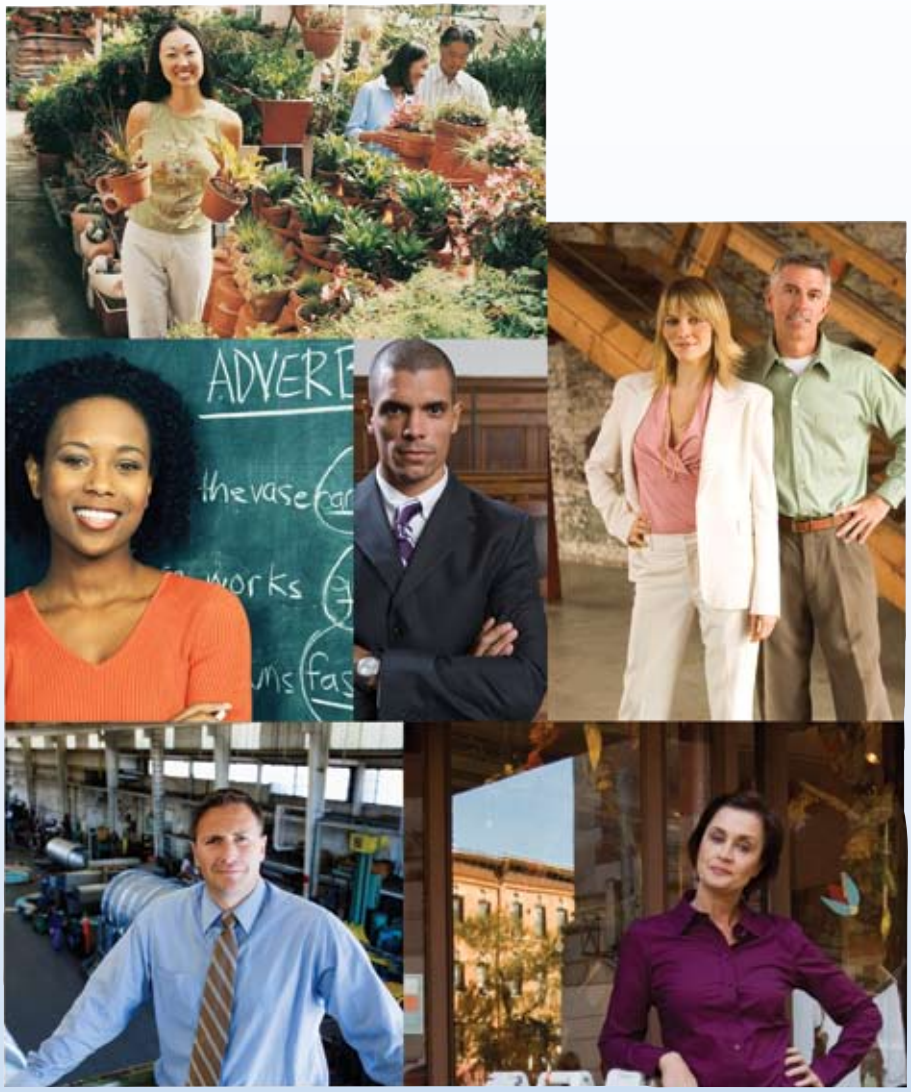
AETNA AVENUE℠

UTAH PLAN GUIDE

Your Destination for Small Business Solutions℠



Plans effective August 1, 2009

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We want you to know®

Aetna®

Health care is a journey ...

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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.

Health/dental insurance plans, life and disability insurance plans/policies are underwritten by Aetna Life Insurance Company (Aetna).

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

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

Dental, life and disability plans — providing valuable protection

- PPO
- PPO Max
- Preventive
- Basic term life insurance
- Disability plans
- Packaged life and disability plans

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. Our representatives are available to answer your questions and work with you when you need them.

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

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

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

- DocFind® to locate doctors in the neighborhood
- 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

Knowledgeable customer service — a valuable resource for members

- Ready to answer questions
- Online access 24 hours a day, 7 days a week
- E-mail access for answers to your questions

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

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 want you to know that Aetna delivers.

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

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.

DO YOU VALUE ...

Basic benefits for your employees Limiting the expense to your business Allowing employees to buy-up and share more of the cost	*You might be a ...* **Basic buyer**	**These plans fit ...** **Value plans** • PPO Basic $1,500 • PPO Limited 50/50 • PPO $750 Value • PPO $1,000 Value • PPO $1,500 Value • PPO $10,000 100%
Employee responsibility Consumerism's ability to make a difference Tools and resources to support consumerism Innovative plan design	*You might be a ...* **Value seeker**	**These plans fit ...** **Consumer-directed health plans** • PPO $2,500 100% HSA Compatible • PPO $2,500 80% HSA Compatible • PPO $3,500 80/60 HSA Compatible • $2,500 Coinsurance
Traditional benefits plans Limiting the financial impact on employees	*You might be a ...* **Traditionalist**	**These plans fit ...** **Traditional plans** • PPO $250 80/60 • PPO $500 80/60 • PPO $750 80/60 • PPO $1,000 80/60

YOUNG SINGLES

Consumer-directed health plans
Value Plans

YOUNG FAMILIES

Traditional plans

ESTABLISHED FAMILIES

Consumer-directed health plans
Value Plans

EMPTY NESTERS

Consumer-directed health plans

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.

*Aetna's Utah network has more than 5,200 health care providers and 38 hospitals from both the Intermountain and MountainStar health care systems.**

Aetna PPO plan provider network*

Utah counties

Beaver
Box Elder
Cache
Carbon
Daggett
Davis
Duchesne
Emery
Garfield
Grand
Iron
Juab
Kane
Millard
Morgan
Piute
Rich
Salt Lake
San Juan
Sanpete
Sevier
Summit
Tooele
Uintah
Utah
Wasatch
Washington
Wayne
Weber

*Network subject to change.

Aetna Avenue

MEDICAL OVERVIEW

WHAT IS PICK-A-PLAN 3?

Pick-A-Plan 3 is Aetna Small Group's suite of plans designed specifically with small businesses in mind. These plans provide choice, flexibility and simplicity.

Pick-A-Plan 3 offers the following advantages:

Greater employee choice
Employers with 5 or more enrolling employees can offer any 3 of the 18 available plan designs.

Flexibility and affordability
Employers with 5 or more enrolling employees can create a customized benefits package from any of our plan types and plan designs. Aetna offers a variety of plans at different price points. Employers may designate a level of contribution that meets their budget.

Total freedom
Aetna offers 18 plan choices that range in price and benefits to help meet each individual employee's needs, whether they are lower premiums or lower out-of-pocket costs at the time services are received.

Easy administration
Setting up this program is simple:

1. The employer can choose up to 3 plans from the Employer Application
2. The employer chooses how much to contribute
3. Each employee chooses the plan that's right for him or her

AETNA PPO PLAN

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

- Emergency care coverage — anywhere, anytime, 24 hours a day
- Large provider network
- No claim forms in network
- If members choose a provider from 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, except for emergency treatment
- Deductibles and coinsurance apply

	Pick-A-Plan 3
Target audience	Every small business with 5+ enrolled employees
Plan choices	Up to 3 of the 18 available plans
Minimum participation	
2 – 4 enrolled employees	Single or dual option available
5 or more enrolled employees	Triple option available
Employer contribution	50% of the employee rate or $120 defined contribution or the actual cost of the plans picked, whichever is less.
Rating options	5 – 50 employees — tabular

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

CONSUMER-DIRECTED HEALTH PLANS (CDHP)

Consumer-directed health insurance plans are benefit programs that combine a high-deductible health plan (HDHP) with a Health Savings Account to offer financial protection while shifting accountability to use lower-cost services.

When paired with a HSA, they provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

What makes Aetna's Small Group high-deductible health plans (HDHP) unique?

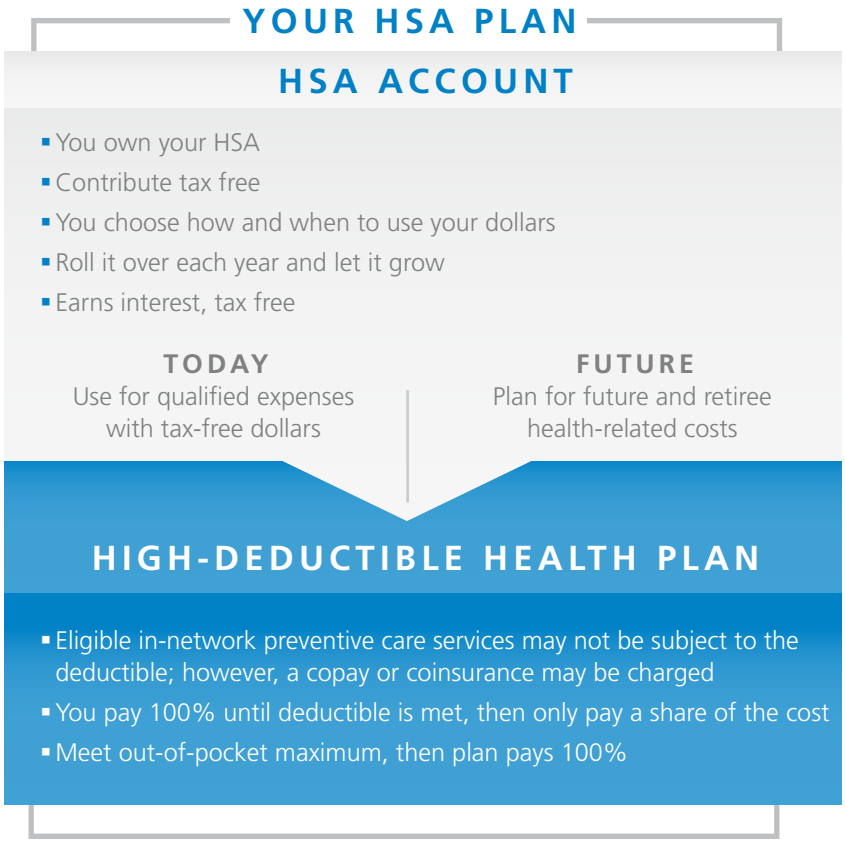
All of our HDHPs include an embedded deductible which means lower out-of-pocket costs!

What is an embedded deductible?

With an Aetna HDHP each covered family member only needs to satisfy his or her individual deductible before plan coinsurance applies. Most HDHPs in today's marketplace require satisfaction of the entire family deductible first.

HEALTH SAVINGS ACCOUNT (HSA)

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



Annual HSA contributions for 2009 are $3,000 per individual/$5,950 per family. Maximums will be adjusted for the cost of living in future years.

For more information, refer to www.irs.gov.

Administrative fees

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

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

The HRA and the HSA provide members with financial support for higher out-of-pocket health care expenses. 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. First-year POP fees waived with the purchase of medical with 5-plus enrolled employees.

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.

COBRA administration

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

*First year POP fees waived with the purchase of medical with 5-plus enrolled employees.
**Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for $75 fee. Non-discrimination testing only available for FSA and POP products.
***Aetna FSA pricing is inclusive for POP. Debit cards are available for FSA only. Contact Aetna for further information.
†For HRA, if the employer opts out of Streamline, the fee is increased $1.50 per participant.

Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information subject to change.
Aetna reserves the right to change any of the above fees and to impose additional fees upon prior written notice.

AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah PPO $250 80/60		Utah PPO $500 80/60		Utah PPO $750 Value	
OON Reimbursement		Recognized amount*		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Member Coinsurance (Applies to most services)	20%	40%	20%	40%	20%	40%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$250 per member (two-member maximum)	$500 per member (two-member maximum)	$500 per member (two-member maximum)	$1,000 per member (two-member maximum)	$750 per member (three-member maximum)	$1,500 per member (three-member maximum)
Calendar Year Coinsurance Limit*** (does not include deductible)	$1,500 per member (two-member maximum)	$3,000 per member (two-member maximum)	$2,000 per member (two-member maximum)	$4,000 per member (two-member maximum)	$2,500 per member (three-member maximum)	$5,000 per member (three-member maximum)
Lifetime Maximum Benefit	$2,000,000		$2,000,000		$2,000,000	
Primary Physician Office Visit	$10 copay (deductible waived)	40%	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%
Specialist Office Visit	$20 copay (deductible waived)	40%	$25 copay (deductible waived)	40%	$40 copay (deductible waived)	40%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	$0 (deductible waived)	40%	$0 (deductible waived)	40%	$20 (deductible waived)	40%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	30%	50%	30%	50%	30%	50%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	20%	40%	20%	40%	20%	40%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$10 copay (deductible waived)	40%	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%
Well-Child Exams (Age and frequency schedules apply)	$10 copay (deductible waived)	40%	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%
Routine GYN (Frequency schedules apply)	$20 copay (deductible waived)	40%	$25 copay (deductible waived)	40%	$40 copay (deductible waived)	40%
Inpatient Hospital	20%	40%	20%	40%	20%	40%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 20% 20%	 40% 40%	 20% 20%	 40% 40%	 $200 copay + 20% 20%	 $200 copay + 40% 40%
Emergency Room (Copay waived if admitted.)	20% after $100 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network
Urgent Care	$50 copay (deductible waived)	40%	$50 copay (deductible waived)	40%	$75 copay (deductible waived)	40%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$10/$30/$50	$10/$30/$50 + 20%	$10/$30/$50	$10/$30/$50 + 20%	$15/$40/$60 3X Retail for 90 day supply via MOD	$15/$40/$60 + 20%
Self-Injectable Drugs (retail and mail order)	20%	20%	20%	20%	20%	20%

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year. For the Value plans, once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.

***All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Coinsurance Limit. Certain member cost sharing elements including deductible, copays, pharmacy, mental health and substance abuse do not apply toward the Coinsurance Limit. Once 2 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year. For the Value plans, once 3 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah PPO $750 80/60		Utah PPO $1,000 80/60		Utah PPO $1,000 Value	
OON Reimbursement		Recognized amount*		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Member Coinsurance (Applies to most services)	20%	40%	20%	40%	20%	40%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$750 per member (two-member maximum)	$1,500 per member (two-member maximum)	$1,000 per member (two-member maximum)	$2,000 per member (two-member maximum)	$1,000 per member (three-member maximum)	$2,000 per member (three-member maximum)
Calendar Year Coinsurance Limit*** (does not include deductible)	$2,250 per member (two-member maximum)	$4,500 per member (two-member maximum)	$2,500 per member (two-member maximum)	$5,000 per member (two-member maximum)	$2,500 per member (three-member maximum)	$5,000 per member (three-member maximum)
Lifetime Maximum Benefit	$2,000,000		$2,000,000		$2,000,000	
Primary Physician Office Visit	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%	$25 copay (deductible waived)	40%
Specialist Office Visit	$25 copay (deductible waived)	40%	$30 copay (deductible waived)	40%	$40 copay (deductible waived)	40%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	$0 (deductible waived)	40%	$0 (deductible waived)	40%	$25 copay (deductible waived)	40%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	30%	50%	30%	50%	30%	50%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	20%	40%	20%	40%	20%	40%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%	$25 copay (deductible waived)	40%
Well-Child Exams (Age and frequency schedules apply)	$15 copay (deductible waived)	40%	$20 copay (deductible waived)	40%	$25 copay (deductible waived)	40%
Routine GYN (Frequency schedules apply)	$25 copay (deductible waived)	40%	$30 copay (deductible waived)	40%	$40 copay (deductible waived)	40%
Inpatient Hospital	20%	40%	20%	40%	20%	40%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 20% 20%	 40% 40%	 20% 20%	 40% 40%	 $200 copay + 20% 20%	 $200 copay + 40% 40%
Emergency Room (Copay waived if admitted.)	20% after $150 copay (deductible waived)	Paid as in-network	20% after $150 copay (deductible waived)	Paid as in-network	20% after $200 copay (deductible waived)	Paid as in-network
Urgent Care	$50 copay (deductible waived)	40%	$75 copay (deductible waived)	40%	$75 copay (deductible waived)	40%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$15/$30/$50	$15/$30/$50 + 20%	$15/$30/$60	$15/$30/$60 + 20%	$15/$40/$60 3X Retail for 90 day supply via MOD	$15/$30/$60 + 20%
Self-Injectable Drugs (retail and mail order)	20%	20%	20%	20%	20%	20%

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AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah PPO $1,500 80/60		Utah PPO $1,500 Value	
OON Reimbursement		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	Network	Out-of-Network	Network	Out-of-Network
Member Coinsurance (Applies to most services)	20%	40%	20%	40%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$1,500 per member (two-member maximum)	$3,000 per member (two-member maximum)	$1,500 per member (three-member maximum)	$3,000 per member (three-member maximum)
Calendar Year Coinsurance Limit*** (does not include deductible)	$3,000 per member (two-member maximum)	$5,000 per member (two-member maximum)	$3,000 per member (three-member maximum)	$5,000 per member (three-member maximum)
Lifetime Maximum Benefit	$2,000,000		$2,000,000	
Primary Physician Office Visit	$25 copay (deductible waived)	40%	$30 copay (deductible waived)	40%
Specialist Office Visit	$35 copay (deductible waived)	40%	$50 copay (deductible waived)	40%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	$0 (deductible waived)	40%	$30 copay (deductible waived)	40%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	30%	50%	30%	50%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	20%	40%	20%	40%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$25 copay (deductible waived)	40%	$30 copay (deductible waived)	40%
Well-Child Exams (Age and frequency schedules apply)	$25 copay (deductible waived)	40%	$30 copay (deductible waived)	40%
Routine GYN (Frequency schedules apply)	$35 copay (deductible waived)	40%	$50 copay (deductible waived)	40%
Inpatient Hospital	20%	40%	20%	40%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 20% 20%	 40% 40%	 $200 copay + 20% 20%	 $200 copay + 40% 40%
Emergency Room (Copay waived if admitted.)	20% after $200 copay (deductible waived)	Paid as in-network	20% after $200 copay (deductible waived)	Paid as in-network
Urgent Care	$75 copay (deductible waived)	40%	$75 copay (deductible waived)	40%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$15/$40/$60	$15/$40/$60 + 20%	$15/$40/$60 3X Retail for 90 day supply via MOD	$15/$30/$60 + 20%
Self-Injectable Drugs (retail and mail order)	20%	20%	20%	20%

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year. For the Value plans, once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.

***All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Coinsurance Limit. Certain member cost sharing elements including deductible, copays, pharmacy, mental health and substance abuse do not apply toward the Coinsurance Limit. Once 2 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year. For the Value plans, once 3 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah PPO $2,000 80/60		Utah PPO $3,000 80/60		Utah PPO $10,000 100%	
OON Reimbursement		Recognized amount*		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Member Coinsurance (Applies to most services)	20%	40%	20%	40%	0%	25%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$2,000 per member (two-member maximum)	$4,000 per member (two-member maximum)	$3,000 per member (two-member maximum)	$6,000 per member (two-member maximum	$10,000 per member $10,000 family+	$10,000 per member $10,000 family+
Calendar Year Coinsurance Limit*** (does not include deductible)	$3,500 per member (two-member maximum)	$7,000 per member (two-member maximum)	$4,000 per member (two-member maximum)	$8,000 per member (two-member maximum)	$10,000 per member $10,000 family++	$20,000 per member $20,000 family++
Lifetime Maximum Benefit	$2,000,000		$2,000,000		$2,000,000	
Primary Physician Office Visit	$30 copay (deductible waived)	40%	$30 copay (deductible waived)	40%	$15 copay (deductible waived)	25%
Specialist Office Visit	$40 copay (deductible waived)	40%	$50 copay (deductible waived)	40%	0%	25%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	$0 (deductible waived)	40%	$0 (deductible waived)	40%	0%	25%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	30%	50%	30%	50%	0%	25%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	20%	40%	20%	40%	0%	25%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$30 copay (deductible waived)	40%	$30 copay (deductible waived)	40%	$15 copay (deductible waived)	25%
Well-Child Exams (Age and frequency schedules apply)	$30 copay (deductible waived)	40%	$30 copay (deductible waived)	40%	$15 copay (deductible waived)	25%
Routine GYN (Frequency schedules apply)	$40 copay (deductible waived)	40%	$50 copay (deductible waived)	40%	$15 copay (deductible waived)	25%
Inpatient Hospital	20%	40%	20%	40%	0%	25%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 20% 20%	 40% 40%	 20% 20%	 40% 40%	 0% 0%	 25% 25%
Emergency Room (Copay waived if admitted.)	20% after $200 copay (deductible waived)	Paid as in-network	20% after $200 copay (deductible waived)	Paid as in-network	0%	Paid as in-network
Urgent Care	$75 copay (deductible waived)	40%	$75 copay (deductible waived)	40%	0%	25%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$20/$40/$60	$20/$40/$60 + 20%	$20/$40/$60	$20/$40/$60 + 20%	$20/$40/$60	$20/$40/$60 + 20%
Self-Injectable Drugs (retail and mail order)	20%	20%	20%	20%	20%	20%

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.

***All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Coinsurance Limit. Certain member cost sharing elements including deductible, copays, pharmacy, mental health and substance abuse do not apply toward the Coinsurance Limit. Once 2 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

+Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Expenses accumulate separately toward the preferred and non-preferred deductibles. 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 is required to contribute more than the Individual Deductible amount toward the Family Deductible.

++All covered expenses accumulate separately toward the preferred and non-preferred coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the coinsurance Limit. Certain member cost sharing elements including copays, pharmacy, mental health and substance abuse do not apply toward the coinsurance Limit. Once the Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah $2,500 100% HSA compatible		Utah $2,500 80% HSA compatible		Utah $3,500 80% HSA compatible	
OON Reimbursement		Recognized amount*		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	In-Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Member Coinsurance (Applies to most services)	0%	25%	20%	40%	20%	40%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$2,500 individual $5,000 family	$5,000 individual $10,000 family	$2,500 per member $5,000 family	$5,000 per member $10,000 family	$3,500 per member $7,000 family	$6,000 per member $12,000 family
Calendar Year Coinsurance Limit*** (Includes deductible)	$2,500 individual $5,000 family	$10,000 individual $20,000 family	$5,800 per member $11,600 family	$12,000 per member $24,000 family	$5,800 per member $11,600 family	$12,000 per member $24,000 family
Lifetime Maximum Benefit	$2,000,000		$2,000,000		$2,000,000	
Primary Physician Office Visit	0%	25%	20%	40%	20%	40%
Specialist Office Visit	0%	25%	20%	40%	20%	40%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	0%	25%	20%	40%	20%	40%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	0%	25%	30%	50%	30%	50%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	0%	25%	20%	40%	20%	40%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%
Well-Child Exams (Age and frequency schedules apply)	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%
Routine GYN (Frequency schedules apply)	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%	$0 copay (deductible waived)	25%
Inpatient Hospital	0%	25%	20%	40%	20%	40%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 0% 0%	 25% 25%	 20% 20%	 40% 40%	 20% 20%	 40% 40%
Emergency Room (Copay waived if admitted.)	0%	Paid as in-network	20%	Paid as in-network	20%	Paid as in-network
Urgent Care	0%	25%	20%	40%	20%	40%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	100% (paid by plan) after medical plan deductible	75% (paid by plan) after medical plan deductible	$15/$30/$50 after medical plan deductible	$15/$30/$50 + 20% after medical plan deductible	$15/$30/$50 after medical plan deductible	$15/$30/$50 + 20% after medical plan deductible
Self-Injectable Drugs (retail and mail order)	100% (paid by plan) after medical plan deductible	75% (paid by plan) after medical plan deductible	20% after medical plan deductible	20% after medical plan deductible	20% after medical plan deductible	20% after medical plan deductible
Prescription Drug Deductible	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Expenses accumulate separately toward the preferred and non-preferred deductibles. 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 is required to contribute more than the Individual Deductible amount toward the Family Deductible.

***The Coinsurance Limit for HSA compatible plans includes preferred & non-preferred out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts). All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Once the Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year. No one family member is required to contribute more than the Individual Deductible amount toward the Family Deductible.

AETNA SMALL GROUP PPO PLANS

NEW PLAN NAME	Utah $2,500 Coinsurance		Utah Basic PPO $1,500 70/55		Utah Limited Benefit 50/50	
OON Reimbursement		Recognized amount*		Recognized amount*		Recognized amount*
Network	Open Choice PPO	N/A	Open Choice PPO	N/A	Open Choice PPO	N/A
Member Benefits	Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Member Coinsurance (Applies to most services)	20%	40%	30%	45%	50%	50%
Calendar Year Deductible** (In-Network and Out-of-Network accumulate separately)	$2,500 per member (two-member maximum)	$5,000 per member (two-member maximum)	$1,500 per member (two-member maximum)	$3,000 per member (two-member maximum)	$1,500 per member (two-member maximum)	$3,000 per member (two-member maximum)
Calendar Year Coinsurance Limit*** (does not include deductible)	$5,000 per member (two-member maximum)	$10,000 per member (two-member maximum)	$4,500 per member (two-member maximum)	$9,000 per member (two-member maximum)	$4,500 per member (two-member maximum)	$9,000 per member (two-member maximum)
Lifetime Maximum Benefit	$2,000,000		$2,000,000		$2,000,000 Lifetime maximum $25,000 annual benefit maximum	
Primary Physician Office Visit	20%	40%	$35 copay (deductible waived)	45%	50%	50%
Specialist Office Visit	20%	40%	$35 copay (deductible waived)	45%	50%	50%
Chiropractic Services	Covered under PT/OT/ST		Covered under PT/OT/ST		Covered under PT/OT/ST	
Outpatient Lab and X-ray (services included with office visit cost sharing)	20%	40%	30% after deductible; $500 max benefit for lab, X-ray and complex imaging combined, Network and Out-of-Network combined	45% after deductible; $500 max benefit for lab, X-ray and complex imaging combined, Network and Out-of-Network combined	50% after deductible; $500 max benefit for lab, X-ray and complex imaging combined, Network and Out-of-Network combined	50% after deductible; $500 max benefit for lab, X-ray and complex imaging combined, Network and Out-of-Network combined
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	30%	50%	See Outpatient Lab and X-ray	See Outpatient Lab and X-ray	See Outpatient Lab and X-ray	See Outpatient Lab and X-ray
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	20%	40%	30%	45%	50%	50%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined		30 visits per cal year all therapies combined, Network and Out-of-Network combined	
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	$0 copay (deductible waived)	25%	$35 copay (deductible waived)	45%	$30 copay (deductible waived)	50%
Well-Child Exams (Age and frequency schedules apply)	$0 copay (deductible waived)	25%	$35 copay (deductible waived)	45%	$30 copay (deductible waived)	50%
Routine GYN (Frequency schedules apply)	$0 copay (deductible waived)	25%	$35 copay (deductible waived)	45%	$30 copay (deductible waived)	50%
Inpatient Hospital	20%	40%	30%	45%	50%	50%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	20% 20%	40% 40%	$200 copay + 30% 30%	$200 copay + 45% 45%	$200 copay+ 50% 50%	$200 copay + 50% 50%
Emergency Room (Copay waived if admitted.)	20%	Paid as in-network	30%	Paid as in-network	50%	Paid as in-network
Urgent Care	20%	40%	30%	45%	50%	50%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$15/$40/$60	$15/$40/$60 + 20%	$10 Generics. Member pays 100% for Brand meds 3X Retail for 90 day supply via MOD	$10 + 20% for Generics; Member pays 100% for Brand meds	$10 Generics. Member pays 100% for Brand meds 3X Retail for 90 day supply via MOD	$10 + 20% for Generics; Member pays 100% for Brand meds
Self-Injectable Drugs (retail and mail order)	20%	20%	20%	20%	20%	20%

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll.

**Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.

***All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Coinsurance Limit. Certain member cost sharing elements including deductible, copays, pharmacy, mental health and substance abuse do not apply toward the Coinsurance Limit. Once 2 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

AETNA SMALL GROUP INDEMNITY PLAN

NEW PLAN NAME	Aetna Indemnity
OON Reimbursement	
Network	N/A
Member Benefits	N/A
Member Coinsurance (Applies to most services)	30%
Calendar Year Deductible* (In-Network and Out-of-Network accumulate separately)	$1,000 per member (two-member maximum)
Calendar Year Coinsurance Limit** (does not include deductible)	$3,000 per member (two-member maximum)
Lifetime Maximum Benefit	$2,000,000
Primary Physician Office Visit	30%
Specialist Office Visit	30%
Chiropractic Services	Covered Under PT/OT/ST
Outpatient Lab and X-ray (services included with office visit cost sharing)	30%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scans)	40%
Outpatient Physical, Occupational, Speech and Chiropractic Therapy	30%
PT/OT/ST/CT Limits	30 visits per cal year all therapies combined, Network and Out-of-Network combined
Physical Exams – Adults (Age and frequency schedules apply; $300 max benefit per exam)	30%
Well-Child Exams (Age and frequency schedules apply)	30%
Routine GYN (Frequency schedules apply)	30%
Inpatient Hospital	30%
Outpatient Surgery **OP Hospital Department** **Freestanding Facility**	 30% 30%
Emergency Room (Copay waived if admitted.)	30%
Urgent Care	30%
Prescription Drugs Retail: per 30-day supply Mail Order: 2.5 times retail copay, 90-day supply available	$20/$40/$60
Self-Injectable Drugs (retail and mail order)	20%
Prescription Drug Deductible	$200 Individual $400 Family

*Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once 2 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.

**All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Coinsurance Limit. Certain member cost sharing elements including deductible, copays, pharmacy, mental health and substance abuse do not apply toward the Coinsurance Limit. Once 2 individual members of a family each satisfy their Coinsurance Limit separately, all family members will be considered as having met their Coinsurance Limit for the remainder of the calendar year.

Aetna Avenue

DENTAL OVERVIEW

AETNA DENTAL® PLANS

Small business decision makers can choose from a variety of plan design options that help you offer a dental 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℠ 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.

Preferred Provider Organization (PPO) plan

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

PPO Max plan

While the PPO Max dental insurance plan uses the PPO network, members who use out-of-network dentists will be covered based on the Aetna PPO fee schedule. For more information, see the "How Aetna pays claims for out-of-network benefits" brochure. This brochure will be mailed directly to members after they enroll. The member will share in more of the costs and may be balance-billed. This plan offers members a quality dental insurance plan with a significantly lower premium that encourages in-network usage.

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.

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

DMI may not be available in all states.

SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees	**Option 1 PPO Max 1000**	**Option 2 PPO Active 1000**		**Option 3 PPO 1000**
Available Without Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000	$1,000	$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing - single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	80%	100%
Child Cleaning	100%	100%	80%	100%
Sealants - per tooth	100%	100%	80%	100%
Fluoride application - with cleaning	100%	100%	80%	100%
Space maintainers	100%	100%	80%	100%
BASIC SERVICES				
Amalgam filling - 2 surfaces	80%	80%	60%	80%
Resin filling - 2 surfaces, anterior	80%	80%	60%	80%
Oral Surgery				
Extraction - exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth - soft tissue	80%	80%	60%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	40%	50%
Partial upper denture (resin base)	50%	50%	40%	50%
Crown - Porcelain with noble metal	50%	50%	40%	50%
Pontic - Porcelain with noble metal	50%	50%	40%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	40%	50%
Oral Surgery				
Removal of impacted tooth - partially bony	50%	50%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	40%	80%
Molar root canal therapy	50%	50%	40%	50%
Periodontic Services				
Scaling & root planing - per quadrant	50%	50%	40%	80%
Osseous surgery - per quadrant	50%	50%	40%	50%
***ORTHODONTIC SERVICES**	Not covered	Not covered	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	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; Members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Options 4, 5, & 6.
Plan Options 1 & 4; 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.

SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees	Option 4 PPO Max1500	Option 5 PPO Active 1500		Option 6 PPO 1500
Available Without Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	$1,500	$1,500	$1,000	$1,500
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
X-rays				
Bitewing - single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	80%	100%
Child Cleaning	100%	100%	80%	100%
Sealants - per tooth	100%	100%	80%	100%
Fluoride application - with cleaning	100%	100%	80%	100%
Space maintainers	100%	100%	80%	100%
BASIC SERVICES				
Amalgam filling - 2 surfaces	80%	80%	60%	80%
Resin filling - 2 surfaces, anterior	80%	80%	60%	80%
Oral Surgery				
Extraction - exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth - soft tissue	80%	80%	60%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	40%	50%
Partial upper denture (resin base)	50%	50%	40%	50%
Crown - Porcelain with noble metal	50%	50%	40%	50%
Pontic - Porcelain with noble metal	50%	50%	40%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	40%	50%
Oral Surgery				
Removal of impacted tooth - partially bony	50%	50%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	80%	80%	60%	80%
Molar root canal therapy	50%	50%	40%	50%
Periodontic Services				
Scaling & root planing - per quadrant	80%	80%	60%	80%
Osseous surgery - per quadrant	50%	50%	40%	50%
***ORTHODONTIC SERVICES**	50%	50%	40%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,000

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.
Access to negotiated discounts; Members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Options 4, 5, & 6.
Plan Options 1 & 4; 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.

SMALL GROUP VOLUNTARY DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 3 – 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees	**Voluntary Option 1 PPO 1000** PPO Plan 100/80/50	**Voluntary Option 2 PPO 1500** PPO Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive services)	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,500
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
X-rays		
Bitewing - single film	100%	100%
Complete series	100%	100%
PREVENTIVE SERVICES		
Adult Cleaning	100%	100%
Child Cleaning	100%	100%
Sealants - per tooth	100%	100%
Fluoride application - with cleaning	100%	100%
Space maintainers	100%	100%
BASIC SERVICES		
Amalgam filling - 2 surfaces	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%
Oral Surgery		
Extraction - exposed root or erupted tooth	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%
***MAJOR SERVICES**		
Complete upper denture	50%	50%
Partial upper denture (resin base)	50%	50%
Crown - Porcelain with noble metal	50%	50%
Pontic - Porcelain with noble metal	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%
Oral Surgery		
Removal of impacted tooth - partially bony	50%	50%
Endodontic Services		
Bicuspid root canal therapy	50%	80%
Molar root canal therapy	50%	50%
Periodontic Services		
Scaling & root planing - per quadrant	50%	80%
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; members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Voluntary Option 2.
All voluntary plans require a minimum of 3 to enroll. Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only. A minimum of 5 employees must enroll.
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 43.

SMALL GROUP OUT-OF-STATE PPO DENTAL PLANS

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	**Low Option No Ortho** PPO Max Plan 100/80/50	**Low Option Ortho** PPO Max Plan 100/80/50	**Medium Option No Ortho** PPO Max Plan 100/80/50	**Medium Option Ortho** PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000	$1,500	$1,500
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing - single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%
Fluoride application - with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
BASIC SERVICES				
Amalgam filling - 2 surfaces	80%	80%	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction - exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth - partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing - per quadrant	50%	50%	50%	50%
Osseous surgery - per quadrant	50%	50%	50%	50%
***ORTHODONTIC SERVICES**	Not covered	50%	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000	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 are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
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 43.
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.

SMALL GROUP OUT-OF-STATE PPO VOLUNTARY DENTAL PLANS

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	**Voluntary Option 1 No Ortho** PPO Max Plan 100/80/50	**Voluntary Option 1 Ortho** PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive services)	$75; 3X Family Maximum	$75; 3X Family Maximum
Annual Maximum Benefit	$1,000	$1,000
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
X-rays		
Bitewing - single film	100%	100%
Complete series	100%	100%
PREVENTIVE SERVICES		
Adult Cleaning	100%	100%
Child Cleaning	100%	100%
Sealants - per tooth	100%	100%
Fluoride application - with cleaning	100%	100%
Space maintainers	100%	100%
BASIC SERVICES		
Amalgam filling - 2 surfaces	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%
Oral Surgery		
Extraction - exposed root or erupted tooth	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%
***MAJOR SERVICES**		
Complete upper denture	50%	50%
Partial upper denture (resin base)	50%	50%
Crown - Porcelain with noble metal	50%	50%
Pontic - Porcelain with noble metal	50%	50%
Inlay - Metallic (3 or more surfaces)	50%	50%
Oral Surgery		
Removal of impacted tooth - partially bony	50%	50%
Endodontic Services		
Bicuspid root canal therapy	50%	50%
Molar root canal therapy	50%	50%
Periodontic Services		
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 are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
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 43.
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.
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.

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

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 Essentials*℠ program.

So what's the bottom line? A portfolio of value-packed products and programs to attract and retain workers — while making the most of the 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 dependent 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 when applicable with the employee to help address medical and disability issues.
- Referrals between health case managers and their disability counterparts when applicable 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 43.

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

TERM LIFE PLAN OPTIONS

	2-9 Employees	10-50 Employees
Basic Life Schedule	Flat $10,000, $15,000, $20,000, $50,000	Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000
Class Schedules	Not Available	Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class
Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60
Age Reduction Schedule	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Guaranteed Issue	$20,000	10-25 employees $75,000 26-50 employees $100,000
Participation Requirements	100%	100% on non-contributory plans; 75% on contributory plans
Contribution Requirements	100% Employer Contribution	Minimum 50% Employer Contribution
AD&D ULTRA®		
AD&D Schedule	Matches Life Benefit	Matches Life Benefit
Additional Features	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	$5,000
Child Amount	Not Available	$2,000

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

DISABILITY PLAN OPTIONS

SHORT TERM BENEFITS	Plan Option 1	Plan Option 2
Plan Amount	Choice of flat $100 increments to a maximum of $500 weekly	Choice of flat $100 increments to a maximum of $500 weekly
Benefits Start — Accident	1 Day	8 Days
Benefits Start — Illness	8 Days	8 Days
Maximum Benefit Period	26 Weeks	26 Weeks
Maternity Benefit	Maternity treated same as any other disability but is subject to pre-existing. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.	Maternity treated same as any other disability but is subject to pre-existing. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.
Pre-Existing Conditions Rule	3/12	3/12
Actively at Work Rule	Applies	Applies
Other Income Offset Integration	N/A	N/A
Other Income Offset Integration	Earnings Loss of 20% or more	Earnings Loss of 20% or more
Definition of Disability	Earnings Loss of 20% or more	Earnings Loss of 20% or more
Class Schedules	Up to 3 classes (with a minimum requirement of 3 employees in each class) available for groups of 10 or more employees	Up to 3 classes (with a minimum requirement of 3 employees in each class) available for groups of 10 or more employees

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	Low Option	Low Option 2	Medium Option	Medium Option 2	High Option
Benefit	Flat $10,000	Flat $15,000	Flat $20,000	Flat $25,000	Flat $50,000
Guaranteed Issue **2-9 Lives** **10-50 Lives**	 $10,000 $10,000	 $15,000 $15,000	 $20,000 $20,000	 $20,000 $25,000	 $20,000 $50,000
Reduction Schedule	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75	Employee's Original Life Amount Reduces to 65% at age 65; 40% at age 70; 25% at age 75
Disability Provision	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60	Premium Waiver 60
Conversion	Included	Included	Included	Included	Included
Accelerated Death Benefit	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration	Up to 75% of benefit; 24 month acceleration
Dependent Life	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000
AD&D ULTRA					
AD&D Ultra®	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit	Matches Basic Life Benefit
AD&D Ultra® Additional Features	Seat Belt/Airbag, Education, Child Care, Repatriation, Coma, Total Disability, 365-Day Covered Loss				
DISABILITY PLAN DESIGN					
Monthly Benefit	Flat $500; No offsets	Flat $1,000; Offsets are Workers' Compensation, any State Disability Plan and Primary and Family Social Security benefits.			
Elimination Period	30 days	30 days	30 days	30 days	30 days
Definition of Disability	Own Occupation: Earnings loss of 20% or more.	Own Occupation: Earnings loss of 20% or more.	Own Occupation: Earnings loss of 20% or more.	Own Occupation: Earnings loss of 20% or more.	First 24 months of benefits: Own Occupation Earnings Loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss.
Benefit Duration	24 months	24 months	24 months	24 months	60 months
Pre-Existing Condition Limitation	3/12	3/12	3/12	3/12	3/12
Types of Disability	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational
Separate Periods of Disability	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter
Mental Health/ Substance Abuse	24 months	24 months	24 months	24 months	24 months
Waiver of Premium	Included	Included	Included	Included	Included
Other Plan Provisions					
Employer Contribution	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid	2-9 Lives – 100% employer paid 10+ Lives – 50-100% employer paid
Minimum Participation	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%	2-9 Lives – 100% 10+ Lives (with Medical) – 70% 26+ Lives (Standalone) – 75%
Eligibility	Active Full-Time Employees	Active Full-Time Employees	Active Full-Time Employees	Active Full-Time Employees	Active Full-Time Employees
Class Schedules	2-9 Lives: Not Available; 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.				
Rate Guarantee	1 year	1 year	1 year	1 year	1 year
Rates PEPM	$8.00	$10.00	$15.00	$16.00	$27.00

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

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

For groups with 2 to 50 eligible employees, Utah

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

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

AFFILIATED, ASSOCIATED OR MULTIPLE COMPANIES

Employers who have more than one business with different Tax Identification Numbers (TINs) may be eligible to enroll as one group if the following are met:

- Only businesses with like or common SIC codes may be written as one group.
- One owner has controlling interest of all business to be included; or
- The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and
- All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only 2 of the 3 businesses to be enrolled, the group will be considered a carve out, will not be Guarantee Issue, and could be declined.
- The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined **must have the minimum and maximum number of employees required by the state.**
- There are 50 or fewer employees in the combined employer groups.
- Complete the Business Eligibility section of the Employer application.
- Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups.
- Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception.
  Example: One owner has controlling interest of all companies to be included:
  Company 1 – Jim owns 75% and Jack owns 25%
  Company 2 – Jim owns 55% and Jack owns 45%
  Both companies can be written as one group since Jim has controlling interest in both.

BENEFIT WAITING PERIOD

- Benefit waiting periods **must be consistently applied to all employees**, including newly hired key employees.
- The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days.
- The eligibility date will be the first day of the policy month following the waiting period.
  Example:
  Group A – effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period.
  Group B – effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period.

- A reduction of the benefit waiting period (example: from 1st of the month following 120 days to 1st of the month following 90 days) **may only be done on the group's anniversary date.**
- An increase in the benefit waiting period (example: from 1st of the month following 90 days to 1st of the month following 120 days) may be requested once in a 12 month period and may be requested either on or off the anniversary date.
- Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer.
- At initial submission of the group the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application and consistently applied to <u>all</u> employees.
- Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date.
- **No retroactive benefit waiting period changes will be allowed.**

CARVE OUTS

- The general types of carve outs that could be considered by Aetna include: Utah Branch Location and Management/ Non-Management, Salary, and Union vs. Non-Union.
- Aetna must enroll **and** maintain a minimum of **10** employees who reside within Aetna's Utah Network Service Area.
- Employers may request to carve out a specific class of employees for coverage, subject to underwriting approval which can be declined, even if the standard participation requirements are met.
- Employers must provide employee class definitions in writing on company letterhead prior to final approval.

CASE SUBMISSION DATES

- Groups with 2 to 50 eligible employees must have all completed paperwork into Aetna Underwriting **no later than the requested effective date**.
- If not received by this date, the effective date will be moved to the next available effective date.

CENSUS DATA

- Census data must be provided for all eligible employees, including COBRA eligible and Utah State Continuation employees.
- Include the name, date of birth, date of hire, gender, dependent status, and residence zip code (when multi-site/multi-state)
- Retirees are not eligible.
- COBRA/State Continuation eligible employees should be included on the census and noted as COBRA/State Continuation.

DEDUCTIBLE CREDIT

- Employees who are eligible and want to receive credit for deductible paid to prior Company should submit a copy of the Explanation of Benefits to Aetna. They may do this either at the initial small group submission or with their first claim.

DEFINITION OF A SMALL GROUP EMPLOYER

- "Small employer" means with respect to a calendar year and to a plan year:
  - Employs on average at least 2 employees but no more than 50 employees on each business day during the preceding calendar year **and**
  - Employs at least 2 employees on the first day of the plan year
- In determining the number of eligible employees, members, or enrollees, companies that are affiliated companies, are eligible to file a combined tax return for purposes of taxation by this state, or are subsidiaries of another company and covered under the parent company's group heath insurance contract or policy, **shall be considered as one group.**
- Medical plans can be offered to sole proprietors, partnerships, or corporations.
- Organizations must not be formed solely for the purposes of obtaining health coverage.
- Taft Hartley groups, Professional Employer Organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) are not eligible.
- Dental and Disability have ineligible industries which are listed separately under their specific sections.

DENTAL

Open enrollments are prohibited.

- Coverage Waiting Period
- For Major and Orthodontic services, employees must be enrolled members of the plan for one year. Waiting Period is waived separately for Major and Orthodontic for employees who were covered by the group's immediately preceding dental plan.
  - To waive the Waiting Period for Major services, the group's immediately preceding group plan must have covered Major Services.
  - To waive the Waiting Period for Orthodontic services, the group's immediately preceding group plan must have covered Orthodontic services.
- **Example:** Prior Major coverage but no Orthodontic coverage. New plan has both Major and Orthodontic coverage. The Waiting Period is waived for Major services but not for Orthodontic services.

Product Packaging

- PPO can be sold standalone.
- Voluntary Dental plans **cannot** be sold or packaged with any other Dental plan offering.

Reinstatement

- For Voluntary Dental Plan Options: Members who were once enrolled then terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules apply from the new effective date including, but not limited to, the Coverage Waiting Period.

Ineligible Industries

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

SIC Range	SIC Description
0761-0783	Seasonal Employees
3911-3915	Jewelry Manufacturing
4111-4121	Passenger Transportation
5271	Mobile Home Dealers
5511-5599	Auto Dealerships
5800-5899	Restaurants
6500-6799	Real Estate
7000-7099	Hotels
7221	Photo Studios
7231-7241	Beauty & Barber Shops
7251-7299	Repairs, Cleaning, Personal Services
7319	Advertising, Misc.
7331-7338	Direct Mailing, Secretarial Services
7361-7363	Employment Agencies
7379	Miscellaneous Computer Services
7381-7382	Security Systems, Armored Cars
7384	Photofinishing Labs
7389	Miscellaneous Business Services
7631	Watch, Clock & Jewelry Repair
7692-7699	Miscellaneous Repair
7800-7999	Amusement, Recreation, and Entertainment
8000-8059	Medical Groups
8071-8099	Medical Groups
8100-8199	Legal
8211-8299	Schools, Libraries, Education
8300-8399	Social Service
8400-8499	Museums, Art Galleries, Botanical Gardens
8600-8699	Associations & Trusts
8700-8799	Engineering & Management Services
8800-8899	Service – Private Households
8999	Miscellaneous Services
9721	International Affairs

DEPENDENT ELIGIBILITY

- Eligible dependents include an employee's spouse and unmarried children up to age 26.
- An unmarried child of any age who is medically certified as a dependent upon the parent, who the parent claimed as a dependent on the form for income tax returns which they filed with the Internal Revenue Service for the previous fiscal year. This includes a child or child(ren) who are dependent solely on the employee for support includes natural, stepchildren, foster, legally adopted children, proposed adoptive children, and a child court order.
- Attainment of limiting age will not terminate the coverage of the child(ren) while the child(ren) is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance. Proof of Incapacity and dependency shall be furnished to Aetna by the employee or the member within 31 days of the child(ren)'s attainment of the limiting age and subsequently as may be required by Aetna, but not more frequently than annually after the two-year period following the child(ren)'s attainment of the limiting age.
- Domestic Partners are not considered eligible dependents.
- If both husband and wife work for the same company they may enroll together or separately. Children can only be covered under one parent's plan.
- 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.

EFFECTIVE DATE

- Groups with no prior coverage may request either the 1st or the 15th of the month effective dates.
- The effective date requested by the employer may be up to 60 days in advance.
- When replacing an employer-sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period.
- For example, if the other plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.

ELECTRONIC FUNDS TRANSFER

- Payment for the first month's premium at new business can be processed via an Electronic Funds Transfer.
- This does not apply to future premium payments.

EMPLOYEE ELIGIBILITY

- An eligible employee means either of the following:
  - An employee who works full-time and has a normal workweek of 30 or more hours. The definition includes a sole proprietor, a partner of a partnership or an independent contractor if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer. This does not include an individual who works on a temporary or substitute basis for a small employer; an employer's spouse or dependent of an employer.
  - Eligible employees will also include: Union employees, even if currently covered under the union plan.
  - Employees reported on the IRS 1099 forms who meet Aetna's standard criteria for determining 1099 status.
  - Part-time employees are not considered eligible employees.
  - Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa.

Retirees

- Retiree coverage is not available.

COBRA /Utah State Continuees

- COBRA/Utah State continuation eligible enrollees are required to be included on the census (they are not eligible for Life and/or Disability).
- Health questions must be answered.
- COBRA/Utah State Continuation qualifying event, length, start and end date must be provided.
- Please Note: COBRA Continuees or Utah State Continuees 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 that the law is applicable to the group, COBRA continues or Utah State Continuees can be included for coverage subject to normal underwriting guidelines.

EMPLOYER CONTRIBUTION

Single or Dual Choice Medical

- The employer must contribute at least 50% of the employee rate.
- Coverage may be denied based upon inadequate contributions.

Pick-A-Plan 3 (Medical)

- The employer must contribute 50% of the employee only rate of whichever plan the employee selects.
- The employer may choose to offer a Defined Contribution of at least $120 or the actual cost of the plan, whichever is less.
- Coverage may be denied based upon inadequate contributions.

Dental

- The employer must contribute at least 50% of the employee-only cost or 25% of the total plan.
- For Voluntary Dental plans: Employer contribution can be from zero to 49% of the cost of the employee only coverage.
- For Voluntary Dental plans: Employee pay all plans are permitted.
- Pick-A-Plan 3 is not available.
- Coverage may be denied based upon inadequate contributions.

Term Life – Packaged Life & Disability

- Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan.
- Employers with 10 – 50 eligible lives: Employer must contribute at least 50% of the cost of the plan (excluding Optional Dependent Life).
- Pick-A-Plan 3 is not available.
- Coverage may be denied based upon inadequate contributions.

Disability

- Employers with less than 10 eligible lives: Employer must contribute 100% of the cost of the plan.
- Employers with 10-50 eligible lives: Employer must contribute at least 50% of the plan.
- Pick-A-Plan 3 is not available.
- Coverage may be denied based upon inadequate contributions.

EMPLOYER ELIGIBILITY

- All Aetna plans can be offered to sole proprietors, partnerships or corporations.
- Employers (Companies/Organizations) must not be formed solely for the purpose of obtaining health coverage.
- Non Guaranteed Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employee/employer relationship exists are not eligible for Small Group coverage.
- Dental and Life products have ineligible industries which are listed separately under Product Specifications. The Dental ineligible industry list does not apply when dental is sold in combination with medical.

EMPLOYERS LEAVING AN AETNA PEO

- Employers leaving a PEO that is not currently insured with Aetna will be required to complete the Aetna PEO form. Underwriting will determine eligibility based upon this completed form.
- Employers leaving a PEO that is currently insured with Aetna do not need to complete the Aetna PEO form. A statement signed by the employer will be sufficient.
- The PEO Form will only be requested from an Aetna PEO client when the employer is still receiving services from the Aetna PEO.

EMPLOYER — MID POLICY BENEFIT CHANGES

- In addition to a plan change at renewal, an upgrade or downgrade in benefits may be requested once in a 12-month period.
- Upgrades are subject to medical underwriting and may either be declined or re-rated.
- Benefits changes are not allowed during the 4 months preceding the group's anniversary date.
- High-deductible health plans (HDHP): The 4 month limitation may be waived if the groups request to add one of the HDHP plans. This will be subject to underwriting approval.
- Request for plan changes must be submitted to Aetna Small Group Underwriting 30 days prior to the requested effective date.
- Late request will be moved to the next applicable effective date pending underwriting approval.

EMPLOYERS REPLACING OTHER GROUP COVERAGE

- A copy of the most recent billing statement that includes the employee listing must be submitted.
- The employer should be told **not to cancel any existing medical coverage** until they have been notified of approval from the Aetna Underwriting unit.

HOLDING COMPANIES

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

Example

- Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).
- Bank A (the holding company) has no ownership; it is simply an umbrella company for the 3 Bank B locations.
- Bank B has 3 locations and all under one TIN.

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

INITIAL PREMIUM CHECK

- The initial premium check should be in the amount of the first month's premium and drawn on a company check.
- The initial premium check is not a binder check. Final premium will be determined upon underwriting review.
- If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer.

LATE ENTRANTS

- An employee or dependent that enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee.
- Applicants without a qualifying life event (i.e. marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below.
- Voluntary cancellation of coverage is **NOT** a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added.

Medical

- Late applicants without a qualifying event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) will be deferred until the next plan anniversary date or the group and may reapply for coverage 30 days prior to the anniversary date.

Dental

- An employee or dependent may enroll at any time; however, coverage is limited to Preventive and Diagnostic Services for the first 12 months.
- No coverage for most Basic and Major Services for the first 12 months (24 months for Orthodontics).
- Late entrant provision does not apply to enrollees less than age 5.

Life or Packaged Life & Disability or Disability

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

LIFE — BASIC TERM

Open Enrollments are prohibited.

Job Classifications (Position) Schedules

- Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to three separate classes are allowed (with a minimum requirement of 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows:

Position/Job Class	Basic Term Life Amount	Disability	Packaged Life/Disability
Executives	$50,000	Flat $500 (8/8)	High
Managers, Supervisors	$20,000	Flat $300 (8/8)	Medium
All other employees	$10,000	Flat $200 (8/8)	Low

Guaranteed Issue Coverage

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

Basic Term Life Amount	Life Amount within Packaged Life & Disability Offering
2 – 9 eligible lives – $20,000	Low Option – $10,000
10 – 25 eligible lives – $75,000	Medium Option – $20,000
26 – 50 eligible lives – $100,000	High Option – $50,000

EVIDENCE OF INSURABILITY (EOI)

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

1) Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit.
2) Coverage is not requested within 31 days of eligibility for contributory coverage.
3) New coverage is requested during the renewal period.
4) Coverage is requested outside of the employer's renewal period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).
5) Reinstatement or restoration of coverage is requested.

ACTIVELY AT WORK

Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day.

CONTINUITY OF COVERAGE (NO LOSS/ NO GAIN)

The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers. If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.

Ineligible Industries Life/AD&D

All industries are eligible except for stand alone for groups of 26+

SIC Range	SIC Description
1000-1499	Mining
2892-2899	Explosives, Bombs & Pyrotechnics
3291-3292	Asbestos Products
3310-3329	Primary Metal Industries
3480-3489	Fire Arms/Ammunitions
5921	Liquor Stores
6211	Security Brokers
6531	Real Estate – Agents
7381	Service – Detective
7500-7599	Auto Repair & Service
7800-7999	Motion Picture, Amusement, Recreation
8010-8043	Medical Doctors/Clinics
8600-8699	Membership Associations
8800-8899	Service – Private Household
9999	Non Classified Establishment

Groups are ineligible for coverage if 60% or more of the eligible employees are over the age or 50.

MEDICAL

- A Utah small employer subject to Guarantee Issue cannot be declined based upon medical conditions or claims experience; however, group rates will be adjusted for medical conditions of eligible employees and their dependents, COBRA, and Utah State Continuation enrollees. This rate up can range from a 1.000 to 1.8571.
- All eligible employees, Utah State Continuation or COBRA enrollees applying for Medical coverage are required to complete the individual health questionnaire section of the Employee enrollment form for groups of 2-50. Failure to do so may result in a maximum 1.8571 RAF (risk adjustment factor) determination.
- Eligible employees must complete the waiver section of the employee application for either the employee and/or their dependents when declining coverage. The health questionnaire does not need to be completed for those individuals who are declining Medical or Life at the Guarantee Issue amount.
- If the employee is requesting coverage above the Guarantee Issue amount for life they will need to complete the individual health questionnaire.

NEWLY FORMED BUSINESS

Newly formed businesses may be considered at the discretion of the underwriter if the following are provided:

- 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 Tax Statement 3H. If not available advise when one will be field; and
- Have payroll records been established? If not when?
- The most recent two consecutive weeks worth of payroll records which include number of hours worked, taxes withheld, wages earned; or
- A letter from a 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.

Groups that are not subject to Guarantee Issue may be declined.

OPTION SALES ALONGSIDE OTHER CARRIERS

Medical

- Standard participation of 75% must be met in order for a group to qualify for coverage.

Dental

- Options sales alongside another Dental carrier are not allowed.
- All Dental plans must be sold on a full replacement basis only.

Life or Packaged Life & Disability

- Option sales alongside another Life or Packaged Life & Disability carrier are not allowed.
- All Life or Packaged Life & Disability plans must be sold on a full replacement basis only.

Disability

- Option sales alongside another Disability carrier are not allowed.
- All Disability plans must be sold on a full replacement basis only.

OUT-OF-AREA WITHIN UTAH

Medical

- Employees residing outside of a Utah Aetna Network Service Area must enroll in the Aetna Indemnity Plan.
- Aetna Indemnity plan is only available if the employee resides outside the Aetna PPO network service area.

Dental

- Employees residing outside of an Aetna Network Service Area.

Life or Packaged Life & Disability

- Not Applicable

Disability

- Not Applicable

OUT-OF-STATE EMPLOYEES

Medical

- Employees residing outside of Utah.
- Employers must have at least 51% of their employees residing in Utah to be considered Guarantee Issue.
- Out-of-State employees that live/work in an out-of-state network area will receive Utah rates and products (inclusive of any required extraterritorial benefits).
- Out-of-State employees that do not reside in an out-of-state network area will receive the Utah Standard Indemnity products (inclusive of any required extraterritorial benefits).
- Out-of-State employees who reside in an area with a PPO only network must enroll in the Utah PPO plan.
- Out-of-State employees who reside in an Indemnity only network must enroll in the Utah Indemnity plan.

Network Availability for Out-of-State

- No PPO is available in the following states: AL, ID, MN, MT, ND, NM, RI, WI, and WY.
- No Indemnity or PPO products are available in HI or VT.

Dental

- Out-of-State employees may only be offered one of the available 6 Out-of-State Dental plans.
- Maximum Out-of-State employee percentage (and/or number of employees) will agree with the Medical guidelines for each state.
- Orthodontic coverage is included for groups of 10 or more eligible employees.
- Orthodontic coverage is only available for dependent children.

Life or Packaged Life & Disability

- Out-of-State employees are eligible for the Basic Term Life depending on the option selected by the Employer.

Disability

- Out-of-State employees are eligible for the Disability plan dependent on the option selected by the Employer.

PACKAGED LIFE & DISABILITY

- Please see benefits in the Life – Basic Term section.
- Ineligible industries for Packaged Life & Disability

SIC Range	SIC Description
1000-1499	Mining
2892-2899	Explosives, Bombs & Pyrotechnics
3291-3292	Asbestos Products
3310-3329	Primary Metal Industries
3480-3489	Fire Arms/Ammunitions
5921	Liquor Stores
6211	Security Brokers
6531	Real Estate – Agents
7381	Service – Detective
7500-7599	Auto Repair & Service
7800-7999	Motion Picture, Amusement, Recreation
8010-8043	Medical Doctors/Clinics
8600-8699	Membership Associations
8800-8899	Service – Private Household
9999	Non Classified Establishment

PARTICIPATION

Medical

- **For Non Contributory plans,** 100% participation is required. All employees, excluding those with coverage through another employer's plan, must enroll.
- **Employers with 2-9 eligible employees:** 100% of eligible, excluding those with coverage through another employer's plan, must participate.
- **Employers with 10-50 eligible employees:** 75% of eligible (rounded), excluding those with coverage through another employer's plan, must participate.
- **Pick-A-Plan 3:** 75% participation with a minimum of 5 enrolled, excluding those with coverage through another employer's plan, must participate.
- Employees waiving due to individual, governmental (Medicare and Champus) or spousal coverage may be required to provide proof of their other coverage by providing a copy of their insurance card if the group does not appear to be meeting the standard participation guidelines (75%).
- Individual and Medicaid coverage is not considered a valid waiver and will count towards the participation. Copies of ID cards may be requested for confirmation.
- All employees waiving coverage must complete Section B and the waiver section of the application. **If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement.**
- Dependent participation is not required.
- Coverage may be denied based upon inadequate participation.

Dental

- **Employers paying 100% of the employee premium:** 100% participation is required. All employees, excluding those with other qualifying existing Dental coverage, must enroll.
- **Groups with 2-3 eligible employees:** 100% participation is required, excluding those with other qualifying existing Dental coverage.
- **Groups with 4-50 eligible employees:** 75% participation is required, excluding those with other qualifying Dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.
- Coverage may be denied based upon inadequate participation.

Voluntary Dental

- Not available for groups with less than 3 eligible employees.
- At least 25% of the employees must participate, excluding employees with other qualifying coverage. Enrollees excluding those with other qualifying existing Dental coverage or a minimum of 3 enrollees whichever is greater is required.

Life or Packaged Life & Disability

- **For Non Contributory plans,** 100% participation is required.
- **Groups with less than 10 eligible employees,** 100% participation is required.
- **Groups with 10 – 50 eligible employees,** 75% participation is required if the plans are at least partially contributory.
- Coverage may be denied based upon inadequate participation.

Disability

- **For Non Contributory plans,** 100% participation is required.
- **Groups with less than 10 eligible employees,** 100% participation is required.
- **Groups with 10-50 eligible employees,** 75% participation is required if the plans are at least partially contributory.
- Coverage may be denied based upon inadequate participation.

PICK-A-PLAN 3

- Pick-a-Plan 3 allows employers to offer up to three Aetna plans to their employees with standard participation and contribution guidelines.
- Employees who choose to enroll in the richer plan are responsible for the difference.
- The group must have 5 or more enrolled employees in order to offer Pick-a-Plan 3.
- One person must enroll in each plan and remain enrolled for the plans to remain active at renewal.

1099 Employees

- Allowed (See 1099 Employee Section)

PLAN CHANGE ANCILLARY ADDITIONS (LIFE OR DENTAL)

- Employers may request Plan Changes up to the renewal date for changes that are to be effective on the renewal date.
- Employers must request Plan Changes off of the renewal date at least 2 weeks prior to the desired effective date.
- The future renewal date of the ancillary products will be the same as the medical plan renewal date.

PLAN CHANGES — EMPLOYEES

- Employees are not eligible to change plans until the group's open enrollment period which is upon their annual renewal (except for qualified Special Enrollment events).

PLAN CHANGES — EMPLOYER

- After the first 30 days of enrollment, Employers may request a change in medical benefits 6 months after the original effective date.
- Upgrades are only allowed once in a twelve month rolling period and are subject to medical underwriting.
- Upgrades may be declined based upon underwriting review.
- Downgrades are allowed once in a twelve month rolling period and are subject to medical underwriting.
- The requests for changes must be submitted to Aetna Small Group Underwriting 30 days prior to the requested effective date.
- Late requests will be moved to the next applicable effective date pending underwriting approval.

PRODUCT AVAILABILITY

Medical

- Single or Dual Choice
  - –All groups with less than 5 eligible employees enrolling may choose either Single or Dual choice medical selections.
  - –Employer may offer any of the 18 plans to their employees.
- Pick-a-Plan 3: Allowed (See Pick-a-Plan 3 section)
- 1099 Employees: Allowed (See 1099 Employee Section)
- If the Basic PPO $1,500 or the Limited Benefit 50/50 plan are paired with any plan in the Pick-A-Plan 3, the group will be tabular rated, regardless of size. No exceptions allowed.

Dental

- **Employers with 3 or more eligible,** Dental may be sold on a standalone basis or along with the Medical on a bundled or unbundled basis.
- **Employers with less than 3 eligible employees or 2 enrolled:**
  - –Dental must be sold with Medical and can not be sold on a Standalone basis.
  - –Voluntary Dental products are not available for groups with less than 3 eligible employees.

PRODUCT SPECIFICATIONS

- If the Employer selects both Medical and Dental coverage's, it must be offered to all employees.
  - Eligible employees do not have to enroll in both plans. Employees may enroll in Dental and not Medical and vice-versa.
- Orthodontic coverage is included for groups with 10 or more eligible employees and is available for dependent children only.
- Pick-a-Plan 3: Not Available
- 1099 Employees: Not Allowed

Life or Packaged Life & Disability

- **Employers with 2 – 9 eligible employees,** Life or Packaged Life & Disability must be sold with medical and cannot be sold on a Standalone basis.
- **Employers with 10 to 25 eligible employees,** Life or Packaged Life & Disability may be sold when packaged with medical, dental or on a Standalone basis.
- **Employers with 26 – 50 eligible employees,** Life or Packaged Life & Disability is available either packaged with Medical or Dental or on a Standalone basis.
- Employees may elect Life coverage even if they do not elect Medical coverage or vice versa.
- **Employers with less than 10 eligible employees,** certain plan differences apply.
- Pick-a-Plan 3: Not Available
- 1099 Employees: Not Allowed

Disability

- **Employers with 2 – 9 eligible employees,** Disability must be sold with medical and cannot be sold on a Standalone basis.
- **Employers with 10 - 25 eligible employees,** Disability may be sold when packaged with Medical, Dental or on a Standalone basis.
- **Employers with 26 – 50 eligible employees,** Disability is available either packaged with Medical or on a Standalone basis.
- Employees may elect Life coverage even if they do not elect Medical coverage or vice versa.
- **Employers with less than 10 eligible employees,** certain plan differences apply.
- Pick-a-Plan 3: Not Available
- 1099 Employees: Not Allowed

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).
- Disability rates are guaranteed for 2 years (24 months).

RENEWAL BENEFIT CHANGES

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

SIGNATURE DATES

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

SPIN OFF GROUPS (CURRENT AETNA CUSTOMERS LEAVING AN AETNA GROUP ONLY)

- Aetna will consider the group guarantee issue with the following:
  - A letter from the group or broker indicating the group is enrolling as a spin off. Letter needs to include the name of the group they are spinning off from.
  - Ownership documents showing that the spin off company is a newly formed separate entity.
  - A minimum of 2 weeks payroll. If the group that is spinning off has been in business longer than 2 weeks, payroll will be required for the amount of time in business up to a maximum of 6 consecutive weeks.
- Medical claims will be requested and used along with the health information included on the employee application in order to provide an accurate RAF.

TAX DOCUMENTATION

- When a company is Doing Business as (DBA), a copy of the Filed Assumed Name Certificate or Business Name Registration (Fictitious Name or DBA) should be provided.
- Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status.
- The employer must submit a copy of the most recently filed 3H (Quarterly Wage Tax Statement) which must contain the names, salaries, and withholdings for all employees of the employer group along with a signature of the company representative.
- In the event that a 3H is not available because the employer was not in business during the preceding calendar quarter or the employer has outsourced payroll functions, a copy of the payroll documentation from the company or the company's payroll administrator or employee leasing company; organization documents, or other reasonable proof must be provided.
- When a 3H or payroll records are submitted:
  - Employees who have terminated, work part-time or are newly-hired should be noted accordingly on the document.
  - Any handwritten comments added to the document must be signed and dated by the employer.
  - For newly-hired employees not listed on the document the employer must provide at least 2 weeks of payroll (which includes hours worked, wages earned, and taxes withheld) or a letter from the employer verifying the names of all employees and numbers of hours worked.
  - Churches must provide Form 941 including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.
  - Other documentation may be requested by Underwriting upon receipt and review of sold case documents for final underwriting approval and installation.
  - Altered legal documentation will not be accepted.
  - Proprietors, Partners or Officers of the business who do not appear on the 3H or payroll must submit one of the following identified documents along with a completed and signed Proof of Eligibility Form

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

1099 EMPLOYEES

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

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

TOWNSHIPS AND MUNICIPALITIES

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

Underwriting requirements

- QWTS
- W2 – Elected or Appointed officials and Trustees "may" be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS rather they may be paid via W2. 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.

LIMITATIONS AND EXCLUSIONS

These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

MEDICAL

Services and supplies that are generally not covered include, but are not limited to:

- All medical or hospital services not specifically covered in, 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
- Medical expenses for a pre-existing condition are not covered (full postponement rule) for the first 365 days after the insured's enrollment date. Lookback period for determining a pre-existing condition (conditions for which diagnosis, care or treatment was recommended or received) is 180 days prior to the enrollment date. The pre-existing condition limitation period will be reduced by the number of days of prior creditable coverage the member has as of the enrollment date.
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special duty nursing
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

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

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

AD&D ULTRA

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

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

DISABILITY

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from you committing, or attempting to commit a criminal act
- Is due to war or any act of war (declared or not declared)
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Is not a non-occupational disease (STD only)
- Is not a non-occupational injury (STD only)
- Results from driving an automobile while intoxicated, ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred)

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense, the person will not be deemed to be disabled and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three (3) months prior to coverage effective date.

*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.

Register for Producer World,® our secure producer site, at ***www.aetna.com/producers.***

For questions about Producer World, call 1-877-249-2472, or e-mail ***ASGBLUT@aetna.com.***

GROUP ENROLLMENT CHECKLIST

For presale quote requests:

E-mail
ASGQuoteUT@aetna.com

OR

Fax to 1-866-748-9094

Send paperwork to:

Aetna Small Group Underwriting
PO Box 24005
Fresno, CA 93779-4005

OR

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

STEP 1

Complete/review Employer Application

- ❒ Complete all pages of application in ink.
- ❒ Employer signature must be an owner or corporate officer.
- ❒ No altered applications. (New application required.)
- ❒ Applications cannot be more than 60 days old.
- ❒ Plan options indicated.

STEP 2

Complete/review Employee Enrollment/ Change Form

- ❒ Completely filled out by each employee in ink.
- ❒ Alterations are allowed as long as all changes are initialed and dated by the employee.
- ❒ Waivers/Declinations of coverage section completed.

- Required for employees — indicate other group coverage. Copies of ID cards are needed only for the percentage needed to meet participation.
- Required for dependents — indicate other group coverage — list dependent(s) name(s) and reason for declining.

STEP 3

Provide the following information

- ❒ **All Business Entities**
  A copy of the firm's most recent Quarterly Wage and Tax Statement
- ❒ **Sole Proprietor**
  Schedule C {IRS Form 1040 C, 1040 F, 1040 SE or 1040 ES (estimated tax)}
- ❒ **Partner**
  Latest filed Schedule K-1 {IRS Form 1065 Schedule K-1, 1040 SE, 1040 ES (estimated tax)}
- ❒ **Corporate Officer**
  IRS Forms 1120, 1120 A or 1120 W (C-Corp & Personal Service Corp)
  IRS Form 1120 S Schedule K-1 or 1040 ES (estimated tax) (S-Corp)
  IRS Form 8832 (Entity Classification; for LLCs treated as a corporation)
- ❒ **Limited Liability Company (LLC) Member**
  Articles of Organization along with the Operating Agreement

STEP 4

Complete/review Initial Premium Check

- ❒ A premium check for 100% of the first month's Medical, Dental and Life premiums payable to "Aetna Health Inc." (A company check is required and Aetna's receipt of the check does not guarantee acceptance of the group.)

STEP 5

Provide documentation of previous coverage with last premium statement

- ❒ 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 tax and wage statement.

STEP 6

Complete/review Producer and General Agent information

- ❒ Complete, sign and date the Agent Certification section of the Employer Application.
- ❒ Review Steps 1 through 5 for completion prior to submission.
- ❒ Verify underwriting guidelines were reviewed and understood.
- ❒ Submit a copy of the Aetna Quote package.
- ❒ Complete and review Aetna Agent Agreement, if applicable.

Effective dates may be the 1st or the 15th of the month only. Applications must be received in Aetna Underwriting by the requested effective date.

AETNA AVENUE℠

Your Destination for Small Business Solutions℠

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health 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**.

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