6 months after the original effective date. ■ Groups that have Pick-a-Plan (all plans) are not eligible for mid-policy benefit changes. ■ Upgrades are only allowed once in a twelve month rolling period and are subject to medical underwriting. ■ Upgrades may be declined based upon underwriting review. ■ The requests for changes must be submitted to Aetna Small Group Underwriting 30 days prior to the requested effective date. ■ Late requests will be moved to the next applicable effective date pending underwriting approval. ■ 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.
Product Availability	**Medical** ■ Pick-A-Plan allows each employee the option to choose their medical product from a wide selection of product offerings selected by the employer. ■ Employer may choose either 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 into. ■ Requests to add more products to the group's contract are subject to medical underwriting, *if the group did not choose Pick-A-Plan (all plans) at their original effective date.* ■ Rates for 2 to 50 will be tabular age banded. ■ Carve Outs: Allowed (See Carve Out section) ■ Pick-A-Plan: Allowed (See Pick-A-Plan section) ■ 1099 Employees: Allowed (See 1099 Employee Section) **Dental** ■ **Employers with 3 or more eligible,** Dental may be sold on a standalone basis or along with the Medical on a bundled or unbundled basis. ■ **Employers with less than 3 eligible employees or 2 enrolled:** > Dental must be sold with Medical and cannot be sold on a standalone basis. > Voluntary Dental products are not available for groups with less than 3 eligible employees. ■ If the Employer selects both Medical and Dental coverages, it must be offered to all employees. > Eligible employees do not have to enroll in both plans. Employees may enroll in Dental and not Medical and vice-versa. ■ Orthodontic coverage is included for groups with 10 or more eligible employees and is available for both adults and dependent children. ■ Carve Outs: Not Allowed ■ Pick-A-Plan: Not Available ■ 1099 Employees: Not Allowed **Life** ■ **Employers with 2 to 9 eligible employees,** Life must be sold with medical and cannot be sold on a standalone basis. ■ **Employers with 10 to 25 eligible employees,** Life is available packaged with either Medical or Dental. ■ **Employer with 26 to 50 eligible employees,** Basic Term Life is available either packaged with Medical or Dental or on a standalone basis. ■ Employees may elect Life coverage even if they do not elect Medical coverage or vice versa. ■ Employers with less than 10 eligible employees, certain plan differences apply. ■ Carve Outs: Not allowed ■ Pick-A-Plan — Not Available ■ 1099 Employees: Not Allowed

Rates — Tabular or Composite

Effective April 1, 2008, the Standard Risk Rates are based on the Employer's zip code.

Tabular Rate Structure

- Employers with Pick-A-Plan (all plans) will be tabular rated.
- Employers with at least 25 enrolling employees have the option of composite or tabular rates.
- All rates are based upon the Employer zip code.

Composite Rate Structure

- Employers with at least 25 enrolling employees may elect composite rating.
- Employers can offer a maximum of 4 Aetna medical plans to their employees.
- One employee **must** enroll into each plan and remain in a plan for it to be available at renewal.
- New hires may only enroll into one of the 4 plans that are offered.
- Employers can not change rating structure until renewal.
- COBRA/Cal COBRA employees are not counted as eligible.

Employers may elect tabular rating at renewal; however, plan change requests may be subject to underwriting approval.
Employers may elect Pick-A-Plan at renewal; however, this may be subject to underwriting approval.

Rate Guarantee

- Medical rates are guaranteed for one year (12 months).
- Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date this does not apply.
- Life rates are guaranteed for 2 years (24 months).

Renewal Benefit Changes

- Requests for plan changes to be effective on the renewal date, must be submitted prior to the renewal date.
- Requests for plan changes to be effective off of the renewal date must be submitted within 30 days of the requested effective date.
- The effective date for the plan change will be based upon notification receipt (this will be the date the email or fax was sent to Aetna).

Signature Dates

- The Aetna Employer Application and all employee applications must be signed and dated **prior to and** within sixty (60) days of the requested effective date.
- All employee applications must be completed by the employee himself/herself.

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

Aetna will consider the group guarantee issue with the following:

- A letter from the group or broker indicating the group is enrolling as a spin-off. Letter needs to include the name of the group they are spinning off from.
- Ownership documents showing that the spin-off company is a **newly formed separate entity**.
- A minimum of 2 weeks payroll. If the group that is spinning off has been in business longer than 2 weeks, payroll will be required for amount of time in business up to a maximum of 6 consecutive weeks.
- Medical claims will be requested and used along with the health information included on the employee application in order to provide an accurate RAF.
- A group that is spinning off of another Aetna group is not eligible for current RAF promotions.

Tax Documentation

- 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.
- Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status.
- The employer must submit a copy of the most recently filed DE 6 (Quarterly Wage Tax Statement) which must contain the names, salaries, and withholdings for all employees of the employer group along with a signature of the company representative.
- In the event that a DE 6 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.
- When a DE 6 or payroll records are submitted:
  - Employees who have terminated, work part-time or are newly hired should be noted accordingly on the document.
  - Any handwritten comments added to the document must be signed and dated by the employer.
  - For newly-hired employees not listed on the document the employer must provide at least 2 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.
  - 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.
  - Other documentation may be requested by Underwriting upon receipt and review of sold case documents for final underwriting approval and installation.
  - Altered legal documentation will not be accepted.
  - Proprietors, Partners or Officers of the business who do not appear on the DE 6 or payroll must submit one of the following identified documents along with a completed and signed Proof of Eligibility Form

Sole Proprietor Franchise Limited Liability Company (operating as a Sole Proprietor)	IRS Schedule SE and Schedule C filed with Form 1040C; or IRS Form 1040; Schedule F or K1
Partner Partnership Limited Liability Partnership	IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)
Corporate Officer Limited Liability Company(operating as C Corp) C-Corporation Personal Service Corporation S-Corporation	Statement by Domestic Stock or Statement of Information IRS Forms 1120; IRS Form 1120 or IRS Form 1120 W (C-Corp & Personal Service Corp) IRS Form 1120 S, Schedule K1 or 1040 ES (estimated tax) (S-Corp) IRS Form 8832 (Entity classification as a corporation)

1099 Employees

At new business 1099 employees must appear on the prior carrier billing statement. 1099 Employees are not defined as an eligible employee and therefore not protected by AB1672; however, Aetna will allow 1099 employee's to enroll subject to the following guidelines:

- 1099 employees must appear on the prior carrier billing statement.
- An Employer may only add 1099 employees to their plan either at the initial enrollment or at renewal.
- 1099 employees must work full-time (minimum of 30 hours per week) on a year-round basis or 20 hours per week if the group covers part-time employees.
- There must be an affiliation between the employer and the employee long enough for a Federal Tax return to be filed.
- The employer must agree to contribute the same amount towards the premium as they would for an employee reported on a W-2.
- The employer must agree to offer coverage to all future 1099 employees.
- No more than 25% of the group may be 1099 employees.
- The 1099 employee verification form must be completed and submitted along with the following documentation:
  - > Letter from the employer requesting to cover 1099 employees.
  - > Copies of the Form 1040 Schedule C and Form 1099 Miscellaneous for the prior year.

Townships and Municipalities

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

Underwriting Requirements

- QWTS
- W2 — Elected or Appointed officials and Trustees "may" be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS rather they may be paid via W2. In that case, obtain a copy of their prior year W2.
- 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.

Vitalidad México con Aetna

- Vitalidad may be offered as a standalone product.
- Vitalidad may be included in our Pick-A-Plan portfolio with all other plans.
- All other underwriting guidelines apply with the exception of the following:

Eligibility

- 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).
- Participation of 65% for groups of 2 to 50 (excluding valid waivers) for those employers which have employees located in a Vitalidad Service Area with a minimum of 1 employee enrolling in Vitalidad.
- The Vitalidad service area is defined as the Mexican cities of Tecate, Mexicali, and Tijuana and including the following US Zip Codes that fall within a 50-mile radius:

91901	91951	92033	92090	92127	92164
91902	91962	92036	92091	92128	92165
91903	91963	92037	92092	92129	92166
91905	91976	92038	92093	92130	92167
91906	91977	92039	92096	92131	92168
91908	91978	92040	92101	92132	92169
91909	91979	92046	92102	92133	92170
91910	91980	92049	92103	92134	92171
91911	91987	92051	92104	92135	92172
91912	91990	92052	92105	92136	92173
91913	92004	92054	92106	92137	92174
91914	92007	92056	92107	92138	92175
91915	92008	92058	92108	92139	92176
91916	92009	92064	92109	92140	92177
91917	92010	92065	92110	92142	92178
91921	92011	92066	92111	92143	92179
91931	92013	92067	92112	92145	92182
91932	92014	92069	92113	92147	92184
91933	92018	92070	92114	92149	92186
91934	92019	92071	92115	92150	92187
91935	92020	92072	92116	92152	92190
91941	92021	92074	92117	92153	92191
91942	92022	92075	92118	92154	92192
91943	92023	92078	92119	92155	92193
91944	92024	92079	92120	92158	92194
91945	92025	92081	92121	92159	92195
91946	92026	92082	92122	92160	92196
91947	92027	92083	92123	92161	92197
91948	92029	92084	92124	92162	92198
91950	92030	92085	92126	92163	92199

Existing California groups buy up/buy down guide
Effective 4/1/09

2008 Plan Name	2009 Plan Name	HMO 10	HMO 15	HMO 20	HMO 30	HMO 40 (new)	HMO HRA 750	HMO HRA 1500	AVN HMO 10	AVN HMO 20	AVN HMO 30	AVN HMO 40 (new)
HMO 10/20	HMO 10		D	D	D	D	D	D	D	D	D	D
HMO 10/30	HMO 15	U		D	D	D	D	D	D	D	D	D
HMO 20/40	HMO 20	U	U		D	D	D	D	D	D	D	D
HMO 30/40	HMO 30	U	U	U		D	D	D	D	D	D	D
HMO Deductible	HMO Deductible	U	U	U	D	D	D	D	D	D	D	D
HMO HRA 750	HMO HRA 750	U	U	U	U	U		D	D	D	D	D
HMO HRA 1500	HMO HRA 1500	U	U	U	U	U	U		D	D	D	D
AVN 10/20	AVN 10	U	U	D	D	D	D	D		D	D	D
AVN 20/40	AVN 20	U	U	U	D	D	D	D	U		D	D
AVN 30/40	AVN 30	U	U	U	U	D	D	D	U	U		D
EPO 80	EPO 80	U	U	D	D	D	D	D	D	D	D	D
EPO Limited	MC 10,000 100/50	U	U	U	U	U	U	U	U	U	U	U
MC 250 90/70	MC 250 90/70	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
MC 500 80/60	MC 500 80/60	U	U	D	D	D	D	D	D	D	D	D
MC 1000 70/50	MC 1000 70/50	U	U	U	U	U	D	D	D	D	D	D
MC 1000 80/50/50	MC 1000 80/50/50	U	U	U	U	D	D	D	D	D	D	D
MC 2000 80/50/50	MC 2000 80/50/50	U	U	U	U	D	D	D	D	D	D	D
MC Basic	MC Basic	U	U	U	U	U	U	U	U	U	U	U
MC HSA 2300 80/50	MC HSA 2500 80/50	U	U	U	U	D	U	D	U	D	D	D
MC HSA 3000 100/50	MC HSA 3000 100/50	U	U	U	D	D	D	D	U	D	D	D
MC HSA 3300 80/50	MC HSA 3300 80/50	U	U	U	D	D	D	D	U	D	D	D
MC HRA 3000 80/50	MC HRA 3000 80/50	U	U	U	U	U	U	U	U	U	U	U
MC HRA 5000 80/50	MC HRA 3000 80/50	U	U	U	U	U	U	U	U	U	U	U
PPO 500 90/70	PPO 500 90/70	U	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)

HMO Deductible	EPO 80	MC 250 90/70	MC 250 80/60	MC 500 80/60	MC 750 80/50/50 (new)	MC 1000 70/50	MC 1000 80/50/50	MC 2000 80/50/50	MC 10,000 100/50 (new)	MC Basic	MC HSA 2500 80/50	MC HSA 3000 100/50	MC HSA 3300 80/50	MC HRA 3000 80/50	PPO 500 90/70	PPO 750 80/60 (new)
D	D	U	D	D	D	D	D	D	D	D	D	D	D	D	U	U
D	D	U	U	D	D	D	D	D	D	D	D	D	D	D	U	U
D	D	U	U	D	D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	U	D	D	D	D	D	D	D	D	D	D	U	U
	U	U	U	U	D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	D	D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	U	D	D	D	D	D	D	D	D	D	D	U	U
D	D	U	D	D	D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	U	D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	U	U	D	D	D	D	D	D	D	D	D	U	U
D		U	U	U	U	D	D	D	D	D	D	D	D	D	U	U
U	U	U	U	U	U	U	U	U		D	U	U	U	U	U	U
D	D		D	D	D	D	D	D	D	D	D	D	D	D	U	U
D	D	U		D	D	D	D	D	D	D	D	D	D	D	U	U
D	D	U	U		D	D	D	D	D	D	D	D	D	D	U	U
D	U	U	U	U	D		D	U	D	D	D	D	D	D	U	U
D	U	U	U	U	U	U		D	D	D	D	D	D	D	U	U
D	U	U	U	U	U	U	U		D	D	D	D	D	D	U	U
U	U	U	U	U	U	U	U	U	D		U	U	D	D	U	U
D	U	U	U	U	U	U	U	U	D	D		U	D	D	U	U
D	U	U	U	U	U	U	U	U	D	D	D		D	D	U	U
D	U	U	U	U	U	U	U	U	D	U	U	U		D	U	U
U	U	U	U	U	U	U	U	U	D	U	U	U	D		U	U
U	U	U	U	U	U	U	U	U	D	U	U	U	D		U	U
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D		D

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 HealthFund HMO HRA, Aetna HMO, Aetna Value Network℠ HMO & Vitalidad 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.
- Nonmedically 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.

Aetna EPO, 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.
- Immunizations for travel or work.*
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in the plan documents.
- Nonmedically necessary services or supplies.
- Orthotics, as specified in the plan.
- Over-the-counter medications and supplies.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling.
- Special duty nursing.
- 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 amount (that is, 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.

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

Dental

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

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

Specific service limitations

- DMO plans: Oral exams (4 per year)**
- PPO plans: Oral exams (2 routine and 2 problem focused per year)
- All plans:
  - > Bitewing X-rays (1 set per year)**
  - > Complete series X-rays (1 set every 3 years)**
  - > Cleanings (2 per year)**
  - > Fluoride (1 per year; children under 16)**
  - > Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)**
  - > Scaling and root planing (4 quadrants every 2 years)
  - > Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in the plan documents

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.

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.

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

Submission details and guidelines

Employer Information

Employer Application

Complete all pages of the application

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

Employer Medicare Application

- Complete and sign if any employees are electing an Aetna Medicare plan.
- Only 1st of the month effective dates are available for the entire group's submission.

DE-6 or other applicable tax documents

- Part-time, terminated, seasonal or temporary must be indicated on this wage and tax report.
- For seasonal industries such as farming laborers or season processing fruit plants, four (4) consecutive quarters of wage and tax reports may be requested by underwriting.
- All enrolling employees must be represented on the wage and tax form or included on a payroll report.
- Out-of-state employees require proof of employment if not identified on the DE-6. 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-6, 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-6, 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."

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 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

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

For more information about Aetna's Small Business Solutions, please contact your local Aetna Sales Manager or the Small Group Service Center from 8 a.m. to 5 p.m. PT

Toll Free #:
1-877-249-2472

Fax #:
1-888-258-4530

Email 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 5th business day after the requested effective date.

Notes

Notes

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. HRAs are subject to employer-defined use and forfeiture rules. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc. that operates through mail order. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. 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 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. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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