

AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions®

CASCADE EMPLOYERS HEALTH INSURANCE TRUST (CEHIT) PLAN GUIDE



Washington

PLANS EFFECTIVE OCTOBER 1, 2010

For CEHIT member business with 5 – 50 eligible employees

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Health care is a journey ...

AETNA AVENUE IS THE WAY

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

Small businesses need 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 — medical, dental, and life plans.

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

Health insurance, dental benefits and insurance, and life insurance plans/policies are offered, underwritten or administered 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 plans
- Saver plans
- Traditional plans

Dental and life plans — providing valuable protection

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice
- Preventive
- Basic term life insurance

EASE

Allowing you to focus on your business

Employers want to focus on their customers and growing their business — not the 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 vision, dental and other health care
- Personal Health Record providing a complete picture of health
- Simple Steps To A Healthier Life®, an online health and wellness program
- Temporary ID cards available for members to print as needed

REPUTATION

In business it's everything

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

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

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that small business owners' insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 5 – 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 ...
• PPO Value
• PPO Saver

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 ...
• PPO HSA HDHP

Traditional benefits plans
Limiting the financial impact on employees

You might be a ...
Traditionalist

These plans fit ...
• Traditional PPO plans

HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Consumer-directed health plans
PPO Value plans
PPO Saver plans
Traditional plans

YOUNG SINGLES

Includes singles and couples without children

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

ESTABLISHED FAMILIES

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

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

YOUNG FAMILIES

Traditional plans
PPO Value plans

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

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

EMPTY NESTERS

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

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

ESTABLISHED FAMILIES

Consumer-directed health plans
PPO Value plans
PPO Saver plans
Traditional plans

EMPTY NESTERS

Consumer-directed health plans
Traditional plans

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MEDICAL OVERVIEW

WASHINGTON NETWORK*

Washington has more than 27,300 providers and 93 hospitals in every county.*

- Adams
- Asotin
- Benton
- Chelan
- Clallam
- Clark+
- Columbia
- Cowlitz
- Douglas
- Ferry
- Franklin
- Garfield
- Grant
- Grays Harbor
- Island
- Jefferson
- King
- Kitsap
- Kittitas
- Klickitat+
- Lewis
- Lincoln
- Mason
- Okanogan
- Pacific
- Pend Oreille
- Pierce
- San Juan
- Skagit
- Skamania+
- Snohomish
- Spokane
- Stevens
- Thurston
- Wahkiakum+
- Walla Walla
- Whatcom
- Whitman
- Yakima

WHAT IS PICK-A-PLAN 3?

*Pick-A-Plan 3*** is Aetna’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 can offer any 3 of the 14 available plan designs.**

Flexibility and affordability

Employers 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 14 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 chooses up to 3 plans to offer on the Employer Application
2. The employer chooses how much to contribute
3. Each employee chooses the plan that’s right for him or her

	Pick-A-Plan 3
Target audience	Every small business with 5+ enrolled employees
Plan choices	Up to 3 of the 14 available plans
Minimum participation	
5 or more enrolled employees	Triple option available
Employer contribution	50% of the employee rate that the employee chooses or \$100 defined contribution or the actual cost of the plans, whichever is less
Rating options	5 – 9 employees — tabular 10 – 50 employees — composite

*Network subject to change.

**Available with 5 or more enrolled employees.

***One person must enroll and remain enrolled in each plan for it to be active.

+Counties maintained through Oregon Network.

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.

AETNA HIGH DEDUCTIBLE PPO PLAN (HSA COMPATIBLE)

The Aetna PPO insurance options that are compatible with a health savings account (HSA) provide employers and their qualified employees with an affordable tax-advantaged solution that allows them to better manage their qualified medical and dental expenses.

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

AETNA INDEMNITY PLAN

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

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

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MEDICAL OVERVIEW

CONSUMER-DIRECTED HEALTH PLANS

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

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

When a HDHP is paired with an HSA, employers and their qualified employees have a tax-advantaged solution that allows them to manage their qualified medical and dental expenses. HRAs enable employers to use tax-deductible dollars to reimburse employees for predetermined types of medical expenses. While FSAs allow individuals to use pretax salary dollars to establish an account to help pay for health care and dependent care expenses.

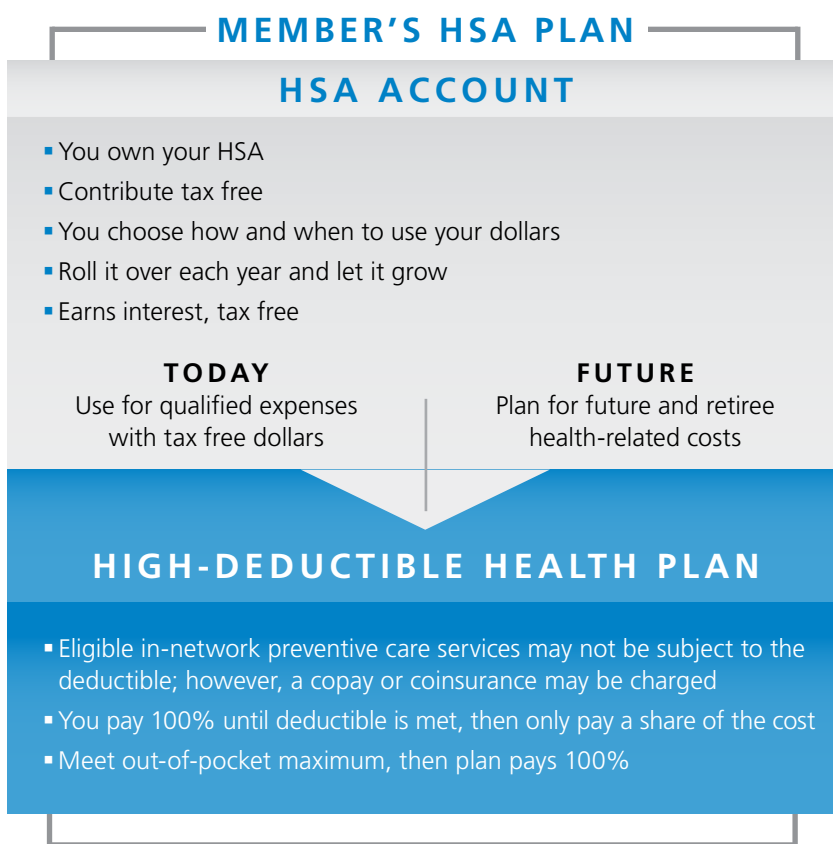
AETNA OFFERS TWO WAYS TO MEET YOUR FAMILY DEDUCTIBLE FOR HIGH-DEDUCTIBLE PLANS

Embedded Aggregate	True Integrated Family Aggregate
Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.	The entire family deductible must be met before coinsurance applies for any individual or family member.

A WAY TO MANAGE HEALTH AND HEALTH CARE EXPENSES

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

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	\$50 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.

COBRA ADMINISTRATION

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

SECTION 125 CAFETERIA PLANS AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

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

Premium Only Plans (POP)

Employees can pay for their portion of the group health insurance expenses on a pretax basis. First-year POP fees waived with the purchase of \$15,000 in life insurance per employee.

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.

*First year POP fees waived with the purchase of \$15,000 in life insurance per employee.

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

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

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

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

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

TRADITIONAL PLANS				
Aetna Plan Options	PPO \$250 90/60 \$20		PPO \$250 80/60 \$25	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	90%	60%	80%	60%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$250 per member	\$500 per member	\$250 per member	\$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,000 per member	\$4,000 per member	\$2,500 per member	\$5,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-Member Maximum		Three-Member Maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	\$20 copay; ded waived	60%	\$25 copay; ded waived	60%
Specialist Office Visit	\$20 copay; ded waived	60%	\$25 copay; ded waived	60%
Outpatient Lab & X-ray	\$20 copay; ded waived	60%	\$25 copay; ded waived	60%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	90%	60%	80%	60%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$20 copay; ded waived	60%	\$25 copay; ded waived	60%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$20 copay; ded waived	60%	\$25 copay; ded waived	60%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	90%	60%	80%	60%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	90%	60%	80%	60%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	60%	\$0 copay; ded waived	60%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	60%	\$0 copay; ded waived	60%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	60%	\$0 copay; ded waived	60%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	60%	\$0 copay; ded waived	60%
Inpatient Hospital	90%	60%	80%	60%
Outpatient Surgery	90%	60%	80%	60%
Transplants (Limited to \$350,000 per member per lifetime)	90%	Not Covered	80%	Not Covered
Emergency Services	90%	Paid as in-network	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$10 / \$30 / \$60	Not Covered	\$10 / \$30 / \$60	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

See page 17 for footnotes.

TRADITIONAL PLANS				
Aetna Plan Options	PPO \$500 80/50 \$25		PPO \$750 80/50 \$25	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$500 per member	\$1,000 per member	\$750 per member	\$1,500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$3,000 per member	\$6,000 per member	\$3,500 per member	\$7,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-Member Maximum		Three-Member Maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Specialist Office Visit	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Outpatient Lab & X-ray	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$25 copay; ded waived	50%	\$25 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants (Limited to \$350,000 per member per lifetime)	80%	Not Covered	80%	Not Covered
Emergency Services	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$10 / \$30 / \$60	Not Covered	\$10 / \$30 / \$60	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

See page 17 for footnotes.

TRADITIONAL PLANS				
Aetna Plan Options	PPO \$1,000 80/50 \$30		PPO \$1,500 80/50 \$30	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,000 per member	\$2,000 per member	\$1,500 per member	\$3,000 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$3,500 per member	\$7,000 per member	\$4,000 per member	\$8,000 per member
Deductible and Coinsurance Maximum Accumulation	Three-Member Maximum		Three-Member Maximum	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	\$30 copay; ded waived	50%	\$30 copay; ded waived	50%
Specialist Office Visit	\$30 copay; ded waived	50%	\$30 copay; ded waived	50%
Outpatient Lab & X-ray	\$30 copay; ded waived	50%	\$30 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$30 copay; ded waived	50%	\$30 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$30 copay; ded waived	50%	\$30 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants (Limited to \$350,000 per member per lifetime)	80%	Not Covered	80%	Not Covered
Emergency Services	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$10 / \$30 / \$60	Not Covered	\$10 / \$30 / \$60	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

See page 17 for footnotes.

VALUE PLANS				
Aetna Plan Options	PPO VALUE \$750 80/50 \$30		PPO VALUE \$1,000 80/50 \$35	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$750 per member	\$1,500 per member	\$1,000 per member	\$2,000 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,000 per member	\$8,000 per member	\$4,000 per member	\$8,000 per member
Deductible and Coinsurance Maximum Accumulation	Per Member		Per Member	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	\$30 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%	\$35 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%
Specialist Office Visit	\$30 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%	\$35 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%
Outpatient Lab & X-ray	\$30 copay; ded waived	50%	\$35 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$30 copay; ded waived	50%	\$35 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$30 copay; ded waived	50%	\$35 copay; ded waived	50%
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Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Inpatient Hospital	80%	50%	80%	50%
Outpatient Surgery	80%	50%	80%	50%
Transplants (Limited to \$350,000 per member per lifetime)	80%	Not Covered	80%	Not Covered
Emergency Services	80%	Paid as in-network	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$20 / \$40 / \$70	Not Covered	\$20 / \$40 / \$70	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

See page 17 for footnotes.

VALUE PLANS		
Aetna Plan Options	PPO VALUE \$1,500 80/50 \$40	
PCP/Referrals Required	No	N/A
Member Benefits	In-Network	Out-of-Network ¹
Plan Coinsurance	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,500 per member	\$3,000 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$4,500 per member	\$9,000 per member
Deductible and Coinsurance Maximum Accumulation	Per Member	
Lifetime Maximum Benefit	Unlimited	
Primary Physician	\$40 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%
Specialist Office Visit	\$40 copay; ded waived ⁴ (office visit limit applies; see footnote for details)	50%
Outpatient Lab & X-ray	\$40 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$40 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$40 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%
Inpatient Hospital	80%	50%
Outpatient Surgery	80%	50%
Transplants (Limited to \$350,000 per member per lifetime)	80%	Not Covered
Emergency Services	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$20 / \$40 / \$70	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included	

See page 17 for footnotes.

SAVER PLANS				
Aetna Plan Options	PPO SAVER \$2,500 70/50		PPO SAVER \$5,000 80/50	
PCP/Referrals Required	No	N/A	No	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	70%	50%	80%	50%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$2,500 per member	\$5,000 per member	\$5,000 per member	\$10,000 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$5,000 per member	Unlimited	\$5,000 per member	Unlimited
Deductible and Coinsurance Maximum Accumulation	Per Member		Per Member	
Lifetime Maximum Benefit	Unlimited		Unlimited	
Primary Physician	\$15 copay; ded waived	50%	\$15 copay; ded waived	50%
Specialist Office Visit	70%	50%	80%	50%
Outpatient Lab & X-ray	\$15 copay; ded waived	50%	\$15 copay; ded waived	50%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	70%	50%	80%	50%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$15 copay; ded waived	50%	\$15 copay; ded waived	50%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	\$15 copay; ded waived	50%	\$15 copay; ded waived	50%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	70%	50%	80%	50%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	70%	50%	80%	50%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%
Inpatient Hospital	70%	50%	80%	50%
Outpatient Surgery	70%	50%	80%	50%
Transplants (Limited to \$350,000 per member per lifetime)	70%	Not Covered	80%	Not Covered
Emergency Services	70%	Paid as in-network	80%	Paid as in-network
Urgent Care	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived	\$50 copay; ded waived
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$20 / \$40 / \$70	Not Covered	\$20 / \$40 / \$70	Not Covered
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included	

See page 17 for footnotes.

CONSUMER-DIRECTED HEALTH PLANS (CDHP)					
Aetna Plan Options	PPO HSA HDHP \$1,500 80/50		PPO HSA HDHP \$2,500 80/50		Indemnity \$500 80%
PCP/Referrals Required	No	N/A	No	N/A	N/A
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	Out-of-Network ⁷
Plan Coinsurance	80%	50%	80%	50%	80%
Calendar Year Deductible (In-Network and Out-of-Network accumulate separately)	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	\$500 per member
Calendar Year Coinsurance Maximum (Deductible and certain payments do not apply)	\$2,000 Individual \$4,000 Family	\$3,000 Individual \$6,000 Family	\$3,000 Individual \$6,000 Family	\$5,000 Individual \$10,000 Family	\$2,500 per member
Deductible and Coinsurance Maximum Accumulation	True Integrated Family Aggregate ⁶		Embedded Aggregate ⁵		Three-Member Maximum
Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited
Primary Physician	80%	50%	80%	50%	80%
Specialist Office Visit	80%	50%	80%	50%	80%
Outpatient Lab & X-ray	80%	50%	80%	50%	80%
Outpatient Complex Imaging (CAT, MRI, MRA/MRS and PET Scan; precertification required)	80%	50%	80%	50%	80%
Chiropractic Services (Limited to 12 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%	80%
Acupuncture Services (Limited to 12 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%	80%
Outpatient Physical, Occupational & Massage Therapy (Limited to 30 visits per calendar year; IN and OON combined)	80%	50%	80%	50%	80%
Speech Therapy (Limited to 20 visits per member per calendar year; IN and OON combined)	80%	50%	80%	50%	80%
Physical Exams – Adults (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%	\$0 copay; ded waived
Well-Child Exams (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%	\$0 copay; ded waived
Routine GYN (Frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%	\$0 copay; ded waived
Mammography (Age and frequency schedules apply)	\$0 copay; ded waived	50%	\$0 copay; ded waived	50%	\$0 copay; ded waived
Inpatient Hospital	80%	50%	80%	50%	80%
Outpatient Surgery	80%	50%	80%	50%	80%
Transplants (Limited to \$350,000 per member per lifetime)	80%	Not Covered	80%	Not Covered	80%
Emergency Services	80%	Paid as in-network	80%	Paid as in-network	80%
Urgent Care	80%	80%	80%	80%	80%
Prescription Drugs ² Retail: up to a 30-day supply Mail Order: Up to a 90-day supply; two-times retail copay	\$20 / \$40 / \$70 after integrated Medical / Rx deductible	Not Covered	\$20 / \$40 / \$70 after integrated Medical / Rx deductible	Not Covered	\$10 / \$30 / \$60
90-Day Rx Transition of Coverage (TOC) for Precertification ³	Included		Included		Included

See page 17 for footnotes.

PLAN VALUE	\$	\$\$	\$\$\$	\$\$\$
PPO Saver \$5,000 80/50				
PPO HSA HDHP \$2,500 80/50				
PPO Saver \$2,500 70/50				
PPO HSA HDHP \$1,500 80/50				
PPO Value \$1,500 80/50				
PPO Value \$1,000 80/50				
PPO Value \$750 80/50				
PPO \$1,500 80/50				
PPO \$1,000 80/50				
PPO \$750 80/50				
PPO \$500 80/50				
PPO \$250 80/60				
PPO \$250 90/60				
Indemnity \$500 80%				

FOOTNOTES

The dollar amount indicates what the member is required to pay and percentage coinsurance amounts indicate what Aetna is required to pay. Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify for certain services such as outpatient complex imaging and non-emergency hospital care. All services are subject to deductible, unless noted otherwise.

Amounts over allowable charges, failure to precertify penalty, copay, payments for emergency/urgent care services, Rx (including self-injectables) and DME do not apply towards the PPO Coinsurance Maximums and continue to be payable after the maximum is reached. Note: On HSA HDHP plans only amounts over allowable charges and failure to precertify penalty do not apply toward the PPO Out-of-Pocket maximum and continue to be payable after the maximum is reached.

For a summary list of Limitations and Exclusions, refer to pages 40-41.

¹Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from an in-network provider. These charges are referred to in your plan documents as "recognized" charges.

²The three Rx Tiers are Tier 1: Generic Formulary, Tier 2: Brand Formulary, Tier 3: Brand Non-Formulary

³Transition of Coverage (TOC) applies to precertification and step therapy for prescription drugs. It helps members of newly enrolled groups to transition to the Aetna drug formulary by providing a 90 calendar day opportunity, beginning on the group's initial effective date, during which time precertification and step therapy will not apply to certain drugs as listed in the formulary guide. Once the 90 calendar days has expired, precertification and step therapy will apply to all drugs requiring precertification and step therapy as listed in the formulary guide. Members who have claims paid for a drug requiring precertification or step therapy during the TOC period, may continue to receive this drug after the 90 calendar days and will not be required to obtain a precertification or step therapy approval for a medical exception to this drug.

⁴Four-visit limit applies to all types of office visits, excluding preventive care, acupuncture, chiropractic, outpatient mental health and outpatient substance abuse services. Any lab or X-ray provided in the physician's office and billed with the office visit is included. Once the four-visit limit has been reached, all other office visits will be covered at coinsurance after deductible.

⁵Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible.

⁶There is no individual deductible or coinsurance maximum to satisfy within the family deductible/coinsurance maximum. Once the family deductible/coinsurance maximum is met, all family members will be considered as having met their deductible/coinsurance maximum for the remainder of the calendar year.

⁷Payment for out-of-network care is determined based upon the lowest of the provider's usual for furnishing it or the charge determines to be appropriate, based on factors such as the cost of providing the same or similar or supply and then manner in which charges for the services or supply are made. These charges are referred to in you plan documents as "reasonable" or "recognized" charges.

Aetna Avenue

DENTAL OVERVIEW

AETNA DENTAL® PLANS

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

The Mouth MattersSM

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

The Dental Maintenance Organization (DMO®) plan

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

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

DMI may not be available in all states.

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

Freedom-of-Choice plan design option

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

*Dual Option** plan*

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

Voluntary Dental option

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

*Discounts for non-covered services may not be available.

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

SMALL GROUP STANDARD DENTAL PLANS				
Available With or Without an Aetna Medical Plan to Groups with 5 – 50 Eligible Employees	Option 1 Scheduled Plan	Option 2 Freedom-of-Choice — Monthly selection between the DMO and the PPO		Option 3-09 PPO \$1,000, 90th
	Per schedule	DMO Plan 100/90/60	PPO Max Plan 100/70/40	PPO Plan 100/80/50
Office Visit Copay	N/A	\$5	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$75; 3X Family Maximum	None	\$50; 3X Family Maximum	\$50; 3X Family Maximum
Annual Maximum Benefit	\$1,000	Unlimited	\$1,000	\$1,000
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	\$18	100%	100%	100%
Comprehensive oral exam	\$30	100%	100%	100%
Limited oral exam – Problem focused	\$27	100%	100%	100%
X-rays				
Bitewing – single film	\$9	100%	100%	100%
Complete series	\$55	100%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	\$39	100%	100%	100%
Child Cleaning	\$30	100%	100%	100%
Sealants – per tooth	\$24	100%	100%	100%
Fluoride application – with cleaning	\$39	100%	100%	100%
Space maintainers	\$81	100%	100%	100%
BASIC SERVICES				
Amalgam filling – 2 surfaces	\$39	90%	70%	80%
Resin filling – 2 surfaces, anterior	\$45	90%	70%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	\$26	90%	70%	80%
Extraction of impacted tooth – soft tissue	\$69	90%	70%	80%
*MAJOR SERVICES				
Complete upper denture	\$297	60%	40%	50%
Partial upper denture (resin base)	\$243	60%	40%	50%
Crown – Porcelain with noble metal ¹	\$243	60%	40%	50%
Pontic – Porcelain with noble metal ¹	\$230	60%	40%	50%
Inlay – Metallic (3 or more surfaces)	\$239	60%	40%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	\$89	60%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	\$189	90%	40%	50%
Molar root canal therapy	\$225	60%	40%	50%
Periodontic Services				
Scaling & root planing – per quadrant	\$53	90%	40%	50%
Osseous surgery – per quadrant	\$247	60%	40%	50%
*Orthodontic Services	Not covered	\$2,300 copay	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

SMALL GROUP STANDARD DENTAL PLANS				
Available With or Without an Aetna Medical Plan to Groups with 5 – 50 Eligible Employees	Option 4-09 PPO \$1,000, 90th Ortho	Option 5 PPO Max	Option 6-09 PPO \$1,500, 90th	Option 7-09 PPO \$1,500, 90th Ortho
	PPO Plan 100/80/50	PPO Max 1500 100/80/50	PPO Plan 100/80/50	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	\$1,500	\$1,500	\$1,500
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Limited oral exam – Problem focused	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 ¹	50%	50%	50%	50%
Pontic – Porcelain with noble metal ¹	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing – per quadrant	50%	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%	50%
*Orthodontic Services	50%	50%	Not covered	50%
Orthodontic Lifetime Maximum	\$1,000	\$1,000	Does not apply	\$1,000

SMALL GROUP STANDARD DENTAL PLANS		
Available With or Without an Aetna Medical Plan to Groups with 5 – 50 Eligible Employees	Option 8-09 PPO \$2,000, 90th	Option 9-09 PPO \$2,000, 90th Ortho
	PPO Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum
Annual Maximum Benefit	\$2,000	\$2,000
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Limited oral exam – Problem focused	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 metal¹	50%	50%
Pontic – Porcelain with noble metal¹	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	80%	80%
Molar root canal therapy	50%	50%
Periodontic Services		
Scaling & root planing – per quadrant	80%	80%
Osseous surgery – per quadrant	50%	50%
*Orthodontic Services	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	\$1,000

SMALL GROUP STANDARD DENTAL PLANS		
Available With or Without an Aetna Medical Plan to Groups with 5 – 50 Eligible Employees	Option 10-09 Indemnity R&C	Option 11 -09 DMO Access
	100/80/50	Plan 42
Office Visit Copay	N/A	\$10
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	None
Annual Maximum Benefit	\$1,000	Unlimited
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	No Charge
Comprehensive oral exam	100%	No Charge
Limited oral exam – Problem focused	100%	No Charge
X-rays		
Bitewing – single film	100%	No Charge
Complete series	100%	No Charge
PREVENTIVE SERVICES		
Adult Cleaning	100%	No Charge
Child Cleaning	100%	No Charge
Sealants – per tooth	100%	\$10
Fluoride application – with cleaning	100%	No Charge
Space maintainers	100%	\$100
BASIC SERVICES		
Amalgam filling – 2 surfaces	80%	\$32
Resin filling – 2 surfaces, anterior	80%	\$55
Oral Surgery		
Extraction – exposed root or erupted tooth	80%	\$30
Extraction of impacted tooth – soft tissue	80%	\$80
*MAJOR SERVICES		
Complete upper denture	50%	\$500
Partial upper denture (resin base)	50%	\$513
Crown – Porcelain with noble metal ¹	50%	\$488
Pontic – Porcelain with noble metal ¹	50%	\$488
Inlay – Metallic (3 or more surfaces)	50%	\$463
Oral Surgery		
Removal of impacted tooth – partially bony	50%	\$175**
Endodontic Services		
Bicuspid root canal therapy	50%	\$195
Molar root canal therapy	50%	\$435**
Periodontic Services		
Scaling & root planing – per quadrant	50%	\$65
Osseous surgery – per quadrant	50%	\$445**
*Orthodontic Services	Not covered	\$2,300 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply

SMALL GROUP VOLUNTARY DENTAL PLANS			
Available With or Without an Aetna Medical Plan to Groups with 5 – 50 Eligible Employees	Voluntary Option 1-09 PPO \$1,000	Voluntary Option 2-09 PPO \$1,000, 90th	Voluntary Option 3-09 PPO \$1,500
	PPO 1000 Plan 100/80/50	PPO 1000 Plan 100/80/50	PPO 1500 Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$75; 3X Family Maximum	\$75; 3X Family Maximum	\$75; 3X Family Maximum
Annual Maximum Benefit	\$1,000	\$1,000	\$1,500
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Problem-focused oral exam	100%	100%	100%
X-rays			
Bitewing – single film	100%	100%	100%
Complete series	100%	100%	100%
PREVENTIVE SERVICES			
Adult Cleaning	100%	100%	100%
Child Cleaning	100%	100%	100%
Sealants – per tooth	100%	100%	100%
Fluoride application – child	100%	100%	100%
Space maintainers – fixed	100%	100%	100%
BASIC SERVICES			
Amalgam filling – 2 surfaces	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%
Oral Surgery			
Extraction -- exposed root or erupted tooth	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%
*MAJOR SERVICES			
Complete upper denture	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%
Crown – Porcelain with noble metal ³	50%	50%	50%
Pontic – Porcelain with noble metal ³	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	50%	50%	50%
Endodontic Services			
Bicuspid root canal therapy	50%	50%	50%
Molar root canal therapy	50%	50%	50%
Periodontic Services			
Scaling & root planing – per quadrant	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%
*Orthodontic Services	Not covered	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	Does not apply	\$1,000

FOOTNOTES

Standard Dental Footnotes

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 2 & 11.

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

Fixed dollar amounts on the DMO in Plan Options 2 & 11 including the Office Visit and Ortho copays are the member's responsibility.

¹There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in Plan Option 11.

Access to negotiated discounts: On the PPO plans in Plan Options 2-9, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2 & 11 and on the PPO in Plan Options 8 & 9.

Out-of-Network plan payments are limited by geographic area on the PPO in Plan Option 10 to the prevailing fee at the 80th and Plan Options 3, 4, 6, 7, 8 & 9 to the prevailing fees at the 90th percentile.

Plan Options 2 & 5: 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 to dependent children only.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears in the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 42.

Out-of-State members receive the Scheduled Plan Option 1.

Voluntary Dental Footnotes

¹Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.

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

Out-of-Network plan payments are limited by geographic area on the PPO in Voluntary Plan Options 1 & 3 to the prevailing fee at the 80th and Voluntary Plan Option 2 to the prevailing fees at the 90th percentile.

Orthodontic coverage is available to dependent children only.

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

Out-of-State members receive Scheduled Option 1, refer to the Standard plan list.

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 42.

Aetna Avenue

LIFE INSURANCE OVERVIEW

LIFE INSURANCE

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

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

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

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

Giving you (and your employees) what you want

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

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

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

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

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

Our fresh approach to life

With Aetna Life Essentials, your employees have access to programs during their active lives to help promote healthy, fulfilling lifestyles. In addition, Aetna Life Essentials provides for critical caring and support resources for often-overlooked needs during the end of one's life. 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 life insurance package and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. It includes extra, no-cost features, such as coverage for education or child-care expenses that make this protection even more valuable.

Benefits include:

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

TERM LIFE PLAN OPTIONS		
	5 – 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 5-50 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

Aetna Avenue

CEHIT UNDERWRITING GUIDELINES

WA CEHIT UNDERWRITING GUIDELINES	
	<p>This material is intended for brokers and agents and is for informational purposes only. It is not intended to be all inclusive. Other policies and guidelines may apply.</p> <p>Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of the Regional Underwriting Manager except where Head Underwriter approval is indicated. This information is the property of Aetna and its affiliates (Aetna), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing.</p>
Affiliated, Associated or Multiple Companies	<p>Employers who have more than one business with different Tax Identification Numbers (TINs) may be eligible to enroll as one group if the following are met:</p> <ul style="list-style-type: none"> ▪ One owner has controlling interest of all business to be included; or ▪ The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and ▪ All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only 2 of the 3 businesses to be enrolled, the group will be considered a carve out, will not be Guarantee Issue, and could be declined. ▪ The enrolling business (the group that is being used as the policy name) as well as the other businesses to be combined must have the minimum number of employees required by the state. ▪ There are 50 or fewer employees in the combined employer groups. ▪ A completed Common Ownership form is submitted. ▪ Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups. ▪ SIC code will be based upon the group with the majority of the enrollment. Other documentation to prove this may be requested. ▪ Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception. <p>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.</p>
Benefit Waiting Period	<ul style="list-style-type: none"> ▪ Benefit waiting periods must be consistently applied to all employees, including newly hired key employees. ▪ The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days. ▪ The eligibility date will be the first day of the policy month following the waiting period. ▪ Example: Group A — effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period. Group B — effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period. ▪ Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer. ▪ At initial submission of the group the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application and consistently applied to all employees. ▪ Changes to the benefit waiting period may be requested 6 months after the original effective date. ▪ Changes to the benefit waiting period can only occur one time in 12 months or on the group's anniversary date. ▪ No retroactive benefit waiting period changes will be allowed.

Carve Outs	<ul style="list-style-type: none"> ▪ The general types of carve out that could be considered by Aetna include Washington Branch Location and Management/ Non-Management, Salary/Hourly, Union vs. Non-Union. ▪ Aetna must enroll and maintain a minimum of eight (8) employees who reside within Aetna’s Washington 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.
Case Submission Dates	<ul style="list-style-type: none"> ▪ In order for Aetna to honor the requested effective date, all completed paperwork must be received by Total Benefits Solutions no later than the end of day, 10 business days prior to the requested effective date.
Census Data	<ul style="list-style-type: none"> ▪ Census data on all eligible, including COBRA/State Continuation eligible employees must include name, age or date of birth, date of hire, gender, dependent status, and residence zip code. ▪ Retirees are not eligible. ▪ COBRA/State enrollees should be included on the census and noted as COBRA/State Continuation.
Composite Rating	<p>Composite Rating for New Business</p> <ul style="list-style-type: none"> ▪ Employer may offer a maximum of three plans. ▪ At least one person must enroll in each plan for it to be offered to new hires. ▪ The composite rate for each plan will be determined based on the census quoted. ▪ Upon final enrollment, the composite rate for each plan will be processed based upon the final enrolled employees. <p>Composite Rating for Renewing Business</p> <ul style="list-style-type: none"> ▪ Renewal rates will be based on the enrolled employees in each plan at the time the renewal is processed. ▪ Only the plans available after the initial enrollment will be rated for the renewal. ▪ If you have had a census increase or decrease of less than 20% from your prior year’s census, your rating calculation will not change. Example: If you were composite rated last year with 10 employees, and now you have nine employees, you will still receive composite rating since your change in census is less than 20%. This policy serves to reduce the frequency of employee’s having to switch between tabular and composite rates from year to year.
Deductible Credit	<ul style="list-style-type: none"> ▪ Employees who are eligible and want to receive credit for deductible paid to prior Company should submit a copy of the Explanation of Benefits to Aetna. They may do this at initial small group submission or with their first claim.
Definition of Employer Eligibility	<ul style="list-style-type: none"> ▪ Employer means any sole proprietor, partnership, or corporation that satisfies and completes the Adoption Agreement for enrollment into the Cascade Employer’s Health Insurance Trust (CEHIT). ▪ Based upon the Trust Agreement, the employer must enroll and maintain enrollment at least five employees in order to qualify for coverage. If on, or after January 1, 2005, a participating employer has or had less than five employees, such employer shall continue to be eligible to renew its coverage. If a group falls below five employees, they will continue to be renewed. ▪ Employers must not be formed solely for the purpose of obtaining health coverage. ▪ Taft Hartley and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible for enrollment in CEHIT.
Dental	<p>Open enrollments are prohibited.</p> <p>Coverage Waiting Period</p> <ul style="list-style-type: none"> ▪ For Major and Orthodontic services, employees must be enrolled members of the plan for one year (not applicable to DMO). Waiting Period is waived separately for Major and Orthodontic for employees who were covered by the group’s immediately preceding dental plan. ▪ To waive the Waiting Period for Major Services, the group’s immediately preceding group plan must have covered Major Services. ▪ To waive the Waiting Period for Orthodontic services, the group’s immediately preceding group plan must have covered Orthodontic services. Example: Group had prior Major coverage but no Orthodontic coverage, however the new plan has both Major and Orthodontic coverage, the waiting Period is waived for Major services but not for the Orthodontic Services. <p>Product Packaging</p> <ul style="list-style-type: none"> ▪ DMO can be sold as standalone or packaged with any PPO Option as a Dual Option. ▪ PPO can be sold standalone or packaged with the DMO as a Dual Option. ▪ Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold. ▪ Voluntary Dental plans cannot be sold or packaged with any other plan as a Dual Option offering. <p>Reinstatement</p> <ul style="list-style-type: none"> ▪ For Voluntary Dental Plan Options: Members who were once enrolled then terminated their coverage by discontinuing their contributions may be 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.

WASHINGTON CEHIT PLAN GUIDE

Dependent Eligibility	<ul style="list-style-type: none"> ▪ Eligible dependents include an employee’s spouse. 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. ▪ Domestic partners are eligible. ▪ Grandchildren are eligible if court ordered. ▪ Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26. ▪ For dependent life, children are eligible from 14 days to up to their 19th birthday, or to up to their 23rd birthday, if in school. ▪ Dependents are not eligible for AD&D or Disability coverage. ▪ For Medical and Dental, dependents must enroll in the same benefits as the employee (participation is not required). ▪ Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan. See product-specific Life/AD&D and Disability guidelines under Product Specifications. ▪ Individuals cannot be covered as an employee and dependent under the same plan.
Effective Date	<ul style="list-style-type: none"> ▪ Effective date must be the 1st or the 15th of the month. ▪ 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 on the prior carrier, without regard to the grace period. For example, if the prior plan has a premium date of the 1st, the Aetna plan will be effective on the 1st and not the 15th.
Electronic Funds Transfer	<ul style="list-style-type: none"> ▪ Payment for the first month’s premium at new business can be processed via an Electronic Funds Transfer. ▪ Once the group is issued customers can pay their monthly premiums online or by calling an automated phone number, 1-866-350-7644, with no extra charge. This eliminates the need for checks, envelopes and postage while also supplying peace of mind that payments have been received
Employee Eligibility	<ul style="list-style-type: none"> ▪ An eligible employee is defined as an employee who works on a full-time basis with a normal work week of 20 or more hours. ▪ Eligible Employees includes self employed individuals, sole proprietors, partners of a partnership and may include an independent contractor (subject to Aetna Underwriting approval) if included as an employee under a health benefit plan of the employer, but not working less than 20 hours per week. ▪ Part-time employees, working less than 20 hours per week, seasonal and substitute employees are not eligible. ▪ 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. Subject to Aetna Underwriting approval. <p>Retirees</p> <ul style="list-style-type: none"> ▪ Retiree coverage is not available. <p>COBRA</p> <ul style="list-style-type: none"> ▪ COBRA/State Continuation eligible employees are required to be included on the census. ▪ COBRA/State Continuation qualifying reason, length, start and end date must be provided.
Employer Contribution	<p>Single Choice Medical</p> <ul style="list-style-type: none"> ▪ The employer must contribute at least 50% of the employee rate. ▪ Coverage may be denied based upon inadequate contributions. <p>Pick-A-Plan 3 (Medical)</p> <ul style="list-style-type: none"> ▪ 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 \$100 or the actual cost of the plan, whichever is less. ▪ Coverage may be denied based upon inadequate contributions. <p>Dental</p> <ul style="list-style-type: none"> ▪ The employer must contribute at least 50% of the employee-only cost or 25% of the total plan. ▪ Voluntary Dental plans: Employer contribution can be from zero to 49% of the cost of the employee only coverage ▪ Pick-A-Plan 3 is not available. ▪ Coverage may be denied based upon inadequate contributions. <p>Term Life</p> <ul style="list-style-type: none"> ▪ 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.

Employers leaving an Aetna PEO	<ul style="list-style-type: none"> ▪ Employers leaving a PEO that is not currently insured with Aetna will be required to complete the Aetna PEO form. Underwriting will determine eligibility based upon this completed form. ▪ Employers leaving a PEO that is currently insured with Aetna do not need to complete the Aetna PEO form. A statement signed by the employer will be sufficient. ▪ The PEO Form will only be requested from an Aetna PEO client when the employer is still receiving services from the Aetna PEO.
Employers Replacing Other Group Coverage	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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. <p>Example</p> <ul style="list-style-type: none"> – 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	<ul style="list-style-type: none"> ▪ The initial premium check should be in the amount of the first month's premium and drawn on a company check. ▪ Initial premium check should be made payable to Aetna. ▪ The initial premium check is not a binder check and does not bind Aetna to provide coverage. ▪ If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer. ▪ If the initial premium check is returned for non-sufficient funds, coverage will be terminated retroactive to the effective date.
Late Entrants	<ul style="list-style-type: none"> ▪ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. ▪ Applicants without a qualifying life event (i.e. marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below. ▪ Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added. <p>Medical</p> <ul style="list-style-type: none"> ▪ Late applicants without a qualifying event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll. <p>Dental</p> <ul style="list-style-type: none"> ▪ 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. <p>Life</p> <ul style="list-style-type: none"> ▪ 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.

<p>Life – Basic Term</p>	<p>Open Enrollments are prohibited. All classes must be clearly defined either on the employer application or on company letterhead.</p> <p>Job Classifications (Position) Schedules Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to three separate classes are allowed (with a minimum requirement of 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:</p> <table border="1"> <thead> <tr> <th>Position/Job Class</th> <th>Basic Term Life Amount</th> </tr> </thead> <tbody> <tr> <td>Executives</td> <td>\$50,000</td> </tr> <tr> <td>Managers, Supervisors</td> <td>\$20,000</td> </tr> <tr> <td>All Other Employees</td> <td>\$10,000</td> </tr> </tbody> </table> <p>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:</p> <table border="1"> <thead> <tr> <th>Case Size</th> <th>Basic Term Life Amount</th> </tr> </thead> <tbody> <tr> <td>2-9 Eligible lives</td> <td>\$20,000</td> </tr> <tr> <td>10-25 Eligible lives</td> <td>\$75,000</td> </tr> <tr> <td>25-50 Eligible lives</td> <td>\$100,000</td> </tr> </tbody> </table> <p>Evidence of Insurability (EOI) EOI is required when one or more of the following conditions exist:</p> <ol style="list-style-type: none"> 1) Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit. 2) New coverage is requested during the renewal period. 3) Coverage is requested outside of the employer’s renewal period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) <p>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.</p> <p>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.</p>	Position/Job Class	Basic Term Life Amount	Executives	\$50,000	Managers, Supervisors	\$20,000	All Other Employees	\$10,000	Case Size	Basic Term Life Amount	2-9 Eligible lives	\$20,000	10-25 Eligible lives	\$75,000	25-50 Eligible lives	\$100,000
Position/Job Class	Basic Term Life Amount																
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10-25 Eligible lives	\$75,000																
25-50 Eligible lives	\$100,000																
<p>Live/Work Guidelines</p>	<ul style="list-style-type: none"> ▪ Product availability for group benefit offerings are always determined by the zip code of the Employer. ▪ If the employee resides at a distance further than the 30 mile radius, exception requests should be directed to Underwriting for a feasibility determination. ▪ Employees who are enrolling using the Live/Work Guidelines should include their home address and zip code as well as the work site address and zip code. All correspondence will be mailed to the employee’s home address as listed on the application. ▪ Employees enrolled in dental who reside in a Non-DMO network code may enroll in an DMO product offered by their Employer if they live within a 30 miles radius of their work site that is within the DMO Service Area. 																

<p>Medical</p>	<ul style="list-style-type: none"> ▪ All eligible groups are required to complete the group health questionnaire for groups of 5-50. Failure to do so may result in a maximum 3.00 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. ▪ If the employee is requesting coverage above the Guarantee Issue amount for life they will need to complete the individual health questionnaire. ▪ Groups with 5 to 9 employees enrolled will be tabular rated. ▪ Groups with 10 to 50 employees enrolled will be composite rated. ▪ If you have had a census increase or decrease of less than 20% from your prior year's census, your rating calculation will not change. See composite rate section.
<p>Newly Formed Business (in operation less than 3 months)</p>	<p>Employers must provide the following documentation for consideration:</p> <ul style="list-style-type: none"> ▪ Employer Identification Number/Federal Tax I.D. Number; and ▪ Quarterly Wage and Tax Statement., If not available, when will one be filed; and ▪ At least 2 weeks worth of payroll (which includes hours worked and wages earned) or a letter from the employer listing the names of all employees and number of hours worked each week. ▪ The following documents are also required: <ul style="list-style-type: none"> – If Sole Proprietor: State Business License (not a professional license) – If Partnership or Limited Liability Partnership: Partnership Agreement. – If Limited Liability Corporation: Articles of Organization and the Operating Agreement. – If Corporation: Articles of Incorporation including signature pages of all officers.
<p>Option Sales Alongside other Carriers</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Standard participation of 75% must be met in order for a group to qualify for Aetna coverage. <p>Dental</p> <ul style="list-style-type: none"> ▪ Options sales alongside another Dental carrier are not allowed. ▪ All Dental plans must be sold on a full replacement basis only. <p>Life</p> <ul style="list-style-type: none"> ▪ Not applicable
<p>Out of Area Within Washington</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Employees residing outside of a Washington Aetna Network Service Area must enroll in the Aetna Indemnity Plan. ▪ Aetna Indemnity plan is only available if the employee resides outside of the Aetna PPO network service area. <p>Dental</p> <ul style="list-style-type: none"> ▪ Employees residing outside of an Aetna Network Service Area. ▪ Employees who reside within Washington but outside of a DMO service area may be offered an In-State PPO plan. <p>Life</p> <ul style="list-style-type: none"> ▪ Not Applicable
<p>Out-of-State Employees</p>	<ul style="list-style-type: none"> ▪ Employees residing outside the state of Washington and reside in an Aetna PPO Network Service Area will be enrolled into a Washington PPO plan. ▪ Employees residing outside the state of Washington and reside in an Aetna Indemnity Network Service Area will be enrolled into the Washington Indemnity plan. <p>Network Availability for Out-of-State</p> <ul style="list-style-type: none"> ▪ Louisiana employees need to be rated independently and installed on a separate Louisiana contract. ▪ No PPO is available in the following states: Alabama, Idaho, Minnesota, Montana, New Mexico, North Dakota, Rhode Island, Wisconsin, and Wyoming. ▪ No Indemnity or PPO products are available in Hawaii or Vermont. <p>Dental</p> <ul style="list-style-type: none"> ▪ Employees who live/work outside of Washington are eligible to be enrolled into the Washington Scheduled Indemnity plan. ▪ Maximum out-of-state employee percentage and/or number of employees will match the Medical guidelines.

WASHINGTON CEHIT PLAN GUIDE

<p>Participation</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ For Non Contributory plans, 100% participation is required. All employees, excluding those with coverage through another employer’s plan, must enroll. ▪ Employers with 5 to 50 eligible employees: 75% of eligible, excluding those with coverage through another employer’s plan, must participate. ▪ Employees waiving due to individual, governmental (Medicare, Champus, Medi-Cal) or spousal coverage may be required to provide proof of their other coverage by providing a copy of their insurance card if the group does not appear to be meeting the standard participation guidelines (75%). ▪ Individual coverage is not considered a valid waiver and will count towards the participation. Copies of ID cards may be requested for confirmation. ▪ All employees waiving coverage must complete Section B and the waiver section of the application. ▪ If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement. <p>Dental</p> <ul style="list-style-type: none"> ▪ 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 5-50 eligible employees: 75% participation is required, excluding those with other qualifying existing Dental coverage. <p>Voluntary and Standalone Voluntary Dental</p> <ul style="list-style-type: none"> ▪ Not available for groups with less than 5 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. <p>Life</p> <ul style="list-style-type: none"> ▪ 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. <p>All</p> <ul style="list-style-type: none"> ▪ Coverage can be denied based upon inadequate participation.
<p>PEO (Professional Employer Organization)</p>	<ul style="list-style-type: none"> ▪ As long as we can determine the group is a small employer via a QWTS or payroll records, the group may be considered. ▪ If the small employer may contract for services with a PEO as long as the PEO provides payroll specific to our small group and we can determine it is a small group even though the small group may be reported under the PEO Tax ID, the group may be considered subject to underwriting approval.
<p>Pick-A-Plan 3</p>	<ul style="list-style-type: none"> ▪ Employers may offer up to three Aetna plans to their employees. ▪ The group must have 5 or more enrolled employees. ▪ One person must be enrolled into each plan and remain in the plan for it to be offered at renewal. ▪ 5-9 enrolled will be tabular rated; 10-50 enrolled will be composite rated. <p>Mid-Policy Benefit Changes</p> <ul style="list-style-type: none"> ▪ Groups that have selected Pick-A-Plan 3 are not eligible for mid year policy changes. <p>Carve Outs</p> <ul style="list-style-type: none"> ▪ Allowed (See Carve Out section) <p>1099 Employees</p> <ul style="list-style-type: none"> ▪ Subject to Underwriting Approval (See 1099 Employee Section)
<p>Plan Change Ancillary Additions (Life or Dental)</p>	<ul style="list-style-type: none"> ▪ 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.
<p>Plan Changes — Employees</p>	<ul style="list-style-type: none"> ▪ 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).

<p>Plan Changes — Employer</p>	<ul style="list-style-type: none"> ▪ 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. ▪ 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.
<p>Product Availability</p>	<p>Medical</p> <ul style="list-style-type: none"> ▪ Pick-A-Plan 3 allows each employee the option to choose their medical product from a selection of product offerings selected by the employer. ▪ Carve Outs: Allowed (See Carve Out section) ▪ Pick-A-Plan 3: Allowed (See Pick-A-Plan 3 section) ▪ 1099 Employees: Allowed (See 1099 Employee Section) <p>Dental</p> <ul style="list-style-type: none"> ▪ Employers with 5 or more eligible, Dental may be sold on a standalone basis or along with the Medical on a bundled or unbundled basis. ▪ 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. ▪ Carve Outs: Not Allowed ▪ Pick-A-Plan 3: Not Available ▪ 1099 Employees: Not Allowed <p>Life</p> <ul style="list-style-type: none"> ▪ Employers with 5-9 eligible employees, Life must be sold with medical and cannot be sold on a Standalone basis. ▪ Employers with 10-25 eligible employees, Basic Term Life is available packed with either Medical or Dental. ▪ Employer with 26-50 eligible employees, Basic Term Life is available either packaged with Medical or Dental or on a Standalone basis. ▪ Employees may elect Life coverage even if they do not elect Medical coverage or vice versa. ▪ Employers with less than 10 eligible employees, certain plan differences apply. ▪ Carve Outs: Not allowed ▪ Pick-A-Plan 3 — Not Available ▪ 1099 Employees: Not Allowed
<p>Rates — Tabular or Composite</p>	<p>Tabular Rate Structure</p> <ul style="list-style-type: none"> ▪ For groups with 5-9 employees they will be tabular rated. ▪ All rates are based upon the Employer zip code. <p>Composite Rate Structure</p> <ul style="list-style-type: none"> ▪ For groups with 10-50 employees will be composite rated. ▪ Employers can offer a maximum of 3 Aetna medical plans to their employees. ▪ One employee must enroll into each plan and remain in a plan for it to be available at renewal. ▪ New hires may only enroll into one of the 3 plans that are offered. ▪ Upon final enrollment, the composite rate for each plan will be processed based upon the final enrolled employees. ▪ If the total premium varies by more than 10%, the new business rates will be adjusted to match the final rates. <p>Composite Rating for Renewing Business:</p> <ul style="list-style-type: none"> ▪ Renewal rates will be based on the enrolled employees in each plan at the time the renewal is processed. ▪ Only the plans available after the initial enrollment will be rated for the renewal. ▪ If you have had a census increase or decrease of less than 20% from your prior year's census, your rating calculation will not change. Example: If you were composite rated last year with 10 employees, and now you have nine employees, you will still receive composite rating since your change in census is less than 20%. This policy serves to reduce the frequency of employee's having to switch between tabular and composite rates from year to year

WASHINGTON CEHIT PLAN GUIDE

Rate Guarantee	<ul style="list-style-type: none"> ▪ Medical rates are guaranteed for one year (12 months). ▪ Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date this does not apply. ▪ Life rates are guaranteed for 2 years (24 months). 								
Renewal Benefit Changes	<ul style="list-style-type: none"> ▪ Requests for plan changes to be effective on the renewal date must be submitted prior to the renewal date. ▪ Requests for plan changes to be effective off of the renewal date must be submitted within 30 days of the requested effective date. ▪ The effective date for the plan change will be based upon notification receipt (this will be the date the email or fax was sent to Aetna). 								
Signature Dates	<ul style="list-style-type: none"> ▪ 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)	<ul style="list-style-type: none"> ▪ Aetna will consider the group guarantee issue with the following: <ul style="list-style-type: none"> ▪ 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. 								
Tax Documentation	<ul style="list-style-type: none"> ▪ For groups of 5-9 enrolling employees, the employer must submit a copy of the most recent 5208A and 5208B (Quarterly Wage and Tax Statement), which must contain the names, salaries, and withholdings for all employees of the employer group. ▪ If an employee is missing from the 5208A and 5208B payroll must be provided. ▪ In the event that a 5208A and 5208B are 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. ▪ Payroll records should have the tax identification number for the employer on them if submitted from an outsourced payroll company. ▪ When a 5208A and 5208B or payroll records are submitted: <ul style="list-style-type: none"> – Employees who have terminated, work part-time, are seasonal, 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. – Newly hired employees should be written in on the Quarterly Wage & Tax Statement and signed by the employer. – The underwriter may request payroll in questionable situations. – Churches must provide Form 941 including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941. ▪ For groups of 10 to 50 enrolling employees who <u>do not appear</u> on the prior carrier billing statement; Proprietors, Partners, or Corporate officers must complete the Aetna Proof of Eligibility Form and submit one of the documents listed below. ▪ For groups of 10 to 50 enrolling employees who <u>appear</u> on the prior carrier billing statement; Proprietors, Partners, or Corporate officers must complete the Aetna Proof of Eligibility Form and do not need to submit one of the following documents (Aetna reserves the right to request IRS forms upon receipt and review of the group): <table border="1" data-bbox="334 1209 1263 1436" style="margin-left: 20px; width: 100%;"> <tr> <td style="background-color: #e0e0e0;">C-Corporation</td> <td>W2</td> </tr> <tr> <td style="background-color: #e0e0e0;">S-Corporation</td> <td>IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</td> </tr> <tr> <td style="background-color: #e0e0e0;">Partnership</td> <td>IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</td> </tr> <tr> <td style="background-color: #e0e0e0;">Limited Liability Company (LLC) Sole Proprietor</td> <td>May file as either C Corporation or Partnership IRS Schedule SE and Schedule C filed with Form 1040; or IRS Form 1040 Schedule F or K-1</td> </tr> </table> <ul style="list-style-type: none"> ▪ Aetna Proof of Eligibility Form – one form per individual is to be completed. ▪ Non-profit groups may provide payroll documents as long as they also submit the appropriate form detailing their non-profit status. ▪ Other documentation may be requested by Aetna Underwriting upon receipt and review of sold case documents. ▪ Altered legal documentation will not be accepted at any time. 	C-Corporation	W2	S-Corporation	IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)	Partnership	IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)	Limited Liability Company (LLC) Sole Proprietor	May file as either C Corporation or Partnership IRS Schedule SE and Schedule C filed with Form 1040; or IRS Form 1040 Schedule F or K-1
C-Corporation	W2								
S-Corporation	IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)								
Partnership	IRS Form 1065 Schedule K-1; or IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)								
Limited Liability Company (LLC) Sole Proprietor	May file as either C Corporation or Partnership IRS Schedule SE and Schedule C filed with Form 1040; or IRS Form 1040 Schedule F or K-1								

<p>1099 Employees</p>	<p>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:</p> <ul style="list-style-type: none"> ▪ 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.
<p>Townships and Municipalities</p>	<ul style="list-style-type: none"> ▪ 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. <p>Underwriting Requirements</p> <ul style="list-style-type: none"> ▪ 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 and should provide a copy of their prior year W2. ▪ If elected officials are to be covered provide 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

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

AETNA PPO & INDEMNITY

- All medical or hospital services not specifically covered or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- Infertility services, including, but not limited to artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics, except as specified in the plan
- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special-duty nursing
- 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

Pre-existing conditions exclusion provision

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

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

If you had less than three months of group or three months of individual (including Medicare, Medicaid) of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage. Creditable Coverage includes health coverage issued on a group or individual basis; Medicare; Medicaid; health care for members of the uniformed services; a program of the Indian health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan (any plan established by a state, the government of the United States, or a foreign country); any health benefit plan under Section 5(e) of the Peace Corps Act; and the State Children's Health Insurance Program (S-CHIP).

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

In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any Certificates of Creditable Coverage you have. Please contact your Aetna Member Services representative at **1-888-802-3862** if you need assistance in obtaining a Certificate of Creditable Coverage from your prior carrier or if you have any questions on the information noted above. Pre-existing condition exclusion provisions are waived for any individual under the age of 19 and do not apply to pregnancy.

Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; if applicable, the pre-existing exclusion will be applied from the individual's effective date of coverage.

LIMITATIONS AND EXCLUSIONS

DENTAL

Listed below are some of the charges and services for which this dental plan does not provide coverage. For a complete list of exclusions and limitations, refer to the plan documents.

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

Specific service limitations

- DMO plans: Oral exams (4 per year)
- PPO plans: Oral exams (2 routine and 2 problem-focused per year)
- All plans:
 - Bitewing X-rays (1 set per year)
 - Complete series X-rays (1 set every 3 years)
 - Cleanings (2 per year)
 - Fluoride (1 per year, children under 16)
 - Sealants (1 treatment per tooth, every 3 years on permanent molars, children under 16)
 - Scaling & 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 and an accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel, this does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

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

SUBMISSION DETAILS AND GUIDELINES

Effective dates may be the first or 15th day of the month only.

Applications must be received by Aetna no later than the end of business day, 10 business days prior to the requested effective date.

Send paperwork to:

Total Benefit Solutions
218 Main Street #513
Kirkland, WA 98033
1-425-897-7150
www.tbsmga.com

EMPLOYER INFORMATION

Employer Application

Complete all pages of the application

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

5208A and 5208B or other applicable tax documents

- Part-time, terminated, seasonal or temporary must be indicated on this wage and tax report.
- For seasonal industries such as farming laborers or season processing fruit plants, four (4) consecutive quarters of wage and tax reports may be requested by underwriting.
- All enrolling employees must be represented on the wage and tax form or included on a payroll report.

- Out-of-state employees require proof of employment if not identified on the 5208A and 5208B. This would be the quarterly wage and tax statement filed in that particular state where the employee is living and/or working.
- If owner, partner, or corporate officer is not listed on the 5208A and 5208B, submit the Small Group Proof of Eligibility form signed by the employee along with the requested documents.
- If newly hired employees are not identified on the 5208A and 5208B, submit a minimum of two weeks payroll indicating compensation and taxes withheld.

Premium Check made payable to Aetna

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

Copy of current/prior medical/dental carrier's latest bill

- Include employee roster and premium summary page.

EMPLOYEE INFORMATION

Employee applications completed and signed by each employee

- Any alterations must be initialed and dated by the employee.
- Individual waiver forms completely filled out for each employee and/or family member waiving coverage (to be signed by the employee).
- Employees need to sign and date the signature page prior to the requested effective date.

Dental Submissions (in addition to items under Employee Information section)

- Employee Enrollment Forms
- Waiver completed for employees not electing Dental

Group Insurance Submissions (in addition to items under Employer Information section)

- Employee Enrollment Form
- Individual Health Statement required if selecting Life amount in excess of Guaranteed Issue Amount
- Waiver completed for employees not electing Life

Complete/Review Broker and General Agent information

- Complete, sign, and date the Agent/Broker Certification section of the Employer

Application

- Review all items on this page for completion prior to submissions
 - Verify underwriting guidelines were reviewed and understood
 - Submit a copy of the Aetna quote package
 - Complete and provide the Aetna Agent Agreement, if applicable
- Avoid potential delays in getting your client approved and enrolled. Make sure your new case submissions are complete.

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

Toll Free #: **1-877-249-2472**

Fax #: **1-888-258-4530**

E-mail Address:

ASGBLAZ_NV_WA@Aetna.com

New Business Case Submission
Total Benefit Solutions
218 Main Street #513
Kirkland, WA 98033

Effective dates may be the first of the month only.

All required paperwork must be received by Aetna by no later than the requested effective date.

CONTACT INFORMATION

BROKER SALES SUPPORT UNIT

Phone #: **1-877-249-2472**
Fax #: **1-888-258-4530**

Choose the following numbers, when prompted, to access the information you need:

- 1 – Billing & enrollment
- 2 – Claims
- 3 – Commission questions
- 4 – Licensing & appointments
- 5 – Renewal assistance
- 6 – Broker liaisons for fulfillment requests & all other questions

E-mail Addresses
ASGBLAZ_NV_WA@aetna.com

Regular Mail
P.O. Box 24004
Fresno, CA 93779-4004

Overnight Mail
1385 East Shaw Avenue
Fresno, CA 93710

New Business Quoting & Sales

Total Benefit Solutions
Phone #: **1-425-897-7150**
Fax #: **1-877-653-2118**
Quotes@tbstrust.com

New Business Case Submission

Total Benefit Solutions
218 Main Street #513
Kirkland, WA 98033
Phone #: **1-425-897-7150**
www.tbsmga.com

Aetna Navigator® & Producer World®

Phone #: **1-800-225-3375**
Monday – Friday
7 a.m. – 9 p.m. ET

Choose the following numbers, when prompted, to access the information you need:

Prompt 1 (Aetna Navigator)

Prompt 3 (Producer World)

- 1 – Assistance with password or user name
- 2 – Assistance with registration
- 3 – Access assistance
- 4 – All other website technical assistance

PLAN SPONSOR SERVICES

Phone #: **1-877-249-7235**

Fax #: **1-866-351-8440**

Choose the following numbers, when prompted, to access the information you need:

1 – Renewals

2 – Claims

3 – Billing & enrollment

Billing

For Lockbox information, see customer bill or please contact the Plan Sponsor Services toll-free number for more information.

Enrollment

Aetna

P.O. Box 24005

Fresno, CA 93779-4005

AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions®

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health insurance, dental benefits and insurance and life insurance plans/policies contain exclusions and limitations. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules and are unfunded liabilities of your employer. Fund balances are not vested benefits. 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 and dental 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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