



The banner features a photograph of three diverse people on the left. The text on the left side of the banner reads: "Choice. Simplicity. Affordability." The central text reads: "Aetna Small Group Business (2 – 50 eligible employees)* *1 – 50 where required by state law" followed by "Broker Alert" in a large font and "Northeast Region" below it. On the right side, it says "We want you to know™" above the Aetna logo and the website "www.aetna.com".

Maine- October 2004

Two new HMO plan options bring even more choice and affordability to Maine small businesses

We are pleased to introduce two new HMO plans (HMO F and HMO G) that will be available to Maine small businesses beginning with January 1, 2005 effective dates. These plans expand our deductible-based HMO options, with varying copay and coinsurance levels to provide additional options to our small group customers and prospects as they look for affordable and convenient coverage in Maine.

We continue to evaluate our product offerings to ensure that we adapt to the changing needs of the small business marketplace and to further enhance our efforts at providing choice, affordability and simplicity to every Maine small business owner.

Attached is plan design information on our two new HMO plans. We encourage you review these materials and familiarize yourself with the plans, because they could be your key to finding even greater success with Aetna.

We have also added a new dental plan offering to respond to your requests for an indemnity plan that pays at the 90th percentile. Details on that plan design are also attached.

All of these new options may now be quoted using our rating software (new Dental option is available for quoting as of 10/15).

Should you want additional information on these new plans, or any of the other plans that we offer to Maine small businesses, simply contact your Aetna Sales Manager or call our broker dedicated support center at 1-888-277-1053, option 5.

As a reminder, we have some broker seminars coming up in Brewer (11/3) and Portland (11/4) where you can learn more information on these plans. To reserve a space at one of these seminars, contact Gretchen Spann at 207-791-7911 or via email at SpannM@aetna.com.

Thank you for your continued business.

[Click here](#) to log into Producer World®.

PLAN DESIGN AND BENEFITS – ME HMO Plan F

PLAN FEATURES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Deductible (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for Prescription Drugs are excluded from charges to meet the Deductible. Once Family Deductible is met all family members will be considered as having met their Deductible for the remainder of the calendar year. No individual can contribute more than the Individual Deductible toward satisfaction of the family Deductible. Only those out-of-pocket expenses resulting from the application of deductibles, coinsurance and copays may be used to satisfy the Out-of-Pocket Maximum.	\$500 Individual \$1000 Family	Not Applicable
Out-of-Pocket Maximum (per calendar year)	\$2,500 Individual \$5,000 Family	Not Applicable
All member copays, coinsurance and deductible accumulate toward the Out-of-Pocket Maximum, excluding member cost sharing for Prescription Drugs. No individual can contribute more than the Individual Out-of-Pocket Maximum toward satisfaction of the family Out-of-Pocket Maximum. Once 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.		
Lifetime Maximum	Unlimited	Not Applicable
Payment for services from a Non-Participating Provider	Not Applicable	Not Applicable
Primary Care Physician Selection	Required	Not Applicable
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Routine Adult Physical Exams / Immunizations Age and frequency schedules apply.	\$20 copay, deductible waived	Not Covered
Well Child Exams / Immunizations Age and frequency schedules apply.	\$20 copay, deductible waived	Not Covered
Routine Gynecological Exams Direct access to Participating Providers One routine exam every 365 days. (Includes Pap smear and related lab fees)	\$25 copay, deductible waived	Not Covered
Routine Mammograms 1 annual mammogram for females age 40 and over.	\$25 copay, deductible waived	Not Covered
Routine Digital Rectal Exams /Prostate Specific Antigen Test 1 exam every 12 months for males ages 52 to 72.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
Colorectal Cancer Screening 1 exam every 12 months for all members age 50 and over.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered

PLAN DESIGN AND BENEFITS – ME HMO Plan F

Routine Eye Exam at Specialist Direct benefit for refraction 1 exam every 12 months for ages 1 through 18 who wears glasses or contacts; 1 exam every 24 months for ages 19+ who wears glasses or contacts; 1 exam every 36 months for ages 1-45 who does not wear glasses or contacts and 1 exam every 24 months age 46+ who does not wear glasses or contacts.	\$25 copay, deductible waived	Not Covered
Routine Hearing Screening–PCP screening only.	Covered as part of physical exam. (Routine hearing exam by an audiologist is not covered)	Not Covered
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Primary Care Physician Visits	\$20 copay (Office Hours), deductible waived \$25 copay (After Hours), deductible waived	Not Covered
Specialist Office Visits	\$25 copay, deductible waived	Not Covered
Maternity OB Visits	\$25 copay, deductible waived. For initial visit only, subsequent visits subject to inpatient hospital cost sharing	Not Covered
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	Not Covered
Allergy Testing	Same as applicable participating provider office visit member cost sharing.	Not Covered
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Diagnostic Laboratory – (if performed as a part of a physician’s office visit and billed by the physician, expenses are covered subject to the applicable physician’s office visit member cost sharing.)	\$25 copay, deductible applies	Not Covered
Diagnostic X-ray except for Complex Imaging Services - outpatient hospital or other outpatient facility	\$25 copay, deductible applies	Not Covered
Diagnostic X-ray for Complex Imaging – outpatient hospital or other outpatient facility (including, but not limited to, MRI, MRA, PET and CT Scans)	10%, deductible applies	Not Covered
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Urgent Care Provider (waived if admitted)	\$125 copay, deductible waived	Refer to participating provider benefit
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (waived if admitted)	\$125 copay, deductible waived	Refer to participating provider benefit
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	\$0 copay, deductible waived	Refer to participating provider benefit.

PLAN DESIGN AND BENEFITS – ME HMO Plan F

HOSPITAL CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient Coverage (including maternity)	10%, deductible applies	Not Covered
Outpatient Surgery	10%, deductible applies	Not Covered
Outpatient Hospital Department Visit (includes, but not limited to outpatient visits for treatment of chemotherapy and radiation therapy)	\$25 copay, deductible applies	Not Covered
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient – Biologically Based Mental Illness	10%, deductible applies	Not Covered
Outpatient - Biologically Based Mental Illness	\$25 copay, deductible waived	Not Covered
Inpatient - Non-Biologically Based Mental Illness Limited to 30 days per calendar year. 2 days non-residential = 1 day inpatient. \$50,000/lifetime maximum, combined with outpatient non-bio mental health	10%, deductible applies	Not Covered
Outpatient - Non-Biologically Based Mental Illness \$1,500 calendar year maximum. \$50,000/lifetime combined with inpatient non-bio mental health; medical management visits – same as physical illness and not counted in calculation of any outpatient treatment visit limits	50%, deductible applies	Not Covered
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient Detoxification	10%, deductible applies	Not Covered
Outpatient Detoxification	\$25 copay, deductible waived	Not Covered
Inpatient Rehabilitation	10%, deductible applies	Not Covered
Outpatient Rehabilitation	\$25 copay, deductible waived	Not Covered
OTHER SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Skilled Nursing Facility Limited to 60 days per calendar year	10%, deductible applies	Not Covered
Home Health Care Limited to 100 visits per calendar year	10%, deductible applies	Not Covered
Hospice Care – Inpatient	10%, deductible applies	Not Covered
Hospice Care – Outpatient	10%, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Speech (ST) Limited to 20 visits per year	\$25 copay, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Physical (PT) Limited to 20 visits per year combined with Occupational Therapy	\$25 copay, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Occupational (OT) Limited to 20 visits per year combined with Physical Therapy	\$25 copay, deductible applies	Not Covered

PLAN DESIGN AND BENEFITS – ME HMO Plan F

Subluxation (Chiropractic) Limited to 36 visits per calendar year with no referral	\$25 copay, deductible applies	Not Covered
Durable Medical Equipment \$2,500 calendar year maximum	50%, deductible applies	Not Covered
Vision Eyewear	\$100 reimbursement every 24 months	Not Covered
Transplants Coverage is provided at an Institutes of Excellence (IOE) contracted facility only	10%, deductible applies	Not Covered
FAMILY PLANNING	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Retail & MOD 1x copay up to a 30 day retail supply 2x copay for 31-60 day retail/MOD supply 3x copay for 61-90 day retail/MOD supply	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs.	Not Covered
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only		
Plan includes: contraceptive drugs and devices obtainable from a pharmacy & diabetic supplies		
Prescription drug calendar year deductible (must be satisfied before any prescription drug benefits are paid)	Not Applicable	Not Covered
Prescription drug calendar year maximum	Not Applicable	Not Covered
SPECIAL PROGRAMS/SERVICES		
Certain Special programs and services are included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One® and Vitamin Advantage™		

***Members may directly access participating providers for certain services as outlined in the plan documents.**

What's Not Covered:

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are *generally not covered*. **However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

- 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.

PLAN DESIGN AND BENEFITS – ME HMO Plan F

- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Hearing aids.
- 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.
- Long Term Rehabilitation.
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the member's enrollment date. A pre-existing exclusion clause may be used if the enrollee had a break in coverage that is greater than 90 days. The look back period for a pre-existing condition is six months from either the date of enrollment or the start of the waiting period whichever is earlier.
- 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 or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.

Disclaimers

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Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Members or Providers may be required to precertify for certain services such as non-emergency inpatient hospital care.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

Plans are offered by: Aetna Health Inc. While this material is believed to be accurate as of the print date, it is subject to change.

PLAN DESIGN AND BENEFITS – ME HMO Plan G

PLAN FEATURES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Deductible (per calendar year) Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Member cost sharing for Prescription Drugs are excluded from charges to meet the Deductible. Once Family Deductible is met all family members will be considered as having met their Deductible for the remainder of the calendar year. No individual can contribute more than the Individual Deductible toward satisfaction of the family Deductible. Only those out-of-pocket expenses resulting from the application of deductibles, coinsurance and copays may be used to satisfy the Out-of-Pocket Maximum.	\$1,000 Individual \$2,000 Family	Not Applicable
Out-of-Pocket Maximum (per calendar year)	\$3,000 Individual \$6,000 Family	Not Applicable
All member copays, coinsurance and deductible accumulate toward the Out-of-Pocket Maximum, excluding member cost sharing for Prescription Drugs. No individual can contribute more than the Individual Out-of-Pocket Maximum toward satisfaction of the family Out-of-Pocket Maximum. Once 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.		
Lifetime Maximum	Unlimited	Not Applicable
Payment for services from a Non-Participating Provider	Not Applicable	Not Applicable
Primary Care Physician Selection	Required	Not Applicable
Referral Requirement	Required for all non-emergency, non-urgent and non-Primary Care Physician services, except direct access services.	None
PREVENTIVE CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Routine Adult Physical Exams / Immunizations Age and frequency schedules apply.	\$25 copay, deductible waived	Not Covered
Well Child Exams / Immunizations Age and frequency schedules apply.	\$25 copay, deductible waived	Not Covered
Routine Gynecological Exams Direct access to Participating Providers One routine exam every 365 days. (Includes Pap smear and related lab fees)	\$25 copay, deductible waived	Not Covered
Routine Mammograms 1 annual mammogram for females age 40 and over.	\$25 copay, deductible waived	Not Covered
Routine Digital Rectal Exams /Prostate Specific Antigen Test 1 exam every 12 months for males ages 52 to 72.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
Colorectal Cancer Screening 1 exam every 12 months for all members age 50 and over.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
Routine Eye Exam at Specialist Direct benefit for refraction 1 exam every 12 months for ages 1 through 18 who wears glasses or contacts; 1 exam every 24 months for ages 19+ who wears glasses or contacts; 1 exam every 36 months for	\$25 copay, deductible waived	Not Covered

PLAN DESIGN AND BENEFITS – ME HMO Plan G

ages 1-45 who does not wear glasses or contacts and 1 exam every 24 months age 46+ who does not wear glasses or contacts.

Routine Hearing Screening–PCP screening only.	Covered as part of physical exam. (Routine hearing exam by an audiologist is not covered)	Not Covered
PHYSICIAN SERVICES		
Primary Care Physician Visits	\$25 copay (Office Hours), deductible waived \$25 copay (After Hours), deductible waived	Not Covered
Specialist Office Visits	\$25 copay, deductible waived	Not Covered
Maternity OB Visits	\$25 copay, deductible waived. For initial visit only, subsequent visits subject to inpatient hospital cost sharing	Not Covered
Allergy Treatment	Same as applicable participating provider office visit member cost sharing.	Not Covered
Allergy Testing	Same as applicable participating provider office visit member cost sharing.	Not Covered
DIAGNOSTIC PROCEDURES		
Diagnostic Laboratory – (if performed as a part of a physician’s office visit and billed by the physician, expenses are covered subject to the applicable physician’s office visit member cost sharing.)	\$25 copay, deductible applies	Not Covered
Diagnostic X-ray except for Complex Imaging Services - outpatient hospital or other outpatient facility	\$25 copay, deductible applies	Not Covered
Diagnostic X-ray for Complex Imaging – outpatient hospital or other outpatient facility (including, but not limited to, MRI, MRA, PET and CT Scans)	30%, deductible applies	Not Covered
EMERGENCY MEDICAL CARE		
Urgent Care Provider (waived if admitted)	\$150 copay, deductible waived	Refer to participating provider benefit
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room (waived if admitted)	\$150 copay, deductible waived	Refer to participating provider benefit
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Ambulance	\$0 copay, deductible waived	Refer to participating provider benefit.

PLAN DESIGN AND BENEFITS – ME HMO Plan G

HOSPITAL CARE	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient Coverage (including maternity)	30%, deductible applies	Not Covered
Outpatient Surgery	30%, deductible applies	Not Covered
Outpatient Hospital Department Visit (includes, but not limited to outpatient visits for treatment of chemotherapy and radiation therapy)	\$25 copay, deductible applies	Not Covered
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient – Biologically Based Mental Illness	30%, deductible applies	Not Covered
Outpatient - Biologically Based Mental Illness	\$25 copay, deductible waived	Not Covered
Inpatient - Non-Biologically Based Mental Illness Limited to 30 days per calendar year. 2 days non-residential = 1 day inpatient. \$50,000/lifetime maximum, combined with outpatient non-bio mental health	30%, deductible applies	Not Covered
Outpatient - Non-Biologically Based Mental Illness \$1,500 calendar year maximum. \$50,000/lifetime combined with inpatient non-bio mental health; medical management visits – same as physical illness and not counted in calculation of any outpatient treatment visit limits	50%, deductible applies	Not Covered
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Inpatient Detoxification	30%, deductible applies	Not Covered
Outpatient Detoxification	\$25 copay, deductible waived	Not Covered
Inpatient Rehabilitation	30%, deductible applies	Not Covered
Outpatient Rehabilitation	\$25 copay, deductible waived	Not Covered
OTHER SERVICES	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Skilled Nursing Facility Limited to 60 days per calendar year	30%, deductible applies	Not Covered
Home Health Care Limited to 100 visits per calendar year	20%, deductible applies	Not Covered
Hospice Care – Inpatient	20%, deductible applies	Not Covered
Hospice Care – Outpatient	20%, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Speech (ST) Limited to 20 visits per year	\$25 copay, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Physical (PT) Limited to 20 visits per year combined with Occupational Therapy	\$25 copay, deductible applies	Not Covered
Outpatient Rehabilitation Therapy – Occupational (OT) Limited to 20 visits per year combined with Physical Therapy	\$25 copay, deductible applies	Not Covered

PLAN DESIGN AND BENEFITS – ME HMO Plan G

Subluxation (Chiropractic) Limited to 36 visits per calendar year with no referral	\$25 copay, deductible applies	Not Covered
Durable Medical Equipment \$2,500 calendar year maximum	50%, deductible applies	Not Covered
Vision Eyewear	\$100 reimbursement every 24 months	Not Covered
Transplants Coverage is provided at an Institutes of Excellence (IOE) contracted facility only	30%, deductible applies	Not Covered
FAMILY PLANNING	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place where it is rendered.	Not Covered
PHARMACY – PRESCRIPTION DRUG BENEFITS	PARTICIPATING PROVIDERS (REFERRED*)	NON-PARTICIPATING PROVIDERS OR PARTICIPATING PROVIDER SELF-REFERRAL
Retail & MOD 1x copay up to a 30 day retail supply 2x copay for 31-60 day retail/MOD supply 3x copay for 61-90 day retail/MOD supply	\$15 copay for generic drugs, \$25 copay for formulary brand-name drugs, and \$40 copay for non-formulary brand-name drugs.	Not Covered
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only		
Plan includes: contraceptive drugs and devices obtainable from a pharmacy & diabetic supplies		
Prescription drug calendar year deductible (must be satisfied before any prescription drug benefits are paid)	Not Applicable	Not Covered
Prescription drug calendar year maximum	Not Applicable	Not Covered
SPECIAL PROGRAMS/SERVICES		
Certain Special programs and services are included in your plan: Aetna Navigator™, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Advantage, National Medical Excellence, Natural Alternatives, Natural Products, Vision One® and Vitamin Advantage™		

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- Dental care and dental x-rays.
- Donor egg retrieval.

PLAN DESIGN AND BENEFITS – ME HMO Plan G

- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Hearing aids.
- 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.
- Long Term Rehabilitation.
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the member's enrollment date. A pre-existing exclusion clause may be used if the enrollee had a break in coverage that is greater than 90 days. The look back period for a pre-existing condition is six months from either the date of enrollment or the start of the waiting period whichever is earlier.
- 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 or counseling.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Treatment of behavioral disorders.

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Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Members or Providers may be required to precertify for certain services such as non-emergency inpatient hospital care.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them. Aetna Rx Home Delivery, LLC, is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated reimbursement rates with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services. In prescription plans with copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to members. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the member more than a non-formulary drug because (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from drug manufacturers are not reflected in the cost of a prescription drug obtained by a member.

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AETNA SMALL GROUP DENTAL PLAN OPTIONS FOR MAINE

PLAN DESIGNS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees
 Available Without Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees

	Plan Option 1	Plan Option 2	Plan Option 3	Plan Option 4	Plan Option 5
MEMBER BENEFITS	per schedule	80/60/40	100/80/50	100/80/50	100/80/50
Annual Deductible per Member does not apply to Diagnostic & Preventive Services	\$75; 3x Family Maximum	\$50; 3x Family Maximum	\$50; 3x Family Maximum	\$50; 3x Family Maximum	\$50; 3x Family Maximum
Annual Maximum Benefit	\$1,000	\$1,000	\$1,000	\$1,500	\$1,500
DIAGNOSTIC SERVICES					
Oral Exams					
Periodic oral exam	\$14	80%	100%	100%	100%
Comprehensive oral exam	\$23	80%	100%	100%	100%
Problem-focused oral exam	\$46	80%	100%	100%	100%
X-rays					
Bitewing — single film	\$7	80%	100%	100%	100%
Complete series	\$44	80%	100%	100%	100%
PREVENTIVE SERVICES					
Adult cleaning	\$31	80%	100%	100%	100%
Child cleaning	\$23	80%	100%	100%	100%
Sealants — per tooth	\$19	80%	100%	100%	100%
Fluoride application — with cleaning	\$29	80%	100%	100%	100%
Space maintainers	\$64	80%	100%	100%	100%
BASIC SERVICES					
Amalgam filling — 2 surfaces permanent	\$31	60%	80%	80%	80%
Resin filling — 2 surfaces, anterior	\$35	60%	80%	80%	80%
Oral Surgery					
Extraction — exposed root or erupted tooth	\$20	60%	80%	80%	80%
Extraction of impacted tooth — soft tissue	\$54	60%	80%	80%	80%
MAJOR SERVICES*					
Complete upper denture	\$234	40%	50%	50%	50%
Partial upper denture (resin base)	\$192	40%	50%	50%	50%
Crown — Porcelain with noble metal	\$192	40%	50%	50%	50%
Pontic — Porcelain with noble metal	\$181	40%	50%	50%	50%
Inlay — Metallic (3 or more surfaces)	\$189	40%	50%	50%	50%
Oral Surgery					
Removal of impacted tooth — partially bony	\$70	40%	50%	50%	50%
Endodontic Services					
Bicuspid root canal therapy	\$149	40%	50%	50%	80%
Molar root canal therapy	\$178	40%	50%	50%	50%
Periodontic Services					
Scaling & root planing — per quadrant	\$42	40%	50%	50%	80%
Osseous surgery — per quadrant	\$195	40%	50%	50%	50%
Orthodontic Services*					
Orthodontic Lifetime Maximum	Does not apply	Does not apply	\$1,000	\$1,000	\$1,000

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

Most Oral Surgery, Endodontic and Periodontic procedures are covered as Basic Services in Plan Option 5 and are not subject to the Coverage Waiting Period.

All dollar amounts and percentages indicate what the plan will pay. Actual plan payments on Plan Options 2-5 are limited by geographic area prevailing fees at the 80th percentile for Plan Options 2-4 and the 90th percentile on Plan Option 5.

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

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 the last page of this insert.

Dental Limitations and Exclusions

- 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.
- > 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)
- All other limitations and exclusions in your plan documents.

Specific service limitations

- > Oral Exams (2 routine and 2 problem-focused per year)
- > Bitewing X-rays (1 set per year)

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This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of healthcare/dental services. However Aetna itself is not a provider of healthcare/dental services, and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery, participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery® service, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Some benefits are subject to limitations or visit maximums. Members or Providers may be required to pre-certify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

While this material is believed to be accurate as of the print date, it is subject to change.