PLANS EFFECTIVE October 1, 2010
For businesses with 2-50 eligible employees
As a small business owner, providing value to your customers and growing your business are your top priorities. Yet, today health care is a business issue for every entrepreneur.

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

Aetna offers a variety of plans for small business — from medical plans, to dental, life and disability plans.

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

Health/dental benefits and health/dental insurance plans, life and disability insurance/policies plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company, Aetna Dental Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.
**CHOICE**

*For business owners and employees*

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

**Medical plans** — supporting members on their health care journey
- Traditional plans
- Preferred plans
- HSA-Compatible plans

**Dental, life and disability plans** — providing valuable protection
- DMO®
- Participating Dental Network (PDN)
- PDN Max
- Freedom-of-Choice plan design
- Dual Option
- Voluntary
- Term Life Insurance
- Packaged Life and Disability

**EASE**

*Allowing you to focus on your business*

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

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

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

**Aetna Navigator℠** — our online resource for employers, members and providers
- Look up rates for providers, facilities and hospitals for common services and treatment
- Simple Steps To A Healthier Life®, an online health and wellness program
- Track medical claims online
- Discount programs for eye, dental and other health care
- Personal Health Record providing a complete picture of health
- Temporary ID cards available for members to print as needed

**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.

**REPUTATION**

*In business it’s everything*

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

Our account executives, underwriters and customer service representatives are committed to providing your small business the valuable service it deserves.
We know that small business owners’ insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2-50 employees and our insurance benefits programs are designed to work for this size group. We’ll work with you to determine the right plans for your business and assist you through implementation.

### Aetna’s Market Map

**Guiding your small business health care journey**

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

<table>
<thead>
<tr>
<th>Basic benefits for your employees</th>
<th>You might be a …</th>
<th>These plans fit …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting the expense to your business</td>
<td>Basic buyer</td>
<td>OAMC 2500&lt;br&gt;OAMC Preferred 5000&lt;br&gt;OAMC $10,000 Family</td>
</tr>
<tr>
<td>Allowing employees to buy-up and share more of the cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee responsibility</th>
<th>You might be a …</th>
<th>These plans fit …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumerism’s ability to make a difference</td>
<td>Value seeker</td>
<td>OAMC Preferred 2000&lt;br&gt;CPOS 3000 80% Value&lt;br&gt;OAMC HSA 5000 90%</td>
</tr>
<tr>
<td>Tools and resources to support consumerism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovative plan design</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traditional benefits plans</th>
<th>You might be a …</th>
<th>These plans fit …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting the financial impact on employees</td>
<td>Traditionalist</td>
<td>OAMC Preferred 2000&lt;br&gt;OAMC Preferred 3000&lt;br&gt;OAMC HSA 3000 90%</td>
</tr>
</tbody>
</table>

**DO YOU VALUE …**
# Health Insurance Benefits for Every Stage of Life

## Young Singles

- Includes singles and couples without children

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

## Young Families

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

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

## Established Families

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

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

## Empty Nesters

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

The kids are leaving home. It’s a wistful time, but also an exciting one. What are the plans? Travel? Leisure? Reassessing health coverage needs? These employees are probably looking for a policy that combines financial security with quality coverage for prescriptions, hospital inpatient/outpatient services and emergency care.
<table>
<thead>
<tr>
<th>Texas Counties</th>
<th>OAMC/Preferred Provider Benefits Plan (PPO) Network</th>
<th>OAMC/PPO/CPOS/HMO Network</th>
<th>OAMC/Preferred Provider Benefits Plan (PPO) Network</th>
<th>OAMC/PPO/CPOS/HMO Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson</td>
<td>•</td>
<td></td>
<td>Comal</td>
<td>•</td>
</tr>
<tr>
<td>Andrews</td>
<td>•</td>
<td></td>
<td>Comanche</td>
<td>•</td>
</tr>
<tr>
<td>Angelina</td>
<td>•</td>
<td></td>
<td>Concho</td>
<td>•</td>
</tr>
<tr>
<td>Aransas</td>
<td>•</td>
<td></td>
<td>Cooke</td>
<td>•</td>
</tr>
<tr>
<td>Archer</td>
<td>•</td>
<td></td>
<td>Cottle</td>
<td>•</td>
</tr>
<tr>
<td>Armstrong</td>
<td>•</td>
<td></td>
<td>Crane</td>
<td>•</td>
</tr>
<tr>
<td>Atascosa</td>
<td>•</td>
<td></td>
<td>Crosby</td>
<td>•</td>
</tr>
<tr>
<td>Austin</td>
<td>•</td>
<td></td>
<td>Crockett</td>
<td>•</td>
</tr>
<tr>
<td>Bailey</td>
<td>•</td>
<td></td>
<td>Culberson</td>
<td>•</td>
</tr>
<tr>
<td>Bandera</td>
<td>•</td>
<td></td>
<td>Dallam</td>
<td>•</td>
</tr>
<tr>
<td>Bastrop</td>
<td>•</td>
<td></td>
<td>Dallas</td>
<td>•</td>
</tr>
<tr>
<td>Baylor</td>
<td>•</td>
<td></td>
<td>Dawson</td>
<td>•</td>
</tr>
<tr>
<td>Bee</td>
<td>•</td>
<td></td>
<td>De Witt</td>
<td>•</td>
</tr>
<tr>
<td>Bell</td>
<td>•</td>
<td></td>
<td>Delta</td>
<td>•</td>
</tr>
<tr>
<td>Bexar</td>
<td>•</td>
<td></td>
<td>Denton</td>
<td>•</td>
</tr>
<tr>
<td>Blanco</td>
<td>•</td>
<td></td>
<td>Dickens</td>
<td>•</td>
</tr>
<tr>
<td>Borden</td>
<td>•</td>
<td></td>
<td>Dimmit</td>
<td>•</td>
</tr>
<tr>
<td>Bosque</td>
<td>•</td>
<td></td>
<td>Donley</td>
<td>•</td>
</tr>
<tr>
<td>Brazoria</td>
<td>•</td>
<td></td>
<td>Duval</td>
<td>•</td>
</tr>
<tr>
<td>Brazos</td>
<td>•</td>
<td></td>
<td>Eastland</td>
<td>•</td>
</tr>
<tr>
<td>Brewster</td>
<td>•</td>
<td></td>
<td>Ector</td>
<td>•</td>
</tr>
<tr>
<td>Briscoe</td>
<td>•</td>
<td></td>
<td>Edwards</td>
<td>•</td>
</tr>
<tr>
<td>Brooks</td>
<td>•</td>
<td></td>
<td>El Paso</td>
<td>•</td>
</tr>
<tr>
<td>Brown</td>
<td>•</td>
<td></td>
<td>Ellis</td>
<td>•</td>
</tr>
<tr>
<td>Burleson</td>
<td>•</td>
<td></td>
<td>Erath</td>
<td>•</td>
</tr>
<tr>
<td>Burnet</td>
<td>•</td>
<td></td>
<td>Falls</td>
<td>•</td>
</tr>
<tr>
<td>Caldwell</td>
<td>•</td>
<td></td>
<td>Fannin</td>
<td>•</td>
</tr>
<tr>
<td>Calhoun</td>
<td>•</td>
<td></td>
<td>Fayette</td>
<td>•</td>
</tr>
<tr>
<td>Callahan</td>
<td>•</td>
<td></td>
<td>Fisher</td>
<td>•</td>
</tr>
<tr>
<td>Cameron</td>
<td>•</td>
<td></td>
<td>Floyd</td>
<td>•</td>
</tr>
<tr>
<td>Camp</td>
<td>•</td>
<td></td>
<td>Foard</td>
<td>•</td>
</tr>
<tr>
<td>Carson</td>
<td>•</td>
<td></td>
<td>Fort Bend</td>
<td>•</td>
</tr>
<tr>
<td>Castro</td>
<td>•</td>
<td></td>
<td>Franklin</td>
<td>•</td>
</tr>
<tr>
<td>Chambers</td>
<td>•</td>
<td></td>
<td>Freestone</td>
<td>•</td>
</tr>
<tr>
<td>Cherokee</td>
<td>•</td>
<td></td>
<td>Frio</td>
<td>•</td>
</tr>
<tr>
<td>Childress</td>
<td>•</td>
<td></td>
<td>Gaines</td>
<td>•</td>
</tr>
<tr>
<td>Clay</td>
<td>•</td>
<td></td>
<td>Galveston</td>
<td>•</td>
</tr>
<tr>
<td>Cochran</td>
<td>•</td>
<td></td>
<td>Garza</td>
<td>•</td>
</tr>
<tr>
<td>Coke</td>
<td>•</td>
<td></td>
<td>Gillespie</td>
<td>•</td>
</tr>
<tr>
<td>Coleman</td>
<td>•</td>
<td></td>
<td>Glasscock</td>
<td>•</td>
</tr>
<tr>
<td>Collin</td>
<td>•</td>
<td></td>
<td>Goliad</td>
<td>•</td>
</tr>
<tr>
<td>Collingsworth</td>
<td>•</td>
<td></td>
<td>Gonzales</td>
<td>•</td>
</tr>
<tr>
<td>Colorado</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Counties</td>
<td>OAMC/Preferred Provider Benefits Plan (PPO) Network</td>
<td>OAMC/PPO/CPOS/HMO Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------</td>
<td>----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerr</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kimble</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>King</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinney</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kleberg</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knox</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Salle</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamar</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamb</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lavaca</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lee</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leon</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liberty</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limestone</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipcomb</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live Oak</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Llano</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loving</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lubbock</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lynn</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madison</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marion</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martin</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mason</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matagorda</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maverick</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McCullough</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McLean</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McMullen</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medina</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menard</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midland</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milam</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mills</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitchell</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montgomery</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moore</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morris</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motley</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nacogdoches</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navarro</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newton</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nolan</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nueces</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ochiltree</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oldham</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palo Pinto</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panola</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parker</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parmer</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pecos</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polk</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presidio</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potter</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rains</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Randall</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reagan</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red River</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reeves</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugio</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roberts</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robertson</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rockwall</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runnels</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rusk</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sabine</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Augustine</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Jacinto</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Patricio</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Saba</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schleicher</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scurry</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shackelford</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelby</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sherman</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smith</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somervell</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starr</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephens</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterling</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stonewall</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutton</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swisher</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tarrant</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taylor</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terrell</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terry</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throckmorton</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Titus</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tom Green</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travis</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trinity</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tyler</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upshur</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upton</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uvalde</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Val Verde</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Zandt</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waller</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Webb</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wharton</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheeler</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wichita</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilbarger</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willacy</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Williamson</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilson</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winkler</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wise</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wood</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoakum</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zapata</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zavala</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Network subject to change.
WELLNESS ON US®

Wellness for your employees means a healthier business for you. Our small business health benefits and insurance plans in Texas include $0 copay in-network for preventive care. It’s one more way to help your employees get a step closer to better health. Check out what your employees can get for $0:

- Routine vision screening — $0 copay
- Routine physicals — $0 copay
- Child wellness visits — $0 copay
- Routine mammogram — $0 copay
- Routine ob/gyn visits — $0 copay
- Immunizations — $0 copay

AETNA OPEN ACCESS® MANAGED CHOICE® (OAMC) PLAN

For those who want the advantages of a managed care insurance plan while giving employees flexibility to access any providers without a referral.

- No PCP selection required (members who prefer to have their family physician coordinate their care may designate a PCP if they choose).
- No referrals required.
- Members can choose any provider from Aetna’s extensive network for a covered service.
- Members may visit any out-of-network recognized provider for a covered service.
- For certain plans, members pay office visit copay each time member goes to a participating specialist or non-specialist physician.
AETNA CHOICE® POS (CPOS) PLAN

No need for referrals; freedom to select provider of choice

The Aetna Choice POS plan offers all the health plan benefits of a point-of-service plan with two easy ways to access care when members need it. Members have the freedom to visit the participating doctor or hospital of their choice for covered services. Best of all, members seeking health care do not need referrals. This plan allows members to:

■ Visit a participating physician of primary care and pay the plan’s copayment for covered benefits.
■ Go directly to any specialist from within Aetna’s network of providers and pay the applicable specialist copayment for covered benefits.
■ Go directly to any licensed out-of-network physician, subject to payment of a deductible and coinsurance.
■ Large provider networks.

WHAT MAKES AETNA’S HDHP PLANS UNIQUE?

All of our HSA plans include an embedded deductible which means lower out-of-pocket costs!

WHAT IS AN EMBEDDED DEDUCTIBLE?

Unlike many HSA plans, with an Aetna HSA plan each covered family member only needs to satisfy his or her individual deductible before plan coinsurance applies, not the entire family deductible. Many HSA plans in today’s marketplace do not include embedded deductibles, thereby requiring enrolled members to satisfy the entire family deductible before plan coinsurance applies.

AETNA HIGH-DEDUCTIBLE OPEN ACCESS MANAGED CHOICE (OAMC) (HSA-COMPATIBLE)

The Aetna Open Access Managed Choice benefits plan insurance options that are compatible with a Health Savings Account (HSA) provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

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

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

- Emergency care coverage anywhere, anytime, 24 hours a day.
- Large provider network.
- No claim forms in-network.
- If members choose a provider from Aetna’s network of participating physicians and hospitals, out-of-pocket costs will be lower.
- If members choose a physician or hospital outside of the network, out-of-pocket costs will be higher.

AETNA HMO PLUS PLAN

This health benefits plan values the role of the physician of primary care to serve as the coordinator of the member’s health care. For preferred services and supplies, the member must elect a physician of primary care. Members seeking health care have the flexibility to access care in or out of the network. Except for certain direct access benefits, members self-referring to network Specialists or seeking out-of-network care will share more of the cost of care through a deductible and coinsurance.

The Aetna HMO Plus plan provides:

- Flexibility to self-refer. Physician of primary care election is required to access preferred benefits.
- No lifetime dollar maximums in-network.
- Large provider networks.
- For preferred services and supplies, members are encouraged to choose a physician of primary care from Aetna’s network of participating providers.
- Members visit a physician of primary care for routine care or for injury or illness; members pay applicable copay each time covered benefits are accessed within the network with a physician of primary care referral.
- Members may visit any out-of-network licensed provider, without a physician of primary care referral for a covered benefit; members share the cost of care through deductible/coinsurance.
**AETNA INDEMNITY PLAN**

This insurance plan option is available for employees who live outside of the network plan’s service area.

- Individual coordinates his or her own health care.
- No PCP required.
- No referral required.
- Members can access any recognized physician or hospital for covered services.
- Employer may offer a Preferred Provider Benefits plan to in-area employees and the Indemnity plan to out-of-area employees.
- Deductibles and coinsurance apply.
- Annual and lifetime maximums may apply.
- No network providers.
- Members are responsible for paying provider directly and submitting claims for reimbursement.

**HEALTH SAVINGS ACCOUNT (HSA)**

*No set-up or administrative fees*

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

### MEMBER’S HSA PLAN

<table>
<thead>
<tr>
<th>HSA ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>You own your HSA</td>
</tr>
<tr>
<td>Contribute tax free</td>
</tr>
<tr>
<td>You choose how and when to use your dollars</td>
</tr>
<tr>
<td>Roll it over each year and let it grow</td>
</tr>
<tr>
<td>Earns interest, tax free</td>
</tr>
</tbody>
</table>

### HIGH-DEDUCTIBLE HEALTH PLAN

- Eligible in-network preventive care services will not be subject to the deductible
- You pay 100% until deductible is met, then only pay a share of the cost
- Meet out-of-pocket maximum, then plan pays 100%
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
The Aetna HealthFund HRA combines the protection of a deductible-based health plan with a health fund that pays for eligible health care services. The member cannot contribute to the HRA, and employers have control over HRA plan designs. The fund is available to an employee for qualified expenses on the plan’s effective date. The HRA and the HSA provide members with financial support for higher out-of-pocket health care expenses. Aetna’s consumer-directed health products and services give members the information and resources they need to help make informed health care decisions for themselves and their families while helping lower employers’ costs.

SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS
Employees can reduce their taxable income, and employers can pay less in payroll taxes. There are three ways to save:

Premium Only Plans (POP)
Employees can pay for their portion of the group health insurance expenses on a pretax basis.

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

Transit Reimbursement Account (TRA)
TRAs allow participants to use pretax dollars to pay transportation and parking expenses for the purpose of commuting to and from work.

Administrative fees

<table>
<thead>
<tr>
<th>FEE DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA</td>
<td>Initial Set-Up $0</td>
</tr>
<tr>
<td></td>
<td>Monthly Fees $0</td>
</tr>
<tr>
<td>POP</td>
<td>Initial Set-Up* $150</td>
</tr>
<tr>
<td></td>
<td>Renewal $75</td>
</tr>
<tr>
<td>HRA and FSA**</td>
<td>Initial Set-Up</td>
</tr>
<tr>
<td></td>
<td>2-25 Employees $350</td>
</tr>
<tr>
<td></td>
<td>26-50 Employees $450</td>
</tr>
<tr>
<td></td>
<td>Renewal Fee 50% of the initial set-up fee</td>
</tr>
<tr>
<td></td>
<td>Monthly Fees*** $5.00 per participant</td>
</tr>
<tr>
<td></td>
<td>Additional Set-Up Fee for “stacked” plans (those electing an Aetna HRA and FSA simultaneously) $150</td>
</tr>
<tr>
<td></td>
<td>Participation Fee for “stacked” participants $9.75 per participant</td>
</tr>
<tr>
<td>Minimum Fees</td>
<td>0-25 Employees $10 per month minimum</td>
</tr>
<tr>
<td></td>
<td>26-50 Employees $5 per month minimum</td>
</tr>
<tr>
<td>TRA</td>
<td>Annual Fee $350</td>
</tr>
<tr>
<td></td>
<td>Transit Monthly Fees $4.25 per participant</td>
</tr>
<tr>
<td></td>
<td>Parking Monthly Fees $3.15 per participant</td>
</tr>
<tr>
<td>COBRA</td>
<td>Annual Fee 20-50 Employees $50</td>
</tr>
<tr>
<td></td>
<td>Monthly Fee $0.85 per employee</td>
</tr>
</tbody>
</table>

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

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

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

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

Aetna reserves the right to change any of the above fees and to impose additional fees upon prior written notice.
**OPEN ACCESS® MANAGED CHOICE® (OAMC)**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC 500 — 10</th>
<th>TX OAMC 1000 — 10</th>
<th>TX OAMC 1500 — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
<td>Out-of-Network*</td>
<td>In-Network</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Calendar Year Deductible**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Calendar Year Out-Of-Pocket Maximum***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$5,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>$20</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>$40</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0</td>
<td>Deductible waived</td>
<td>30%</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>$20</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>$20</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Spinal</td>
<td>$40</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>20 visits per calendar year limit, combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td>$40</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>20 visits per calendar year limit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20% after $150</td>
<td>Paid as In-Network</td>
<td></td>
</tr>
<tr>
<td>(Copay waived if admitted)</td>
<td>Deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50</td>
<td>Deductible waived</td>
<td>40%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>60 visits per calendar year limit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(2,500 per member per calendar year maximum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy — Retail, 30 Day supply; includes</td>
<td>$15/$35/$50</td>
<td>Retail copay + 30%</td>
<td>$15/$35/$50</td>
</tr>
<tr>
<td>Oral Contraceptives and Diabetic Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>90 Day Transition of Coverage (TOC) for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rx Prior Authorization and Step Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Plans are underwritten by Aetna Life Insurance Company.**

*You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.**

***“Out of Pocket Max” excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met.***

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
### OPEN ACCESS® MANAGED CHOICE® (OAMC)

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC 2000 90% — 10</th>
<th>TX OAMC 2500 — 10</th>
<th>TX OAMC Preferred 1000 — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
<td>Out-of-Network*</td>
<td>In-Network</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Calendar Year Deductible**</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$2,500</td>
</tr>
<tr>
<td>Individual</td>
<td>$6,000</td>
<td>$12,000</td>
<td>$7,500</td>
</tr>
<tr>
<td>Family</td>
<td>$8,500</td>
<td>$17,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Calendar Year Out-Of-Pocket Maximum***</td>
<td>$9,000</td>
<td>$18,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Individual</td>
<td>$10,500</td>
<td>$21,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Family</td>
<td>$13,000</td>
<td>$26,000</td>
<td>$21,000</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>$30 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>$50 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>$30 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>$30 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>$50 Deductible waived</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Physical, Occupational and Spinal</td>
<td>$50 Deductible waived</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Speech 20 visits per calendar year limit</td>
<td>$50 Deductible waived</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Emergency Room (Copay waived if admitted)</td>
<td>10% after $200 Deductible waived</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$100 Deductible waived</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Skilled Nursing Facility 30 days per calendar year limit</td>
<td>$100 Deductible waived</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Home Health Care (60 visits per calendar year limit)</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Durable Medical Equipment ($2,500 per member per calendar year maximum)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$15/$40/$60</td>
<td>Retail copay + 30%</td>
<td>$15/$40/$60</td>
</tr>
<tr>
<td>Pharmacy — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies</td>
<td>$20/$40/$70++</td>
<td>Retail copay + 30%</td>
<td>$20/$40/$70++</td>
</tr>
</tbody>
</table>

---

**Plans are underwritten by Aetna Life Insurance Company.**

**You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximum. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.**

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.**

**Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met.**

**Mandatory Generics policy applies. Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.**

---

**Notes:**

- **Copay:** The amount you pay for covered services. Copay is an example of a deductible.
- **Deductible:** The amount you must pay for covered services before the plan pays any benefit. Deductible is an example of a copay.
- **Coinsurance:** The amount you pay once the deductible has been met. The amount you pay is a percentage of the allowed or usual and customary charge for the service.
- **Out-of-pocket maximum:** The amount you will pay in a calendar year. After this amount, the plan pays 100% of covered services for the remainder of the year.
**Open Access® Managed Choice® (OAMC)**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC Preferred 2000 — 10</th>
<th>TX OAMC Preferred 3000 — 10</th>
<th>TX OAMC Preferred 5000 — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>20% 50%</td>
<td>20% 50%</td>
<td>20% 50%</td>
</tr>
</tbody>
</table>

**Calendar Year Deductible**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

**Lifetime Maximum Benefit**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit</th>
<th>Unlimited</th>
<th>Unlimited</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>$30</td>
<td>Deductible waived</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>$60</td>
<td>Deductible waived</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0</td>
<td>Deductible waived</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Outpatient Therapy**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Spinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20 visits per calendar year limit, combined | 50% | 50% | 50% | 50% | 50% | 50% |

**Passed**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20 visits per calendar year limit | 50% | 50% | 50% | 50% | 50% | 50% |

**Inpatient Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20% Professional/ 50% Facility    | 50% | 50% | 50% | 50% | 50% | 50% |

**Outpatient Surgery**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(Copay waived if admitted)         |                   |            |                   |            |                   |            |
20% Professional/ 50% Facility    | 50% | 50% | 50% | 50% | 50% | 50% |

**Emergency Room**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
250 copay                        | 50% | 50% | 50% | 50% | 50% | 50% |

**Complex Imaging**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Spinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20 visits per calendar year limit, combined | 50% | 50% | 50% | 50% | 50% | 50% |

**Prescription Drugs**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Contraceptives and Diabetic Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
$20/$40/$70**                    | 30% | 30% | 30% | 30% | 30% | 30% |

**Pharmacy**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail copay +</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
30% | 30% | 30% | 30% | 30% | 30% |

**90 Day Transition of Coverage (TOC)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
<th>Deductible waived</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Authorization and Step Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Apples | Apples | Apples | Apples | Apples | Apples | Apples |

*Plans are underwritten by Aetna Life Insurance Company.

*You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.**

**Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of Pocket maximum is considered to have been met.**

**Prescription Drug expenses are integrated with the medical plan (i.e., subject to plan deductible and applied toward the out of pocket max).**

**Mandatory Generics policy applies.**

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
**OPEN ACCESS® MANAGED CHOICE® (OAMC)**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
<td>Out-of-Network*</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Calendar Year Deductible**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

**Calendar Year Out-Of-Pocket Maximum**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>N/A</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>N/A</td>
<td>$21,000</td>
</tr>
</tbody>
</table>

**Lifetime Maximum Benefit**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>$30 Deductible waived</td>
<td>$30 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>$50 Deductible waived</td>
<td>$50 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 Deductible waived</td>
<td>$0 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Diagnostic Procedures**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Lab</td>
<td>$30 Deductible waived</td>
<td>$30 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>$30 Deductible waived</td>
<td>$30 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>$0 Deductible waived</td>
<td>$0 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Outpatient Therapy**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational and Spinal</td>
<td>$50 Deductible waived</td>
<td>$50 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Speech**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50 Deductible waived</td>
<td>$50 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Inpatient Hospital Services**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Outpatient Surgery**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Emergency Room**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$250 Deductible waived</td>
<td>$250 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>Paid as In-Network</td>
<td>Paid as In-Network</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Urgent Care**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100 Deductible waived</td>
<td>$100 Deductible waived</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Skilled Nursing Facility**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Hospice Care**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Home Health Care**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Durable Medical Equipment**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$15/$40/$60 Retail copay + 30%</td>
<td>$15/$40/$60 Retail copay + 30%</td>
</tr>
</tbody>
</table>

**Pharmacy Deductible**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy**

<table>
<thead>
<tr>
<th></th>
<th>TX OAMC 3000 100% — 10</th>
<th>TX OAMC 5000 100% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applies</td>
<td>Applies</td>
</tr>
</tbody>
</table>

---

Plans are underwritten by Aetna Life Insurance Company.

* You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.**

***Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met.**

**Prescription Drug expenses are integrated with the medical plan (i.e., subject to plan deductible and applied toward the out of pocket max).**

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
**AETNA HEALTH FUND® (AHF) MANAGED CHOICE® MANAGED CHOICE®
OPEN ACCESS — HSA COMPATIBLE PLANS**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC HSA 3000 90% — 10</th>
<th>TX OAMC HSA 5000 90% — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
<td>Out-of-Network*</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Calendar Year Deductible**</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td></td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Out-Of-Pocket Maximum***</td>
<td>$5,950</td>
<td>$12,000</td>
</tr>
<tr>
<td></td>
<td>$11,900</td>
<td>$24,000</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 Deductible waived</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>$0 Deductible waived</td>
<td>30%</td>
</tr>
<tr>
<td>Diagnostic Outpatient Lab/X-rays/Testing (Facility)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient Therapy — Physical, Occupational or Spinal; (Limited to 20 visits per cal year combined)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient Therapy — Speech; (Limited to 20 visits per cal year)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Emergency Room Copay/Coinsurance</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Urgent Care Copay/Coinsurance</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (30 days per calendar year limit)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Home Health Care (60 visits per calendar year limit)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Durable Medical Equipment ($2,500 per member per calendar year maximum)</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Pharmacy+ — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies+</td>
<td>$10/$30/$60</td>
<td>Retail copay + 30%</td>
</tr>
<tr>
<td></td>
<td>$10/$30/$60</td>
<td>Retail copay + 30%</td>
</tr>
<tr>
<td>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</td>
<td>Applies</td>
<td>Applies</td>
</tr>
<tr>
<td></td>
<td>Applies</td>
<td>Applies</td>
</tr>
</tbody>
</table>

---

Plans are underwritten by Aetna Life Insurance Company.

You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

**All services except office visits for preventive services are subject to deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.**

**Out-of-Pocket Maximum includes deductible, member’s share of coinsurance, copay (if applicable), and pharmacy expenses.**

Prescription Drug expenses are integrated with the medical plan (i.e., subject to plan deductible and applied toward the out of pocket max).

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before other family members will be considered to have met the limit. In-network and out-of-network expenses accumulate separately and do not cross-apply.**

++ Mandatory Generics policy applies.

*Referrals are not required for a member to access in-network, covered services. Member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist. Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
### AETNA HMO PLUS QUALITY POINT-OF-SERVICE (QPOS) NETWORK

**PLAN FEATURES**

<table>
<thead>
<tr>
<th></th>
<th>TX HMO 40 Plus — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Member Coinsurance</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td><strong>Out-Of-Pocket Maximum</strong></td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Office Visits (non-Specialist)</strong></td>
<td>$40</td>
</tr>
<tr>
<td><strong>Office Visits (Specialist)</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td>$40</td>
</tr>
<tr>
<td><strong>Outpatient Lab</strong></td>
<td>$40</td>
</tr>
<tr>
<td><strong>Complex Imaging</strong></td>
<td>$250</td>
</tr>
<tr>
<td><strong>Outpatient Therapy</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>$500 per day; 5 day max</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$300</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$250</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>$500 per day; 5 day max</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>$500 per day; 5 day max</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>$2,500 per member per calendar year maximum</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>$20/$40/$70</td>
</tr>
<tr>
<td><strong>Pharmacy Retail, 30 Day supply; Includes Oral Contraceptives and Diabetic Supplies</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Underwritten by Aetna Health Inc and Aetna Health Insurance Company.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.

*Payment for out-of-network facility care is determined based on Aetna's allowable fee schedule payment. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services were received from a preferred provider. These charges are referred to in your plan documents as “Recognized Charges.” In addition to deductible, copayment and coinsurance, an out-of-network provider may bill a member for the difference between the Recognized Charge and the provider’s billed charge.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before other family members will be considered to have met the limit. In-network and out-of-network expenses accumulate separately and do not cross apply.

**Out of Pocket Max excludes deductible, pharmacy and DME. All other covered expenses (in-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before other family members will be considered to have met the maximum.

*Primary Physician selection and referrals are required for a member to access in-network, covered services.
**OPEN ACCESS® MANAGED CHOICE® (OAMC)**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX OAMC $10,000 Family — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Plan Coinsurance</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td><strong>Individual</strong> $10,000</td>
</tr>
<tr>
<td></td>
<td><strong>Family</strong> $10,000</td>
</tr>
<tr>
<td><strong>Calendar Year Out-Of-Pocket Maximum</strong></td>
<td><strong>Individual</strong> N/A</td>
</tr>
<tr>
<td></td>
<td><strong>Family</strong> N/A</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Office Visits (Non-specialist)</strong></td>
<td>$25</td>
</tr>
<tr>
<td><strong>Office Visits (Specialist)</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td><strong>Outpatient Lab</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient X-Rays/Testing (Facility)</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Complex Imaging</strong> 0%</td>
</tr>
<tr>
<td><strong>Outpatient Therapy</strong></td>
<td><strong>Physical, Occupational and Spinal — 20 visits per calendar year limit, combined</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Speech — 20 visits per calendar year limit</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient Hospital Services</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient Surgery</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency Room (Copay waived if admitted)</strong> $250</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent Care</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled Nursing Facility — 30 days per calendar year limit</strong> 0%</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td><strong>Inpatient</strong> 0%</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient</strong> 0%</td>
</tr>
<tr>
<td><strong>Home Health Care — 60 visits per calendar year limit</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment — $2,500 per member per calendar year maximum</strong></td>
<td>0%</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td><strong>Pharmacy — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies</strong> $20/$40/$70++</td>
</tr>
<tr>
<td></td>
<td><strong>Pharmacy Deductible</strong> N/A</td>
</tr>
<tr>
<td></td>
<td>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</td>
</tr>
</tbody>
</table>

*Plans are underwritten by Aetna Life Insurance Company.*

**You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.*

***Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Once the family Out of Pocket Maximum is met, all family members will be considered as having met their Out of Pocket Maximum for the remainder of the calendar year.*

**Prescription Drug expenses are integrated with the medical plan (i.e., subject to plan deductible and applied toward the out of pocket max).**

**Mandatory Generics policy applies.**

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.

All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Once the family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.
**Open Access® Managed Choice® (OAMC)**

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>TX Basic OAMC 2500 —10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Plan Coinsurance</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>Calendar Year Out-Of-Pocket Maximum</strong>*</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$18,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Unlimted</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Benefit Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits (Non-specialist)</strong></td>
<td>$35 — Deductible waived (3 visits per year, specialist &amp; non-specialist combined at copay; additional visits subject to D&amp;C)</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Office Visits (Specialist)</strong></td>
<td>$35 — Deductible waived (3 visits per year, specialist &amp; non-specialist combined at copay; additional visits subject to D&amp;C)</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>$0 — Deductible waived (preventive visits do not count toward 3 office visit limit)</td>
</tr>
<tr>
<td></td>
<td>30%</td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>50%</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Spinal (20 visits per calendar year limit, combined)</td>
<td>$35 — Deductible waived (3 visits per year, specialist &amp; non-specialist combined at copay; additional visits subject to D&amp;C)</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Speech (20 visits per calendar year limit; in-network and out-of-network combined)</td>
<td>$35 — Deductible waived (3 visits per year, specialist &amp; non-specialist combined at copay; additional visits subject to D&amp;C)</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Emergency Room (Copay waived if admitted)</td>
<td>50% Paid as In-Network</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility (60 days per calendar year limit)</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Home Health Care (60 visits per calendar year limit)</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong> ($2,500 per member per calendar year maximum)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Pharmacy — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies</td>
<td>$15 copay for Generic meds. Member pays 100% for Brand</td>
</tr>
<tr>
<td></td>
<td>$15 copay + 30% for Generic meds. Member pays 100% for Brand</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>N/A</td>
</tr>
<tr>
<td>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</td>
<td>Applies</td>
</tr>
</tbody>
</table>

*All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.*

**Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met. Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
**PREFERRED PROVIDER ORGANIZATION (PPO)**

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>TX PPO 2000 — 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Calendar Year Deductible**</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
</tr>
<tr>
<td>Calendar Year Out-Of-Pocket Maximum***</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$12,000</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td></td>
</tr>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>$30</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>$50</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td></td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>$30</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>$30</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Spinal (20 visits per calendar year limit, combined)</td>
<td>$50</td>
</tr>
<tr>
<td>Speech (20 visits per calendar year limit, in-network and out-of-network combined)</td>
<td>$50</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency Room (Copay waived if admitted)</td>
<td>20% after $150</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75</td>
</tr>
<tr>
<td>Skilled Nursing Facility (30 days per calendar year limit)</td>
<td>20%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20%</td>
</tr>
<tr>
<td>Home Health Care (60 visits per calendar year limit)</td>
<td>20%</td>
</tr>
<tr>
<td>Durable Medical Equipment ($2,500 per member per calendar year maximum)</td>
<td>50%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Pharmacy — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies</td>
<td>$15/$40/$60</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>N/A</td>
</tr>
<tr>
<td>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</td>
<td></td>
</tr>
</tbody>
</table>

Plans are underwritten by Aetna Life Insurance Company.  

*You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor. The out-of-network provider will be paid based on Aetna’s “recognized charge.” This is not the same as the billed charge from the doctor. Aetna pays a percentage of the recognized charge, as defined in your plan. You may have to pay the difference between the out-of-network provider’s billed charge and Aetna’s recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor bills you above Aetna’s recognized charge does not count toward your deductible or out-of-pocket maximums. The recognized charge for out-of-network doctors, hospitals, and other out-of-network facilities or providers is a percentage (100 percent or above) of the rate that Medicare pays them. This benefit applies when you choose to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more.  

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. In-network and out-of-network expenses accumulate separately and do not cross apply. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.**  

***Out of Pocket Max excludes copays, pharmacy, deductible, mental health, substance abuse and DME. All other covered expenses (In-network and Out-of-network) accumulate separately toward the Out of Pocket maximum and do not cross apply. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met. Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.*
### PLAN FEATURES

<table>
<thead>
<tr>
<th>プラン機能</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td>Calendar Year Deductible**</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
</tr>
<tr>
<td>Calendar Year Out-Of-Pocket Maximum***</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$9,000</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
</tr>
<tr>
<td>Office Visits (Non-specialist)</td>
<td>30%</td>
</tr>
<tr>
<td>Office Visits (Specialist)</td>
<td>30%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>0% — Deductible waived</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td></td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient X-Rays/Testing (Facility)</td>
<td>30%</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>40%</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td></td>
</tr>
<tr>
<td>Physical and Occupational (20 visits per calendar year limit, combined)</td>
<td>30%</td>
</tr>
<tr>
<td>Speech (20 visits per calendar year limit; in-network and out-of-network combined)</td>
<td>30%</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>30%</td>
</tr>
<tr>
<td>Emergency Room (Copay waived if admitted)</td>
<td>30%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>30%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (30 days per calendar year limit)</td>
<td>30%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>30%</td>
</tr>
<tr>
<td>Home Health Care (60 visits per calendar year limit)</td>
<td>30%</td>
</tr>
<tr>
<td>Durable Medical Equipment ($2,000 per member per calendar year maximum)</td>
<td>50%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
</tr>
<tr>
<td>Pharmacy — Retail, 30 Day supply; includes Oral Contraceptives and Diabetic Supplies</td>
<td>$15/$40/$60</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>$100 Per member for brand</td>
</tr>
<tr>
<td>90 Day Transition of Coverage (TOC) for Rx Prior Authorization and Step Therapy</td>
<td>Applies</td>
</tr>
</tbody>
</table>

Plans are underwritten by Aetna Life Insurance Company.

**All services subject to deductible unless otherwise noted. Three members must individually meet their deductible before the family deductible is considered to have been met. No one family member may contribute more than the individual deductible amount to the family deductible. Deductible does not apply to the out-of-pocket maximum.

***Out of Pocket Max excludes pharmacy, deductible and DME. All other covered expenses accumulate toward the Out of Pocket maximum. Three members must individually meet their Out of Pocket maximum before the family Out of pocket maximum is considered to have been met.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to pre-certify or obtain approval for certain services such as non-emergency hospital care.
Small business decision makers can choose from a variety of plan design options that help you offer a dental benefits and dental insurance plan that’s just right for your employees.

**The Mouth Matters℠**
Research 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.1 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 Dental/Medical Integration℠ (DMI) program, available at no additional charge to plan sponsors that have both medical and dental coverages with Aetna, focuses on those who are pregnant or have diabetes, coronary artery disease (heart disease) or cerebrovascular disease (stroke) and have not had a recent dental visit. We proactively educate those at-risk members about the impact oral health care can have on their condition. Our member outreach has been proven to successfully motivate those at-risk members who do not normally seek dental care to visit the dentist. Once at the dentist, these at-risk members will receive enhanced dental benefits including an extra cleaning and full coverage for certain periodontal services.

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

**Participating Dental Network (PDN) plan (Options 3-7)**
Members have the choice of using a dentist who participates in Aetna’s network or choosing a licensed dentist who is not in the network. Participating dentists have agreed to offer members services at a negotiated rate and will not balance bill members.*

---

1 The professional entity, Academy of General Dentistry, 2007.

*Discounts for non-covered services may not be available.
DMI may not be available in all states.
**PDN Max plan**

The PDN Max plan uses the same PDN network. When members use out-of-network dentists, however, the service will be covered based on the PDN 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 enables your customer to offer members a quality plan with a significantly lower premium that encourages in-network usage.

**Freedom-of-Choice plan design option**

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

**Dual Option* plan**

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

**Voluntary Dental option**

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

*Dual Option does not apply to Voluntary Dental plans.*
### AETNA SMALL GROUP DENTAL PLANS

**Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees**

**Available Without Medical Plan to Groups with 3-50 Eligible Employees**

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Freedom-of-Choice — Monthly selection between the DMO and the PDN Max Plan</strong></td>
<td>DMO Plan 100/90/60</td>
<td>DMO Plan 100/90/60</td>
<td>PDN Max Plan 100/70/40</td>
</tr>
<tr>
<td><strong>Office Visit Copay</strong></td>
<td>$10</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Annual Deductible per Member</strong> (Does not apply to Diagnostic &amp; Preventive Services)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

#### DIAGNOSTIC SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Exams</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Comprehensive oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Problem-focused oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing — single film</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Complete series</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Child Cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants — per tooth</td>
<td>$10</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride application — with cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>$100</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### BASIC SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam filling — 2 surfaces</td>
<td>$32</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Resin filling — 2 surfaces, anterior</td>
<td>$55</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extraction — exposed root or erupted tooth</td>
<td>$30</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Extraction of impacted tooth — soft tissue</td>
<td>$80</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

#### MAJOR SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete upper denture</td>
<td>$500</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Partial upper denture (resin base)</td>
<td>$513</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Crown — Porcelain with noble metal†</td>
<td>$488</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Pontic — Porcelain with noble metal†</td>
<td>$488</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Inlay — Metallic (3 or more surfaces)</td>
<td>$463</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### ENDODONTIC SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>BicuspH root canal therapy</td>
<td>$195</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Molar root canal therapy</td>
<td>$435**</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### PERIODONTIC SERVICES

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling &amp; root planing — per quadrant</td>
<td>$65</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Osseous surgery — per quadrant</td>
<td>$445**</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,300 copay</td>
<td>$2,300 copay</td>
<td>$2,300 copay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

#### Orthodontic Lifetime Maximum

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>

---

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1-3.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

The copay amounts, including the Office Visit and Ortho Copays on the DMO in Plan Options 1, 2 & 3 are the member’s responsibility.

†There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Option 1.

Access to negotiated discounts: On the PDN plans in Plan Options 3-7, members may be eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN dentist at any time, including during the Coverage Waiting Period. Discounts are not insurance.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 1-3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Options 6.

Plan Options 3, 4, 6& 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO in Plan Options 1 & 2 can be offered with any one of the plans in Plan Options 1, 4, 5-7 in a Dual Option package.

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

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

Aetna Dental Access Network is not insurance or a benefits plan. It only provides access to discounted fees for dental services obtained from providers who participate in the Aetna Dental Access network.

Members are solely responsible for all charges incurred using this access, and are expected to make payment to the provider at the time of treatment.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 44.
## Aetna Small Group Dental Plans

<table>
<thead>
<tr>
<th>Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDN Max Plan 100/80/50</td>
<td>PDN Plan 100/80/50</td>
<td>PDN Plan 100/80/50</td>
<td>PDN Max Plan 80/80/50</td>
<td></td>
</tr>
<tr>
<td>Office Visit Copay</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Annual Deductible per Member (Does not apply to Diagnostic &amp; Preventive Services)</td>
<td>$50; 3X Family Maximum</td>
<td>$50; 3X Family Maximum</td>
<td>$50; 3X Family Maximum</td>
<td></td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$2,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Diagnostic Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Comprehensive oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Problem-focused oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing — single film</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Complete series</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Preventive Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Child Cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Sealants — per tooth</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluoride application — with cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Basic Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam filling — 2 surfaces</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Resin filling — 2 surfaces, anterior</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Oral Surgery

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction — exposed root or erupted tooth</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Extraction of impacted tooth — soft tissue</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Major Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete upper denture</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial upper denture (resin base)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crown — Porcelain with noble metal¹</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Pontic — Porcelain with noble metal¹</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlay — Metallic (3 or more surfaces)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Endodontic Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bicuspid root canal therapy</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Molar root canal therapy</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Periodontic Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling &amp; root planing — per quadrant</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Osseous surgery — per quadrant</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Orthodontic Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 4</th>
<th>Option 5</th>
<th>Option 6</th>
<th>Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>Does not apply</td>
<td>$1,000</td>
<td>$1,500</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>

¹Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1-3.

²Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.

³There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Option 1.

Access to negotiated discounts: On the PDN plans in Plan Options 3-7, members may be eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN dentist at any time, including during the Coverage Waiting Period. Discounts are non-insurance.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 1-3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Option 6.

Plan Options 3, 4 & 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO in Plan Options 1 & 2 can be offered with any one of the plans in Plan Options 1, 4, 5-7 in a Dual Option package.

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

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 44.
# Aetna Small Group Voluntary Dental Plans

<table>
<thead>
<tr>
<th>Available With an Aetna Medical Plan to Groups with 3-50 Eligible Employees</th>
<th>Voluntary Option 1 DMO Access</th>
<th>Voluntary Option 2 DMO Access</th>
<th>Voluntary Option 3 Freedom-of-Choice — Monthly selection between the DMO and the PDN Max Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit Copay</td>
<td>Copay Plan 42</td>
<td>DMO Plan 100/90/60</td>
<td>PDN Max Plan 100/70/40</td>
</tr>
<tr>
<td>Annual Deductible per Member</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

## Diagnostic Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Comprehensive oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Problem-focused oral exam</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X-rays</th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitewing — single film</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Complete series</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Preventive Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Child Cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants — per tooth</td>
<td>$10</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride application — with cleaning</td>
<td>No Charge</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>$100</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Basic Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam filling — 2 surfaces</td>
<td>$32</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Resin filling — 2 surfaces, anterior</td>
<td>$55</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

## Oral Surgery

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction — exposed root or erupted tooth</td>
<td>$30</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Extraction of impacted tooth — soft tissue</td>
<td>$80</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

## Major Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete upper denture</td>
<td>$500</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Partial upper denture (resin base)</td>
<td>$513</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Crown — Porcelain with noble metal</td>
<td>$488</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Pontic — Porcelain with noble metal</td>
<td>$488</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Inlay — Metallic (3 or more surfaces)</td>
<td>$463</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

## Endodontic Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bicuspid root canal therapy</td>
<td>$195</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Molar root canal therapy</td>
<td>$435**</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

## Periodontic Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling &amp; root planing — per quadrant</td>
<td>$65</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Osseous surgery — per quadrant</td>
<td>$445**</td>
<td>60%</td>
<td>60%</td>
</tr>
</tbody>
</table>

## Orthodontic Services

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic copay</td>
<td>$2,300</td>
<td>$2,300</td>
<td>$2,300</td>
</tr>
</tbody>
</table>

## Orthodontic Lifetime Maximum

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Plan Options 1-3</th>
<th>PDN Plan Options 1-3</th>
<th>Voluntary Plan Options 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Lifetime Maximum</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>

---

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 Plan Options 1-3.

2. **Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.**

3. Access to negotiated discounts: On the PDN plans in Voluntary Plan Options 3-6, members may be eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN dentist at any time, including during the Coverage Waiting Period. Discounts are not insurance.

4. Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 2 & 3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Voluntary Option 6.

5. Voluntary Plan Options 3 & 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

6. 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.

7. Orthodontic coverage is available in the DMO in Voluntary Options 1 & 2 to groups with 10 or more eligibles and for dependent children only. 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 44.
## AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PDN Plan</td>
<td>PDN Plan</td>
<td>PDN Plan</td>
<td>PDN Max Plan</td>
</tr>
<tr>
<td></td>
<td>100/80/50</td>
<td>100/80/50</td>
<td>100/80/50</td>
<td>80/80/50</td>
</tr>
<tr>
<td>Office Visit Copay</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Deductible per Member</td>
<td>$50; 3X Family Maximum</td>
<td>$50; 3X Family Maximum</td>
<td>$50; 3X Family Maximum</td>
<td>$50; 3X Family Maximum</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,500</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### DIAGNOSTIC SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Comprehensive oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Problem-focused oral exam</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing — single film</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Complete series</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Child Cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Sealants — per tooth</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluoride application — with cleaning</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### BASIC SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam filling — 2 surfaces</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Resin filling — 2 surfaces, anterior</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### ORAL SURGERY

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction — exposed root or erupted tooth</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Extraction of impacted tooth — soft tissue</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### MAJOR SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete upper denture</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial upper denture (resin base)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crown — Porcelain with noble metal</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Pontic — Porcelain with noble metal</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlay — Metallic (3 or more surfaces)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### PERIODONTIC SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling &amp; root planing — per quadrant</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Osseous surgery — per quadrant</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### ORTHODONTIC SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Voluntary Option 4</th>
<th>Voluntary Option 5</th>
<th>Voluntary Option 6</th>
<th>Voluntary Option 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bicuspid root canal therapy</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Molar root canal therapy</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**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 Plan Options 1-3.

**Specialist procedures are not covered by the plan when performed by a participating Specialist. However, the service is available to the member at a discount.**

1 There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures on the DMO in Plan Option 1.

2 Access to negotiated discounts: On the PDN plans in Voluntary Plan Options 3-6, members may be eligible to receive non-covered services at the PDN negotiated rate when visiting a participating PDN dentist at any time, including during the Coverage Waiting Period. Discounts are not insurance.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Options 2 & 3. All Endodontic and Periodontic services are covered as Basic Services on the PDN in Plan Voluntary Option 6.

Voluntary Plan Options 3 & 7 PDN Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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.

Orthodontic coverage is available on the DMO in Voluntary Options 1 & 2 to groups with 10 or more eligibles and for dependent children only.

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 44.
<table>
<thead>
<tr>
<th>Diagnostic Services</th>
<th>Low Option No Ortho</th>
<th>Low Option Ortho</th>
<th>Medium Option No Ortho</th>
<th>Medium Option Ortho</th>
<th>High Option No Ortho</th>
<th>High Option Ortho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td>Basic Services</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td>Endodontic Services</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td>Periodontal Services</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
</tbody>
</table>

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.

Access to negotiated discounts: On all PPO Max plans, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period. Discounts are not insurance.

PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area. Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

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 44. For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.
### OUT-OF-STATE PPO VOLUNTARY AETNA SMALL GROUP DENTAL PLANS

<table>
<thead>
<tr>
<th></th>
<th>Option 1 No Ortho</th>
<th>Option 1 Ortho</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Plan</strong></td>
<td>PPO Max Plan 100/80/50</td>
<td>PPO Max Plan 100/80/50</td>
</tr>
<tr>
<td><strong>Office Visit Copay</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Annual Deductible per Member</strong></td>
<td>$75; 3X Family Maximum</td>
<td>$75; 3X Family Maximum</td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DIAGNOSTIC SERVICES</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Exams</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Problem-focused oral exam</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Adult Cleaning</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Child Cleaning</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Sealants — per tooth</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Fluoride application — with cleaning</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Space maintainers</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>BASIC SERVICES</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Amalgam filling — 2 surfaces</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Resin filling — 2 surfaces, anterior</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Extraction — exposed root or erupted tooth</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Extraction of impacted tooth — soft tissue</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>MAJOR SERVICES</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Complete upper denture</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Partial upper denture (resin base)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Crown — Porcelain with noble metal</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Pontic — Porcelain with noble metal</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inlay — Metallic (3 or more surfaces)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Removal of impacted tooth — partially bony</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

| **ENDODONTIC SERVICES**    | 50%               | 50%            |
| **Bicuspid root canal therapy** | 50%     | 50%           |
| **Molar root canal therapy** | 50%           | 50%            |

| **PERIODONTIC SERVICES**   | 50%               | 50%            |
| **Scaling & root planing — per quadrant** | 50% | 50% |
| **Osseous surgery — per quadrant** | 50%         | 50% |

| **ORTHODONTIC SERVICES**   | Not covered       | 50%            |
| **Orthodontic Lifetime Maximum** | Does not apply     | $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.

Access to negotiated discounts: On all PPO Max plans, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period. Discounts are not insurance.

PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan’s payment, which is based on the contracted maximum fee for participating providers in the particular geographic area. Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 44.

Aetna Life Insurance Company (Aetna) Small Group packaged life and disability insurance plans include a range of flat-dollar insurance options bundled together in one monthly per-employee rate. These products are easy to understand and offer affordable benefits to help your employees protect their families in the event of illness, injury or death. You’ll benefit from streamlined plan installation, administration and claims processing, and all of the benefits of our standalone life and disability products for small groups. Or, simply choose from our portfolio of group basic term life and disability insurance plans.

LIFE INSURANCE

We know that life insurance is an important part of the benefits package you offer your employees. That’s why our products and programs are designed to meet your needs for:

- Flexibility
- Added value
- Cost-efficiency
- Experienced support

We help you give employees what they’re looking for in lifestyle protection, through our selected group life insurance options. And we look beyond the benefit payout to include useful enhancements through the Aetna Life EssentialsSM program.

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

Giving you (and your employees) what you want

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

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

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

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

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

Our fresh approach to life

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

AD&D Ultra is standardly included with our small group life and disability package and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — 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

DISABILITY INSURANCE

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

Our comprehensive approach to disability helps give us a clear understanding of what you and your employees need … and then helps meet those needs. You’ll get the right resources, the right support and the right care for your employees at the right time:
- Our clinically based disability model ensures claims and duration guidelines are fact-based with objective benchmarks.
- We offer a holistic approach that takes the whole person into account.
- We give you 24-hour access to claim information.
- We provide return-to-work programs to help ensure employees are back to work as soon as it’s medically safe to do so.
- We employ vocational rehabilitation and ergonomic specialists who can help restore employees back to health and productive employment.

INTEGRATED HEALTH AND DISABILITY

With our Integrated Health and Disability program, we can link medical and disability data to help anticipate concerns, take action and get your employees back to work sooner:
- Predictive modeling identifies medical members most likely to experience a disability, potentially preventing a disability from occurring or minimizing the impact for better outcomes.
- HIPAA-compliant so medical and disability staff can share clinical information and work jointly with the employee to help address medical and disability issues.
- Referrals between health case managers and their disability counterparts help ensure better consistency and integration.
- The Integrated Health and Disability program is available at no additional cost when a member has both medical and disability coverage from Aetna.

For a summary list of Limitations and Exclusions, refer to page 45.

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.
## Term Life Plan Options

<table>
<thead>
<tr>
<th></th>
<th>2-9 Employees</th>
<th>10-50 Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life Schedule</strong></td>
<td>Flat $10,000, $15,000, $20,000, $50,000</td>
<td>Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000</td>
</tr>
<tr>
<td><strong>Class Schedules</strong></td>
<td>Not Available</td>
<td>Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more that 5 times the benefit amount of the lowest class</td>
</tr>
<tr>
<td><strong>Premium Waiver Provision</strong></td>
<td>Premium Waiver 60</td>
<td>Premium Waiver 60</td>
</tr>
<tr>
<td><strong>Age Reduction Schedule</strong></td>
<td>Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75</td>
<td>Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75</td>
</tr>
<tr>
<td><strong>Accelerated Death Benefit</strong></td>
<td>Up to 75% of Life Amount for terminal illness</td>
<td>Up to 75% of Life Amount for terminal illness</td>
</tr>
<tr>
<td><strong>Guaranteed Issue</strong></td>
<td>$20,000</td>
<td>10-25 employees $75,000</td>
</tr>
<tr>
<td><strong>Participation Requirements</strong></td>
<td>100%</td>
<td>100% on non-contributory plans</td>
</tr>
<tr>
<td><strong>Contribution Requirements</strong></td>
<td>100% Employer Contribution</td>
<td>Minimum 50% Employer Contribution</td>
</tr>
<tr>
<td><strong>AD&amp;D Ultra®</strong></td>
<td>Matches Life Benefit</td>
<td>Matches Life Benefit</td>
</tr>
<tr>
<td><strong>AD&amp;D Schedule</strong></td>
<td>Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss</td>
<td>Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss</td>
</tr>
<tr>
<td><strong>Optional Dependent Term Life</strong></td>
<td>Not Available</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Spouse Amount</strong></td>
<td>Not Available</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Child Amount</strong></td>
<td>Not Available</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees  
Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees  
Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees  

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.
# Packaged Life and Disability Plan Options

## Basic Life Plan Design

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Option</th>
<th>Medium Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guaranteed Issue 2-9 Lives 10-50 Lives</td>
<td>Flat $10,000</td>
<td>Flat $20,000</td>
<td>Flat $50,000</td>
</tr>
<tr>
<td>Employer’s Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75</td>
<td>$10,000</td>
<td>$20,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Disability Provision</td>
<td>Premium Waiver 60</td>
<td>Premium Waiver 60</td>
<td>Premium Waiver 60</td>
</tr>
<tr>
<td>Conversion</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Accelerated Death Benefit</td>
<td>Up to 75% of benefit; 24 month acceleration</td>
<td>Up to 75% of benefit; 24 month acceleration</td>
<td>Up to 75% of benefit; 24 month acceleration</td>
</tr>
<tr>
<td>Dependent Life</td>
<td>Spouse $5,000; Child $2,000</td>
<td>Spouse $5,000; Child $2,000</td>
<td>Spouse $5,000; Child $2,000</td>
</tr>
</tbody>
</table>

## Disability Plan Design

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Option</th>
<th>Medium Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Benefit</td>
<td>Flat $500; No offsets</td>
<td>Flat $1,000; Offsets are Workers’ Compensation, any State Disability Plan and Primary and Family Social Security benefits</td>
<td>Flat $1,000; Offsets are Workers’ Compensation, any State Disability Plan and Primary and Family Social Security benefits</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td>Definition of Disability</td>
<td>Own Occupation: Earnings loss of 20% or more</td>
<td>Own Occupation: Earnings loss of 20% or more</td>
<td>First 24 months of benefits: Own occupation: Earnings Loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>24 months</td>
<td>24 months</td>
<td>60 months</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>3/12</td>
<td>3/12</td>
<td>3/12</td>
</tr>
<tr>
<td>Types of Disability</td>
<td>Occupational &amp; Non-Occupational</td>
<td>Occupational &amp; Non-Occupational</td>
<td>Occupational &amp; Non-Occupational</td>
</tr>
<tr>
<td>Separate Periods of Disability</td>
<td>15 days during elimination period 6 months thereafter</td>
<td>15 days during elimination period 6 months thereafter</td>
<td>15 days during elimination period 6 months thereafter</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>24 months</td>
<td>24 months</td>
<td>24 months</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

## Other Plan Provisions

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Low Option</th>
<th>Medium Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Contribution</td>
<td>2-9 Lives — 100% employer paid 10+ Lives — 50-100% employer paid</td>
<td>2-9 Lives — 100% employer paid 10+ Lives — 50-100% employer paid</td>
<td>2-9 Lives — 100% employer paid 10+ Lives — 50-100% employer paid</td>
</tr>
<tr>
<td>Minimum Participation</td>
<td>2-9 Lives — 100% 10+ Lives (with Medical) — 70% 26+ Lives (Standalone) — 75%</td>
<td>2-9 Lives — 100% 10+ Lives (with Medical) — 70% 26+ Lives (Standalone) — 75%</td>
<td>2-9 Lives — 100% 10+ Lives (with Medical) — 70% 26+ Lives (Standalone) — 75%</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Active Full Time Employees</td>
<td>Active Full Time Employees</td>
<td>Active Full Time Employees</td>
</tr>
<tr>
<td>Class Schedules</td>
<td>10-50 Lives: Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class even if only two classes are offered</td>
<td>2-9 Lives: Not Available</td>
<td>2-9 Lives: Not Available</td>
</tr>
<tr>
<td>Rate Guarantee</td>
<td>1 year</td>
<td>1 year</td>
<td>1 year</td>
</tr>
<tr>
<td>Rates PEPM</td>
<td>$8.00</td>
<td>$15.00</td>
<td>$27.00</td>
</tr>
</tbody>
</table>

The above rates are valid for effective dates up to December 31, 2010 and are guaranteed for an assumed 12-month first-year policy period.

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees
Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees
Available Standalone (Without Medical or Dental Plans) to Groups with 10-50 Eligible Employees, except those in an ineligible industry

Life and Disability products are underwritten or administered by Aetna Life Insurance Company.
**Aetna Avenue**

**SMALL GROUP UNDERWRITING GUIDELINES**

**FOR BUSINESSES WITH 50 OR FEWER ELIGIBLE EMPLOYEES**

Texas

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

Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of the Regional Underwriting Manager except where Head Underwriter approval is indicated. This information is the property of Aetna and its affiliates (“Aetna”), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing.

### Census Data
- Census data must be provided on all eligibles, including COBRA eligible and/or State Continuation employees. Include name, date of birth, date of hire, gender, dependent status, and residence zip code.
- Retirees are not eligible.
- COBRA and State Continuation eligibles should be included on the census and noted as COBRA/Continuation.
- If both husband and wife work for the same company and apply under one contract, rate will be based on the oldest adult.
- Rates are quoted on a 4-tier structure: single, couple, employee plus child(ren), family.

### Case Submission Dates
- Groups with 2 to 50 eligible's must have all completed paperwork into Aetna Underwriting 1 business day prior to the requested effective date. If not received by this date, the effective date may be moved to the next month.

### COBRA and/or State Continuances
- COBRA coverage will be extended in accordance with the federal law.
- COBRA and state continues are not eligible for Life or Disability coverage.
- COBRA and state continues are included in the Medical underwriting of the group.
- Health information must be provided on COBRA and state continues along with the rest of the group.
- COBRA/State continues qualifying event, length, start and end date must be provided.
- Employers with 20 or more employees (full and part-time) are eligible to offer COBRA coverage.
- Employers with less than 20 employees (full and part-time) are eligible to offer State Continuation.
- Note: COBRA/State continues are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, COBRA/State continues can be included for coverage subject to normal underwriting guidelines.

### 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.
- This may be submitted at the initial small group submission or with their first claim.

### Dependent Eligibility
- Eligible dependents include an employee’s spouse. If both husband and wife work for the same company they may enroll together or separately, except one and two life groups, the spouse must enroll separately. Children can only be covered under one parent’s plan.
- Domestic Partners are eligible.
- Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26.
- Stepchildren are eligible if they reside with the employee.
- Grandchildren younger than age 25 are eligible if they live with, and in, the household of the insured and are dependents of the policyholder for federal income tax purposes.
- Life — children are eligible to age 19 or 23 if attending school on a regular basis and dependent solely on the employee for support.
- Dependents are not eligible for AD&D or Disability coverage.
- For Medical and Dental, dependents must enroll in the same benefits as the employee (participation is not required).
- Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan. See product-specific Life/AD&D and Disability guidelines under Product Specifications.
- Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan.

### Dual and Triple Option
- At least one employee must enroll in each benefits plan offered.

### Effective Date
- The effective date must be the 1st or the 15th of the month.
- The effective date requested by the employer may be up to 60 days in advance.
| **Electronic Funds Transfer** | • Customers can pay their monthly premiums online or by calling an automated phone number, 24/7, with no extra charge. This eliminates the need for checks, envelopes and postage while also supplying peace of mind that payments have been received. |
| **Employee Eligibility** | • An eligible employee is an employee who works on a full-time basis and who usually works at least 30 hours a week;  
• A sole proprietor, partner and an independent contractor is eligible if included as employees under a health benefit plan of a small employer.  
• Part-time, temporary, or substitute employees are not eligible.  
• Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. Union employees are NOT included in the count in determining whether or not the group is a small employer. The employer may carve out union employees as an excluded class.  
• If the employer’s Employee Eligibility Criteria definition differs from the above definition (more than 30 hours), the employer’s actual definition must be provided on the Employer Application at the time of new business submission. Note: the normal workweek cannot be less than 30 hours.  
• Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa. |
| **Retirees** | • Early retiree coverage is not available.  
• Coverage is available for Medicare-eligible retirees and/or active Medicare-eligibles in accordance with the Small Group Medicare Underwriting Guidelines.  
• Medicare eligible retirees who are enrolled in an Aetna Medicare Plan are eligible to enroll in Standard Dental Plans in accordance with these Dental Underwriting Guidelines.  
• Retirees are not eligible for Life, Disability or Voluntary Dental coverage |
| **Employer Definition** | • An employer who employed an average of at least 2 but no more than 50 eligible employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.  
• If the small employer has employees in more than one state, the law will apply if the majority of the eligible employees are employees in TEXAS, or the primary business location is in TEXAS and no state contains a majority of employees.  
• Group applicants that do not meet the above definition of a small employer are not eligible for coverage.  
• Medical plans can be offered to sole proprietorships, partnerships or corporations.  
• Organizations must not be formed solely for the purpose of obtaining health coverage.  
• Taft Hartley groups and closed groups are not eligible.  
• Dental and Disability 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. |
| **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 and does not bind Aetna to provide coverage.  
• If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer.  
• If the initial premium check is returned for non-sufficient funds, coverage will be terminated retroactive to the effective date. |
| **Licensed, Appointed Producers** | • Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna Products.  
• License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted. |
| **Municipalities and Townships** | • A township is generally a small unit that has the status and powers of a local government.  
• A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town, or village. A municipality is typically governed by a mayor and city council, or municipal council. In most countries a municipality is the smallest administrative subdivision to have its own democratically elected officials.  
• Underwriting Requirements  
  – Quarterly Wage and Tax Statement (QWTS)  
  – W2 — Elected or Appointed officials and Trustees “may” be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS rather they may be paid via W2. In that case, obtain a copy of their prior year W2.  
  – If elected officials are to be covered 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. |
| **Newly Formed Business (in operation less than 3 months)** | • The following documentation must be provided for consideration:  
  – Business License (not a professional license). If not available, provide a copy of the Partnership Agreement or Articles of Organization, or Articles of Incorporation; and  
  – Employer Identification Number/Federal Tax I.D Number; and  
  – Quarterly Wage and Tax statement. If not available, when will be filed; and  
  – The most recent two consecutive weeks worth of payroll records which includes hours worked, taxes withheld, check number and wages earned; or  
  – A letter from Certified Public Accountant listing the names of all employees (full and part-time), the number of hours worked each week, dates of hire, and weekly salary. Have payroll records been established? If not, when? Will a quarterly wage and tax statement be filed? If so, when? |
| **PEO (Professional Employer Organization)** | • As long as we can determine the group is a small employer via a QWTS or payroll records, the group may be accepted.  
• You may see situations where the small employer contracts for services with a PEO. As long as the PEO provides payroll specific to our small group and we can determine it is a small group even though the small group may be reported under the PEO Tax ID, this is acceptable. |
| **Prior Aetna Coverage** | • Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until 12 months after the termination date. Additionally, all premiums still owed on the prior Aetna plan must be paid in full before we will approve the new coverage.  
• Medical claims will be reviewed for any individuals who had prior Aetna coverage along with the health information provided on the employee application and included in the overall medical assessment of the group. |
| **Replacing Other Group Coverage** | • Provide a copy of the current billing statement that includes the account summary.  
• The employer should be told not to cancel any existing medical coverage until they have been notified of approval from the Aetna Underwriting unit. |
T E X A S  P L A N  G U I D E

**Ownership**

- Common Companies, or Multiple Associated Affiliated, companies — Two or more waiting Period Documents

**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 the amount of time in business up to a maximum of 6 consecutive weeks.
- Current Aetna customers leaving an Aetna group will have medical claims reviewed along with the health information provided on the employee application and included in the overall medical assessment of the group.

**Tax Information/ Documents**

- A copy of the most recent Quarterly Wage and Tax Statement (QWTS) must be provided for all groups.
- The QWTS must contain the names and wages of all employees of the employer group.
- Employees who have terminated, work part-time or are newly hired should be noted accordingly on the QWTS.
- Any hand written comments added to the QWTS must be signed and dated by the employer. This may be requested at the discretion of the underwriter.
- Newly hired employees should be written in on the Quarterly Wage & Tax Statement and signed by the employer. This may be requested at the discretion of the underwriter. The underwriter may request payroll in questionable situations.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.
- Proprietors, Partners or Officers of the business who do not appear on the QWTS should complete Aetna's Small Group Proof of Eligibility Form and submit one of the following. This list is not all inclusive. The employer may provide any other documentation to establish eligibility.

<table>
<thead>
<tr>
<th>Sole Proprietor</th>
<th>Partner</th>
<th>Corporate Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Franchise</td>
<td>• Partnership</td>
<td>• IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</td>
</tr>
<tr>
<td>• Limited Liability Company (operating as a Sole Proprietor)</td>
<td>• Limited Liability Partnership</td>
<td>• IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040)</td>
</tr>
</tbody>
</table>

**Two or more companies — Affiliated, Associated or Multiple Companies, Common Ownership**

Employers who have more than one business with different Tax Identification Numbers (TINs) may be eligible to enroll as one group if the following are met:
- One owner has controlling interest of all 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, 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.
- 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.

**Waiting Period**

- At initial submission of the group, the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application.
- On-time entrant eligibility date will be the first day of the policy month (1st or 15th of the month) following the waiting period of 0, 30, 60, 90 days.
- A change to the benefit waiting period may only be made on the plan anniversary date.
- No retro active changes will be allowed.
- Only 1 waiting period is allowed.
- Benefit waiting periods must be consistently applied to all employees, including newly hired key employees
- For new hires, the eligibility date will be the first day of the policy month following the waiting period. Examples:
  - 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.
<table>
<thead>
<tr>
<th>PRODUCT SPECIFICATIONS</th>
<th>Medical</th>
<th>Dental</th>
<th>Basic Life/AD&amp;D, Packaged Life and Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Availability</td>
<td>Groups of 50 or fewer eligible employees.</td>
<td>2 eligible employees</td>
<td>Life and/or Disability</td>
</tr>
<tr>
<td></td>
<td>May be written standalone or with ancillary coverage as noted in the following columns.</td>
<td>■ Standard Dental available with Medical.</td>
<td>■ 2-9 eligibles — if packaged with medical</td>
</tr>
<tr>
<td></td>
<td>Only non-occupational injuries and disease will be covered.</td>
<td>■ Voluntary Dental not available.</td>
<td>■ 10-50 eligibles — if packaged with medical or dental.</td>
</tr>
<tr>
<td></td>
<td>■ 3 to 50 eligible employees</td>
<td>■ Standard Dental available with or without Medical.</td>
<td>■ 10-50 eligible employees on a standalone basis.</td>
</tr>
<tr>
<td></td>
<td>■ Voluntary Dental available with or without Medical.</td>
<td>■ Standalone Dental has ineligible Industries which are listed separately under the SIC code section of the guidelines.</td>
<td>Packaged Life and Disability</td>
</tr>
<tr>
<td></td>
<td>■ Standalone available. Standalone Dental has ineligible Industries which are listed separately under the SIC code section of the guidelines.</td>
<td>Orthodontia coverage</td>
<td>■ 2-50 eligible employees if packaged with medical</td>
</tr>
<tr>
<td></td>
<td>■ Available with 10 or more eligible employees with a minimum of 5 enrolled employees for dependent children only.</td>
<td>■ Standard Dental available with or without Medical.</td>
<td>■ 10-50 eligible employees on a standalone basis.</td>
</tr>
<tr>
<td>Excluded Class/Carve Outs</td>
<td>■ Union employees are the only class of employees that may be excluded.</td>
<td>■ Standard Dental</td>
<td>■ A plan sponsor cannot purchase both Life and Packaged Life and Disability plans</td>
</tr>
<tr>
<td></td>
<td>■ Management carve outs are not permitted.</td>
<td>■ Voluntary Dental</td>
<td>■ Product packaging rule is a group level requirement. Employees will be able to individually elect Life, Disability or Packaged Life &amp; Disability insurance even if they do not elect Medical coverage</td>
</tr>
<tr>
<td>Employer Contribution</td>
<td>■ 50% of the employee only cost.</td>
<td>■ Standard Dental</td>
<td>■ 2 to 9 eligible employees</td>
</tr>
<tr>
<td></td>
<td>■ Coverage can be denied based on inadequate contributions.</td>
<td>■ 2 to 50 eligibles</td>
<td>■ 100% of the total cost of the basic Life plan.</td>
</tr>
<tr>
<td></td>
<td>■ 25% of the total cost of the plan or 50% of the cost of employee only coverage</td>
<td>■ Voluntary Dental</td>
<td>■ 10 to 50 eligible employees</td>
</tr>
<tr>
<td></td>
<td>■ 3 to 50 eligible — Employer contribution of less than 50% of the cost of the employee only coverage.</td>
<td>■ Employee-Pay-All plans are permitted.</td>
<td>■ At least 50% of the total cost of the plans excluding Optional Dependent Term Life.</td>
</tr>
<tr>
<td></td>
<td>■ Employee-Pay-All plans are permitted.</td>
<td>Standard and Voluntary</td>
<td>■ All</td>
</tr>
<tr>
<td></td>
<td>■ Coverage can be denied based on inadequate contributions.</td>
<td>■ Coverage can be denied based on inadequate contributions.</td>
<td>■ Coverage can be denied based on inadequate contributions.</td>
</tr>
<tr>
<td>Late Applicants</td>
<td>■ 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.</td>
<td>■ 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.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>■ 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.</td>
<td>■ An employee or dependent may enroll at any time, however, coverage is limited to Preventive &amp; Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).</td>
<td>The applicant will be required to complete an individual health statement/questionnaire and provide EOI.</td>
</tr>
<tr>
<td></td>
<td>■ Late Entrant provision does not apply to enrollees less than age 5.</td>
<td>■ Late Entrant provision does not apply to enrollees less than age 5.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>■ Dental Late Entrant is not applicable to the DMO.</td>
<td>■ Dental Late Entrant is not applicable to the DMO.</td>
<td>The applicant will be required to complete an individual health statement/questionnaire and provide EOI.</td>
</tr>
<tr>
<td></td>
<td>■ An employee or dependent may enroll at any time, however, coverage is limited to Preventive &amp; Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Medical Underwriting</td>
<td>Medical</td>
<td>Dental</td>
<td>Basic Life/AD&amp;D, Packaged Life and Disability</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------</td>
<td>--------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>• Groups cannot be denied based on medical conditions; however, rates may be adjusted for known medical conditions.</td>
<td>• NA</td>
<td>• All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested.</td>
<td></td>
</tr>
<tr>
<td>• Medical conditions of COBRA enrollees are included in this rating calculation.</td>
<td>• NA</td>
<td>• Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts listed below will be required to submit Evidence of Insurability (EOI) which means they must complete an individual health statement and may have to submit to medical evidence via medical records at their expense.</td>
<td></td>
</tr>
<tr>
<td>Out-of-state employees</td>
<td>• Any active employee who lives in a state other than where the company is domiciled is considered an out-of-state employee.</td>
<td>• Out-of-state employees can only be offered one of the specific out-of-state Dental plans; 3 PPO and 3 Indemnity plan designs.</td>
<td>• Not applicable.</td>
</tr>
<tr>
<td>• Out-of-state employees must be enrolled in an MC or PPO plan if available, otherwise an indemnity plan.</td>
<td>• Only one out-of-state Indemnity plan may be selected for the group.</td>
<td>• Maximum out-of-state employee percentage (and/or number of employees) will agree with the Medical guideline for each state.</td>
<td></td>
</tr>
<tr>
<td>• PPO is not available in the following states: AL, HI, ID, MN, MT, ND, RI, UT, VT, WI, WY.</td>
<td>• Out-of-state employees must be enrolled in a PPO Dental plan if available, otherwise an indemnity Dental plan.</td>
<td>• Out-of-state employees must be enrolled in a PPO Dental plan if available, otherwise an indemnity Dental plan.</td>
<td></td>
</tr>
<tr>
<td>• Indemnity is not available in HI or VT.</td>
<td>• OOS PPO dental is not available in the following states: AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, VT, and WY.</td>
<td>• OOS PPO dental is not available in the following states: AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, VT, and WY.</td>
<td></td>
</tr>
<tr>
<td>• If OOS employees include VT residents, no more than 20% of the group’s employees may be in VT.</td>
<td>• Not applicable.</td>
<td>• Not applicable.</td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td>• 100% participation is required, excluding those with other qualifying Medical coverage.</td>
<td>Non-contributory plans</td>
<td>Non-contributory plans</td>
</tr>
<tr>
<td>2 eligible employees</td>
<td>• 100% of eligible employees must participate in Aetna’s plan.</td>
<td>• 100% participation is required, excluding those with other qualifying dental coverage.</td>
<td>• 100% participation is required.</td>
</tr>
<tr>
<td>3 to 50 eligible employees</td>
<td>• 75% participation excluding valid waivers must enroll in Aetna’s plan.</td>
<td>Standard</td>
<td>1 life</td>
</tr>
<tr>
<td></td>
<td>Non-contributory plans</td>
<td>2 to 3 eligibles</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>• 100% participation is required excluding those with other qualifying dental coverage.</td>
<td>100% participation</td>
<td>2 to 9 eligibles</td>
</tr>
<tr>
<td></td>
<td>Example:</td>
<td>10 to 50 eligibles</td>
<td>• 100% participation</td>
</tr>
<tr>
<td></td>
<td>3 eligibles, 1 spousal dental</td>
<td>• 75% participation</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>3 minus 1 = 2 x 100% = 2 must enroll</td>
<td>with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.</td>
<td>• COBRA and state continues are not eligible</td>
</tr>
<tr>
<td></td>
<td>4 to 50 eligibles</td>
<td>Voluntary Dental</td>
<td>• Retirees are not eligible</td>
</tr>
<tr>
<td></td>
<td>75% participation is required excluding those with other qualifying dental coverage.</td>
<td>• 75% participation</td>
<td>• Employees may elect Life insurance even if they do not elect medical coverage and the group must meet the required participation percentage. If not, then Life will be declined for the group. Example:</td>
</tr>
<tr>
<td></td>
<td>with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.</td>
<td>All</td>
<td>9 employees</td>
</tr>
<tr>
<td></td>
<td>Standalone Dental</td>
<td>Voluntary and Standalone</td>
<td>3 waiving medical</td>
</tr>
<tr>
<td></td>
<td>• 75% participation excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.</td>
<td>• Employees may select coverage for eligible dependents under the dental plan even if they elected single coverage on the medical plan or vice versa.</td>
<td>9 must enroll for life</td>
</tr>
<tr>
<td></td>
<td>Voluntary and Standalone</td>
<td>Coverage can be denied based on inadequate participation.</td>
<td>Coverage can be denied based on inadequate participation.</td>
</tr>
<tr>
<td>Plan Change Group Level</td>
<td>Plan anniversary date only</td>
<td>Dental plans must be requested 30 days prior to the desired effective date.</td>
<td>Packaged Life/Disability must be requested 30 days prior to the desired effective date.</td>
</tr>
<tr>
<td></td>
<td>• The future renewal date of the change will be the same as the medical plan anniversary date.</td>
<td>• The future renewal date of the change will be the same as the medical plan anniversary date.</td>
<td>• Non-packaged plans are only available on the plan anniversary date.</td>
</tr>
</tbody>
</table>
## Product Specifications

### Medical Dental Basic Life/AD&D, Packaged Life and Disability

#### Plan Change Employee Level
- 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).
- May change from voluntary to standard and vice versa at anytime.
- 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).

#### 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).

#### Rating Tier
- 4-Tier composite rating applies
- Rates are based on final enrollment
- All quotes are subject to change based upon additional information that becomes available in the quoting process and during the case submission/installation, including but not limited to any change in census.
- 4-tier composite rating applies
- All industries are eligible if sold with medical.
- The following industries are not eligible when Dental is sold standalone or packaged only with Life.
- Basic Term Life
- All industries are eligible
- Packaged Life/Disability
- The following industries are not eligible.

#### Standard Industrial Classification Code (SIC)
- All industries are eligible
- The employer should provide the SIC code (four digit number) or NAIC state code 6 digit code filed with the state on the business tax return and/or the Workers’ Compensation form.
- All industries are eligible if sold with medical.
- The following industries are not eligible when Dental is sold standalone or packaged only with Life.

<table>
<thead>
<tr>
<th>SIC Range</th>
<th>SIC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7933</td>
<td>Bowling Centers</td>
</tr>
<tr>
<td>8611</td>
<td>Business Associations</td>
</tr>
<tr>
<td>7911</td>
<td>Dance Studios, Schools</td>
</tr>
<tr>
<td>7361-7363</td>
<td>Employment Agencies</td>
</tr>
<tr>
<td>7999</td>
<td>Misc Amusement and Recreation</td>
</tr>
<tr>
<td>8699</td>
<td>Misc Membership Organizations</td>
</tr>
<tr>
<td>8999</td>
<td>Misc Services</td>
</tr>
<tr>
<td>7991</td>
<td>Physical Fitness Facilities</td>
</tr>
<tr>
<td>8811</td>
<td>Private Households</td>
</tr>
<tr>
<td>7941-7948</td>
<td>Professional Sports Clubs &amp; Producers, Race Tracks</td>
</tr>
<tr>
<td>8621-8651</td>
<td>Professional Membership Organizations, Labor Unions, Civic Social &amp; Fraternal Organizations, Political Organizations</td>
</tr>
<tr>
<td>7992-7997</td>
<td>Public Golf Courses, Amusements, Membership Sports &amp; Recreation Clubs</td>
</tr>
<tr>
<td>8661</td>
<td>Religious Organizations</td>
</tr>
<tr>
<td>7922-7929</td>
<td>Theatrical Producers, Bands, Orchestras, Actors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIC Range</th>
<th>SIC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3291-3292</td>
<td>Asbestos Products</td>
</tr>
<tr>
<td>7500-7599</td>
<td>Automotive Repairs/Services</td>
</tr>
<tr>
<td>8010-8043</td>
<td>Doctors Offices Clinics</td>
</tr>
<tr>
<td>2892-2899</td>
<td>Explosives, Bombs &amp; Pyrotechnics</td>
</tr>
<tr>
<td>3480-3489</td>
<td>Liquor Stores</td>
</tr>
<tr>
<td>5921</td>
<td>Membership Associations</td>
</tr>
<tr>
<td>8660-8699</td>
<td>Mining</td>
</tr>
<tr>
<td>1000-1499</td>
<td>Motion Picture/Amusement &amp; Recreation</td>
</tr>
<tr>
<td>7800-7999</td>
<td>Non-classified Establishments</td>
</tr>
<tr>
<td>9999</td>
<td>Primary Metal Industries</td>
</tr>
<tr>
<td>3310-3329</td>
<td>Real Estate — Agents</td>
</tr>
<tr>
<td>6531</td>
<td>Security Brokers</td>
</tr>
<tr>
<td>6211</td>
<td>Service — Detective Services</td>
</tr>
<tr>
<td>7381</td>
<td>Service — Private Household</td>
</tr>
<tr>
<td>8800-8899</td>
<td></td>
</tr>
</tbody>
</table>
**DENTAL ONLY**

**Coverage Waiting Period**
- For Major and Orthodontic Services employees must be an enrolled member of the employer's plan for 1 year before becoming eligible.
- There is no waiting period for DMO.
- Discount plans do not qualify as previous coverage.
- Virgin group (no prior coverage) — the waiting periods apply to employees at case inception as well as any future hires.
- Takeover/Replacement cases (prior coverage) — you must provide a copy of the last billing statement in order to provide credit. If a group’s prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a dental plan in place that covered Major (and Ortho, if applicable) immediately preceding our takeover of the business.
  
  Example: Prior Major coverage but no Ortho coverage. Aetna plan has coverage for both Major and Ortho. The Waiting Period is waived for Major services but not for Ortho services.

**Product Packaging**
- Voluntary
  - Dental Dual Option sales are not permitted. All Voluntary plans must be a single plan sold.
  - All Voluntary plans require a minimum of 3 to enroll.
  - Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll.
- Standard
  - DMO can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled.
  - PPO can be sold standalone or packaged with the DMO as a Dual Option with a minimum of 2 enrolled.
  - Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold.
  - Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll.

**Open Enrollment**
- An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible unless a qualifying life event has occurred or the enrollee is less than age 5.

**Reinstatement (applies to Voluntary Plans only)**
- Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.

---

**LIFE AND DISABILITY ONLY**

**Job Classification (Position) Schedules**
- Varying levels of coverage based on job classifications are available for groups with 10 or more lives.
- Up to 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 five (5) times the benefit of the class with the lowest benefit even if only 2 classes are offered. For example, a schedule may be structured as follows:

<table>
<thead>
<tr>
<th>Position/Job Class</th>
<th>Basic Term Life Amount</th>
<th>Disability</th>
<th>Packaged Life &amp; Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executives</td>
<td>$50,000</td>
<td>Flat $500</td>
<td>High Option</td>
</tr>
<tr>
<td>Managers, Supervisors</td>
<td>$20,000</td>
<td>Flat $300</td>
<td>Medium Option</td>
</tr>
<tr>
<td>All other Employees</td>
<td>$10,000</td>
<td>Flat $200</td>
<td>Low Option</td>
</tr>
</tbody>
</table>

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

**Actively-at-work**
- Employees who are both disabled and away from work on the date 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.

**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. Coverage is not requested within 31 days of eligibility for contributory coverage.
  3. New coverage is requested during the anniversary period.
  4. Coverage is requested outside of the employer’s anniversary period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.)
  5. Reinstatement or restoration of coverage is requested.
  6. Requesting Life or Disability at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the Guarantee Issue Limit. 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.
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, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

**Aetna CPOS, HMO and HMO Plus, QPOS & HMO**
- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial)
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- 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, counseling and prescription drugs
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions
Aetna Open Access MC,
Preferred Provider Benefits Plan
(PPO) & Indemnity

- All medical or hospital services not specifically covered, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- infertility services, including but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics, 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

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing conditions exclusion means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 3 months. Pre-existing condition exclusion provisions are waived for any individual under the age of 19.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 3-month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months from your first day of coverage, or if you were in a waiting period, from the day of your waiting period.

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

If you had no prior creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63-day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan’s pre-existing conditions exclusion.

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at using the number on the back of the member ID card if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above.
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)*
- PDN: Oral exams (2 routine and 2 problem-focused per year)

All plans:
- Bitewing X-rays (1 set per year)*
- Complete series X-rays (1 set every 3 years)*
- Cleanings (2 per year)*
- Fluoride (1 per year; children under 16)*
- Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)*
- Scaling & root planing (4 quadrants every 2 years)
- Osseous surgery (1 per quadrant every 3 years)
- Members who do not enroll within the first 31 days of becoming eligible may be subject to a late entrant penalty.

The waiting period may be waived in certain situations.

- All other limitations and exclusions in the plan documents.

*The frequency limits for these services will not apply to the DMO plans if they are needed more frequently due to medical necessity.
Accidental Death and Personal Loss Coverage

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 the motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel, this does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

DISABILITY

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from your committing or attempting to commit, a criminal act
- Is due to participation in an insurrection or rebellion
- Is due to war or any act of war (declared or not declared)

**These do not apply if the loss is caused by an infection that results directly from the injury or surgery needed because of the injury. The injury must not be one that is excluded by the terms of the contract.
SUBMISSION DATE
All new cases with 2-50 employees are preferred to be received by Aetna on or before the 5th business day prior to the requested effective date. Cases will be accepted until the last day of the month prior to the effective date. If a cutoff deadline occurs on a weekend, all new cases sold need to be received on the preceding Friday. If incomplete information is provided or if the submission is not complete until after the cut-off-date, the case could be assigned a later effective date.

REQUIRED FOR NEW BUSINESS
- Employer Master Application
  - Must be completed, signed and dated by employer
- Copy of Sold Rates
  - Must be signed by the employer and attached to the new case submission
- 50/50 Benefit Description Form
  - 50/50 Benefit Description Form signed and dated by the employer
- Enrollment/Change Form/Medical Questionnaire
  - Original copy completed and signed by each employee enrolling for coverage and any continuees.
- Employees waiving/declining coverage must complete the waiver section of the Enrollment/Change form. If coverage is being waived due to other coverage, the carrier name, telephone number and group number must be listed.
- Copy of most recent Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc. of all employees of the employer group.
  - The QWTS must be signed and dated by the owner or officer of the company unless filed electronically. If filed electronically, please provide a copy of the electronic validation.
  - Employees who have terminated or work part-time must be noted accordingly on the QWTS. Terminated employees must have the date of termination listed on the QWTS.
  - Newly-hired employees not listed on the QWTS must provide the first and last month's payroll stub and registry/summary for each employee.
- Sole Proprietor, Partners or Corporate Officers not reported on the Quarterly Wage and Tax form must submit a completed Small Employer (2-50) Proof of Eligibility Form. Also, as identified on the form, additional supporting documentation must be submitted.

Mid America Small Group Underwriting
11675 Great Oaks Way
Alpharetta, GA 30022
Phone (866) 899-4379
Fax (866) 902-2535
If group coverage currently exists, a **copy of the most recent prior carrier bill** must be provided. Individuals contained on the bill should match those listed on the wage and tax statement. If not, please indicate on the bill why they are not on the wage and tax.

- A **check** on company check stock for 100% of the first month’s medical, dental, STD and life premiums payable to “Aetna Health Management, L.L.C.” (Aetna’s receipt of the check does not guarantee acceptance of the group.)

- **Copy of the sold proposal** including rates and plan design(s).

- **Verify contribution and participation requirements** by product.

**GENERAL INFORMATION**

- If applying for PPO or Indemnity medical, please list the prior carrier individual deductible.
  
  $____________________

- If applying for dental, does dental coverage currently exist?
  
  - Yes  
  - No

- If yes and prior plan includes Orthodontia, please provide the prior plan Ortho Max.
  
  $____________________

- Please note that additional documentation may be required. (Common ownership, newly formed business, etc.)

- Provide any additional comments, and ensure that all paperwork is filled out completely, signed and dated.
This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/Dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. 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.