Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

# New Jersey 2–50
# **Plan guide**

Like playing a symphony, the key to creating the right health plan is unlocking the right combination of cost and coverage

**Plans effective January 1, 2014**
**For businesses with 2–50 eligible employees**

**www.aetna.com**

64.10.300.1-NJ F (10/13)

# Unlocking the right health plan

Every company has its own particular needs, driven in part by the health of its employees, by its commitment to health and wellness and, of course, by its financial resources.

We believe creating the right health and benefits insurance plan means unlocking the right combination of these four options to meet a company's specific needs: **Benefits, Network, Cost sharing, Funding.**

## Experience matters

Unlocking the right combination isn't a matter of chance. It's a matter of working with an experienced and knowledgeable guide. A guide like Aetna. We take the time to listen and learn about your needs, share knowledge and provide tools to help achieve the right balance of cost and coverage.

Our approach makes all the difference in the value you get from your plan, and in the satisfaction of your employees.

Today's health care environment demands a new set of solutions to meet new challenges. Together, we can unlock those solutions to create a healthy future for your company and your employees.

64.43.300.1-NJ F (10/13)

# Unlock the right combination

We want to make unlocking the right benefits as easy as possible. So we've organized information in this easy-to-understand guide.



64.44.300.1-NJ F (10/13)

# Changes to your plan due to health care reform

Signed into law in March 2010, the Affordable Care Act is the most life-changing health law since the passing of Medicare in the 1960s. The Affordable Care Act will shape new rules and guidance through 2014 and beyond. We are committed to following the new health care law and to helping you understand its impact.

We have outlined below key changes that may impact your health care benefits:

### Essential health benefits package

As of January 1, 2014, Aetna plans must offer standard coverage known as "essential health benefits." This includes all plans inside and outside of the health insurance exchanges. These benefits provide your employees with essential health benefits, and limit cost sharing.

Here are the broad categories of essential benefits that will be included in your employees' coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric dental
- Pediatric vision

### Out-of-pocket (OOP) maximum mandate

Beginning in 2014, all cost sharing must apply toward the OOP maximum, including in-network medical, behavioral health and pharmacy cost sharing. This does not include premiums, balance billing amounts of non-network providers or spending for noncovered services.

The out-of-pocket maximum must include:

- Copays
- Deductibles
- Coinsurance

### Fees

These fees are included in your premium:

- **Health Insurer Fee —** Annual fee to offset premium subsidies and tax credit-related expenses
- **Transitional Reinsurance Program Contribution —** Helps finance the cost of high-risk individuals in the individual market
- **Patient-Centered Outcomes Research Fee (also known as the Comparative Effectiveness Fee) —** Fee to fund clinical outcomes effectiveness research

### Guaranteed issue

Guaranteed issue of health insurance coverage applies to individual, small group and large group markets. Guaranteed issue is available for:

- Group Health Plans/Insurance Coverage (insured only)
- Individual Health Insurance Coverage (including medical conversion)
- Pharmacy (insured only)
- Behavioral Health (insured only)*

Please note that guaranteed issue is not available for:

- Self-funded plans
- Stand-alone/separate dental or vision
- Hospital Indemnity/Fixed Indemnity
- Medicare and Medicare Supplement
- Medicaid
- Retiree-only plans
- Grandfathered plans
- Association/MEWA plans

### Rating rule changes

The rate review regulations are changing, and we are making sure they stay affordable. We are working to protect you from rate increases without decreasing competition, reducing consumer choice of providers or causing problems.

*Note: no stand-alone insured behavioral health.

### Pediatric dental/vision

Pediatric dental and vision mandates are a separate essential health benefit category and are included with your medical benefits. We will cover those services in 2014 according to the benchmark plan coverage.

# Pediatric Dental

| Plan Name | Traditional HMO/ HNOnly/OA EPO Plans with no deductible | Traditional HMO/ HNOnly/OA EPO Plans with deductible | Consumer-Directed – HMO/ HNOnly/OA EPO HSA-Compatible Plans | Traditional HNOption/OAMC Plans with no in-network deductible | |
|---|---|---|---|---|---|
| | In network | In network | In network | In network | Out of network |
| **Preventive** | 0% | 0%, deductible waived | 0%, deductible waived | 0% | Not covered |
| **Diagnostic** (such as, dental check-up) | 0% | 0%, deductible waived | 0% after deductible | 0% | Not covered |
| **Dental Basic** | 30% | 30% after deductible | 30% after deductible | 30% | Not covered |
| **Dental Major** | 50% | 50% after deductible | 50% after deductible | 50% | Not covered |
| **Dental Ortho** | 50% | 50% after deductible | 50% after deductible | 50% | Not covered |

| Plan Name | Traditional QPOS/HNOption/MC/OAMC Plans with in-network deductible | | Consumer-Directed – HNOption and OAMC HSA-Compatible Plans | | Traditional Indemnity Plan |
|---|---|---|---|---|---|
| | In network | Out of network | In network | Out of network | Out of network |
| **Preventive** | 0%, deductible waived | Not covered | 0%, deductible waived | Not covered | 0%, deductible waived |
| **Diagnostic** (such as, dental check-up) | 0%, deductible waived | Not covered | 0% after deductible | Not covered | 0%, deductible waived |
| **Dental Basic** | 30% after deductible | Not covered | 30% after deductible | Not covered | 30% after deductible |
| **Dental Major** | 50% after deductible | Not covered | 50% after deductible | Not covered | 50% after deductible |
| **Dental Ortho** | 50% after deductible | Not covered | 50% after deductible | Not covered | 50% after deductible |

These plans do not cover all dental expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

# Pediatric Vision

| Plan Name | Traditional HMO/ HNOnly/OA EPO Plans with no deductible | Traditional HMO/ HNOnly/OA EPO Plans with deductible | Consumer-Directed – HMO/ HNOnly/OA EPO HSA-Compatible Plans | Traditional HNOption/OAMC Plans with no in-network deductible | |
|---|---|---|---|---|---|
| | In network | In network | In network | In network | Out of network |
| **Vision exam** (one exam per 12 months) | 0% | 0%, deductible waived | 0%, deductible waived | 0% | 50% after deductible |
| **Preferred eyeglass frames, prescription lenses or prescription contact lenses*** | 0% | 0%, deductible waived | 0% after deductible | 0% | 50% after deductible |
| **Non-preferred eyeglass frames, prescription lenses or prescription contact lenses*** | 50% | 50% after deductible | 50% after deductible | 50% | 50% after deductible |

| Plan Name | Traditional QPOS/HNOption/MC/OAMC Plans with in-network deductible | | Consumer-Directed – HNOption and OAMC HSA-Compatible Plans | | Traditional Indemnity Plan |
|---|---|---|---|---|---|
| | In network | Out of network | In network | Out of network | Out of network |
| **Vision exam** (one exam per 12 months) | 0%, deductible waived | 50% after deductible | 0%, deductible waived | 50% after deductible | 0%, deductible waived |
| **Preferred eyeglass frames, prescription lenses or prescription contact lenses*** | 0%, deductible waived | 50% after deductible | 0% after deductible | 50% after deductible | 0%, deductible waived |
| **Non-preferred eyeglass frames, prescription lenses or prescription contact lenses*** | 50% after deductible | 50% after deductible | 50% after deductible | 50% after deductible | 50% after deductible |

*The pediatric vision plan will cover the following for members through age 18:

- One comprehensive eye examination by an in-network ophthalmologist or optometrist in a 12-month period
- One set of eyeglass frames per 12 months
- One pair of prescription lenses per 12 months
- Prescription contact lenses, maximum per 12 months: daily disposables (up to 3-month supply), extended wear disposable (up to 6-month supply) and non-disposable lenses (one set)
- Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months.

These plans do not cover all vision expenses and have exclusions and limitations. Members should refer to their plan documents to determine which services are covered and to what extent.

# Unlocking the right plan for your business

Our product portfolio includes a range of coverage and cost combinations. You'll find choices for different budgets and benefits strategies. And you'll see that we're more than medical. You can round out your benefits offering with dental as well as life and disability offerings.

Take a look at what's available.

### Medical plans

- Traditional plans
- Consumer-directed plans

### Plan levels

Our health plans will now be assigned a metallic level. The level is based on how much of the total health care cost the plan pays, versus what members pay out of pocket. The levels are called bronze, silver, gold and platinum.

| Health plan levels | Average amount the plan pays for covered services |
|---|---|
| **Bronze** | 60% |
| **Silver** | 70% |
| **Gold** | 80% |
| **Platinum** | 90% |

You'll soon be seeing many changes in health insurance, thanks to health care reform. Many of them affect your business. And some of them might be confusing. Visit the health care reform section on **www.aetna.com** for more information. Or talk with your broker.

### Tools to help your employees stay healthy, informed and productive

With Aetna health plans, your employees get online tools and helpful resources that let them make the most of their benefits. Our most popular tools include:

- **Secure member website.** Your employees get self-service tools, plus health plan and health information through their Aetna Navigator® website. Think of it as the key that unlocks the full value of their health benefits package. Encourage them to sign up at **www.aetna.com**.
- **Member Payment Estimator.** With an Aetna health plan, your employees can compare and estimate costs* for office visits, tests, surgeries and more. This means they can save money**—and avoid surprises. This online tool factors in their deductible, coinsurance and copays, plus contracted rates. They can see how much they have to pay and how much the plan will pay. They can log in to their Aetna Navigator member website to use the tool.
- **Online provider directory.** Finding doctors, specialists, hospitals and more in the Aetna network is easy with our DocFind® directory. It's available at **www.aetna.com** and on the Aetna Navigator member website.
- **My Life Values.** Your employees get 24/7 online services and support for managing their everyday personal and work matters.

*Estimated costs not available in all markets. The tool gives members an estimate of what they would owe for a particular service based on their plan at that very point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after they get the estimate but before the claim for this service is submitted. Or, if the doctor or facility performs a different service at the time of the visit.

**In 2011, members who used Member Payment Estimator before receiving care saved an average of $170 out of pocket on 34 common procedures, according to the Member Payment Estimator Study, Aetna Informatics and Product Development, August 2012.

### Dental plans

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice plan design
- Preventive

### Dental plan extras

There's extra value built into our dental portfolio:

- **Dental-medical integration.** Our program encourages preventive dental care among employees who have diabetes or heart disease, or who are pregnant. This can lead to more of your employees taking steps to stay healthy.
- **Dental discounts.** Aetna ValuePass℠, a MasterCard® prepaid card, is a flexible way to give employees access to our nationwide network of dental services at discounted rates. It guarantees savings that range from 15 to 50 percent off the average retail cost of dental services.* Offer it alongside your current dental plan, as a voluntary plan with no employer contribution, or as a replacement for your current dental benefit, through defined contribution.

### Life and disability plans

- Basic term life insurance
- Packaged life and disability plans

### Life and disability plan extras

- **Aetna Life Essentials℠.** Through our program, your employees get access to expert advice on legal and financial matters — at no added cost. Plus, they get discounts on health products and services, like fitness and vision care.**
- **Funeral planning and concierge service.** Through our collaboration with Everest, we offer our life members pre-planning and at-need services.
- **Aetna Return to Work Solutions℠ program.** Our return-to-work solutions provide customers with the support and resources they need to help get valued employees back to work safely and as soon as possible.

*Savings are based on average retail charges in the geographic area and Aetna's negotiated rates. Actual retail charges and discounts provided by Aetna ValuePass participating providers will vary.

**These services are discount programs, not insurance.

**The Aetna ValuePass℠ program (the "program") is NOT insurance.** The program provides cardholders with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company ("Aetna"), 151 Farmington Avenue, Hartford, CT 06156, **1-888-215-6578**, with dental providers (the "Aetna ValuePass participating providers") in the Aetna Dental Access® network. Aetna is the discount medical plan organization. Your card may be used at any dental provider, but you will only receive discounted fees at Aetna ValuePass participating providers. The range of discounts provided under the program will vary depending on the type of Aetna ValuePass participating provider and type of services received. The card provides payments directly to the providers accepting payments using the funds on your card. In order to receive a discount, you must use the card to pay for services or products furnished by the Aetna ValuePass participating providers. **www.aetnavaluepass.com.**

# Together, we'll unlock the right combination of benefits, network, cost-sharing and funding options for you and your employees.

### About our benefits

Choose from numerous, integrated benefits options that can lead to improved employee engagement and health, while helping you manage your costs. This includes medical, pharmacy, dental, life, disability and vision. Plus, online tools that help employees use their benefits wisely and get help when they need it.

### About our network

We have many full-network and tiered-network options to lower employer costs while still providing employees with access to quality care. Our doctor networks prioritize quality and efficiency to improve the health care experience and make it easy for individuals to get the care they need.

### About our cost sharing

Some of our cost-sharing arrangements encourage employees to become more involved in their own health care and become better health care consumers. Employees with these plans receive more preventive care, have lower overall costs and use online tools more frequently.

### About our funding options

We can show you how a combined network, cost-sharing and benefits approach can help you manage your premium to meet your budget. We also offer a range of funding options — from traditional fully insured to enhanced self-insured solutions — that provide different levels of cost, plan control and information access.

### Network options for healthy outcomes and lower costs

Our network solutions help lower your costs while providing employees with access to trusted doctors and hospitals. Your employees can still get care within the broad Aetna network. But they pay less out of pocket when they use doctors and hospitals in our special networks. The more they use health care providers in these networks, the more likely you are to see lower medical costs.

We make it easier for your employees, too. They get online tools for estimating costs and finding the right doctors and hospitals.

### Cost sharing and premiums for every budget

Your focus is on lower costs. Increasingly, that means greater levels of employee cost sharing. With Aetna in your corner, you can map out a strategy based on your employee base and price point. And you can choose from the full spectrum of health plan types:

- Our fully insured portfolio, traditionally a mainstay for small businesses, provides plans with a range of robust coverage options.
- Emerging self-funded options for small businesses may help you manage costs while offering the needed administrative support.
- Our defined contribution offering combines an attractive benefits package with more predictable costs. As well as motivation for your employees to get more involved in their health care.
- Our consumer-directed health plans have long offered fully featured coverage, along with lower premiums and higher deductibles. Our research has found that members with Aetna HealthFund® plans have lower overall health care costs, receive more preventive care and use online tools more frequently than members with traditional plans.

## Unlock health and wellness

Having a happier, healthier workforce is important to you. So is cost management. We've found that helping your employees get more involved in managing their health and well-being is a great way to meet these goals. Talk to your broker or Aetna representative to learn more about our programs.

### Health assessment and screening incentive*

Members can earn $50 in just a few simple steps. If the employee's spouse is covered under the plan, he or she is also eligible for the same incentive. So a family could earn up to a $100 incentive each year. Here's how:

- Complete or update their Snapshot® health assessment on Simple Steps, and
- Complete a biometric screening

### Wellness programs can make health and fitness part of everyday living:

- Women's health and preventive health reminders
- Simple Steps To A Healthier Life® program
- Informed Health® Line
- Healthy Lifestyle Coaching
- 24-hour nurse line
- Aetna discount programs
- Personal Health Record

## Women's preventive health benefits

These services are generally covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Preferred generic contraceptives and certain preferred brand contraceptives are covered without member copayment. Certain religious organizations or religious employers may be exempt from offering contraceptive services.

## We make things easy for you

Health plan management and administration is our specialty, which makes it easier for you to manage health insurance benefits with:

- **eEnrollment.** Handle enrollments, terminations and other changes online, with less paperwork and greater efficiency.
- **eBilling.** Save time and simplify reconciliation and payment, anytime, anywhere, with our secure system. It lets you get, view and pay all your medical and dental bills online.

*Incentive rewards will be offered in the form of a gift card. This program is included at no additional cost on all plans.

# Aetna Medical Overview

Medical coverage can be a deal-breaker in recruiting and keeping talented employees. Our medical plan portfolio was designed with the needs of businesses like yours in mind. You'll find flexible options, from traditional indemnity to consumer-directed plans. You can choose the plan design and benefits level that fits your budget and achieve the right combination of cost and coverage for your business.

# Medical
## Overview

At Aetna, we are committed to putting the employee at the center of everything we do. You can count on Aetna to provide health plans that help simplify decision making and plan administration so you can focus on the health of your business.

**New Jersey provider network***

**All plans are available in all New Jersey counties.**

Northeast Region Small Group Sales Support Center: **1-888-277-1053**

| | | | | | | |
|---|---|---|---|---|---|---|
| Atlantic | Camden | Essex | Hunterdon | Monmouth | Passaic | Sussex |
| Bergen | Cape May | Gloucester | Mercer | Morris | Salem | Union |
| Burlington | Cumberland | Hudson | Middlesex | Ocean | Somerset | Warren |

## Product Information

| Plan Name | Product Description | PCP Required | Referrals Required | Network |
|---|---|---|---|---|
| **Aetna HMO** | A health maintenance organization (HMO) uses a network of participating providers. Each family member selects a primary care physician (PCP) participating in our network. The PCP provides routine and preventive care and helps coordinate the member's total health care. The PCP refers members to participating specialists and facilities for medically necessary specialty care. Only services provided or referred by the PCP are covered except for emergency, urgently needed care or direct-access benefits, unless approved by the HMO in advance of receiving services. | Yes | Yes | HMO |
| **Aetna Health Network Only℠ (HNOnly)** | Aetna Health Network Only (HNOnly) is a health maintenance organization plan that uses a network of participating providers. Each family member may select a primary care physician (PCP) participating in the Aetna network to provide routine and preventive care and help coordinate the member's total health care. Members never need a referral when visiting a participating specialist for covered services. Only services rendered by a participating provider are covered, except for emergency or urgently needed care. | Optional | No | Aetna Health Network Only (Open Access) |
| **Aetna QPOS®** | The Aetna QPOS plan is a two-tiered product that allows members to access care in one of two ways:<br>1. PCP referred, network, or<br>2. Self-referred, network or non-network.<br>Members have lower out of pocket costs when they use the HMO (referred) tier of the plan and follow the PCP referral process. Member cost sharing increases if members decide to self-refer, network or non-network. | Yes | Yes, for PCP referred care; no, for self-referred care | QPOS |

*Network subject to change.

# Product Information

| Plan Name | Product Description | PCP Required | Referrals Required | Network |
|---|---|---|---|---|
| **Aetna Health Network Option℠ (HNOption)** | Aetna Health Network Option (HNOption) is a two-tiered product that allows members to access care in or out of network. Members have lower out-of-pocket costs when they use the in-network tier of the plan. Member cost sharing increases if members decide to go out of network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care. | Optional | No | Aetna Health Network Option (Open Access) |
| **Aetna Open Access® Elect Choice® (OA EPO)** | The Aetna Open Access Elect Choice plan provides a network-based based managed care product with comprehensive health care benefits. Members are not required to select a PCP to coordinate their care or to obtain referrals for specialty care. Only services rendered by a network provider are covered, except for emergency or urgently needed care. | Optional | No | Elect Choice EPO (Open Access) |
| **Aetna Managed Choice® (MC)** | Aetna's Managed Choice POS plan provides all the benefits of a managed care plan combined with the freedom to visit a doctor or hospital of choice. The plan combines cost-control features with member flexibility to choose quality health care providers. MC is a POS product, and members are still required to select a PCP to coordinate their care and obtain referrals for specialty care. | Yes | Yes, for PCP referred care; no, for self-referred care | Managed Choice POS |
| **Aetna Open Access® Managed Choice® (OA MC)** | Managed Choice members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs. | Optional | No | Managed Choice POS (Open Access) |
| **Aetna Indemnity** | The Aetna Indemnity plan option is available for employees who live outside the plan's network service area.<br>Members coordinate their own health care and may access any recognized provider for covered services without a referral. | No | No | N/A |

## Aetna high deductible HSA-compatible plans

These health plan options are compatible with a health savings account (HSA). HSA-compatible plans provide integrated medical and pharmacy benefits. Preventive care services are waived from the deductible.

HSAs 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. HSAs can be funded by the employer and/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.

It is completely at the discretion of the employer or employee whether or not to establish an HSA.

Note: Employers and employees should consult with their tax advisor to determine eligibility requirements and tax advantages for participation in an HSA plan.

## Health Savings Account (HSA)

### No set-up or administrative fees

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

### Member's HSA plan

- The member owns the HSA.
- Contributions are tax free.
- Members choose how and when to use HSA dollars.
- Members can roll their HSA over each year and let it grow.
- HSAs earn interest, tax free.

### Today

- Can be used for qualified expenses with tax-free dollars

### Future

- Allows members to plan for future and retiree health-related costs

### High-deductible health plan

- Eligible in-network preventive care services will not be subject to the deductible.
- Members pay 100 percent until deductible is met, then only pay a share of the cost
- Members meet out-of-pocket maximum, then plan pays 100 percent

## 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 help employers manage the complex billing and notification processes required for COBRA compliance, while also helping to save them time and money.

## Section 125 cafeteria plans and Section 132 Transit Reimbursement Accounts

With these options, 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 are waived with the purchase of medical with five or more enrolled employees.

### Flexible Spending 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 health care 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.

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.

### Group situs

Medical and dental benefits and rates are based on the group's headquarters location, subject to applicable state laws. Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA and VA (the situs region) will receive the same rates and benefits as the headquarters location.

### Multi-state solution

We offer a multi-state solution to make it easier for businesses like yours to do business with us. We believe it brings more consistency across medical benefits offerings to employers with employees in multiple locations.

Employers based in New Jersey can offer NJ OA EPO and OAMC plans to their employees who live and work outside of the "situs" region. The situs region comprises the following eight states: CT, DC, DE, MD, NJ, NY, PA and VA.

The rates and benefits will match those offered in New Jersey. If the out-of-situs employee lives in a non-network area, the employee will be enrolled in an indemnity plan. Plan sponsors will need to continue to meet underwriting guidelines, subject to all applicable state laws.

In all instances, extraterritorial benefits that may apply on any of the out-of-situs employees will be implemented where required.

# Administrative Fees

| Fee description | Fee | |
|---|---|---|
| **Premium-Only Plan (POP)** | | |
| **Initial set-up*** | $190 | |
| **Monthly fees** | $125 | |
| **Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA)**** | | |
| | **Initial set-up** | **Renewal fee** |
| 2–25 Employees | $360 | $235 |
| 26–50 Employees | $460 | $285 |
| **Monthly fees***** | $5.45 per participant | |
| **Additional set-up fee** for "stacked" plans (those electing an Aetna HRA and FSA simultaneously) | $150 | |
| **Participation fee** for "stacked" participants | $10.45 per participant | |
| **Minimum fees** | | |
| 0–25 Employees | $25 per month minimum | |
| 26–100 Employees | $50 per month minimum | |
| **COBRA Services** | | |
| **Annual fee** | | |
| 20–50 Employees | $165 | |
| **Per employee per month** | | |
| 20–50 Employees | $0.95 | |
| **Initial notice fee** | $3.00 per notice (includes notices at time of implementation and during ongoing administration) | |
| **Minimum fees** | | |
| 20–50 Employees | $25 per month minimum | |
| **Transit Reimbursement Account (TRA)** | | |
| **Annual fee** | $350 | |
| **Transit monthly fees** | $4.25 per participant | |
| **Parking monthly fees** | $3.15 per participant | |

*Non-discrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for $100 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. For FSA, the debit card is available for an additional $1 per participant per month. Mailing reimbursement checks direct to employee homes is an additional $1 per participant per month.

Aetna 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 – HMO and HNOnly Plans

| Plan Name | Referral Plan / Open Access Plan | NJ Gold HMO 500D / NJ Gold HNOnly 500D | NJ Gold HMO 70% / NJ Gold HNOnly 70% | NJ Gold HMO 1500 70% / NJ Gold HNOnly 1500 70% | NJ Silver HMO 2000 50% / NJ Silver HNOnly 2000 50% | NJ Silver HMO 2000 70% / N/A |
|---|---|---|---|---|---|---|
| **Member Benefits** | | In-network providers | In-network providers | In-network providers | In-network providers | In-network providers |
| **Calendar Year Deductible** | | $0 Individual/ $0 Family | $0 Individual/ $0 Family | $1,500 Individual/ $3,000 Family | $2,000 Individual/ $4,000 Family | $2,000 Individual/ $4,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | | $6,000 Individual/ $12,000 Family | $6,000 Individual/ $12,000 Family | $3,500 Individual/ $7,000 Family | $6,000 Individual/ $12,000 Family | $5,000 Individual/ $10,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | | Non-embedded | Non-embedded | Non-embedded | Non-embedded | Embedded |
| **Not Included In Maximum Out-of-Pocket** | | Noncovered expenses | Noncovered expenses | Noncovered expenses | Noncovered expenses | Noncovered expenses |
| **Primary Care Physician Office Visit** | | $30 copay | $30 copay | $20 copay, deductible waived | $30 copay, deductible waived | 30% after deductible |
| **Specialist Office Visit** | | $50 copay | $50 copay | $40 copay, deductible waived | $50 copay, deductible waived | 30% after deductible |
| **Walk-In Clinic Visit** | | $30 copay | $30 copay | $20 copay, deductible waived | $30 copay, deductible waived | 30% after deductible |
| **Chiropractic Services** (30 visits per calendar year) | | 25% | 25% | 25%, deductible waived | 25%, deductible waived | 30% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | | $0 copay | $0 copay | $0 copay, deductible waived | $0 copay, deductible waived | 0%, deductible waived |
| **Diagnostic Testing: Lab** | | $15 copay | $10 copay | $5 copay, deductible waived | $15 copay, deductible waived | 30% after deductible |
| **Diagnostic Testing: X-ray** | | $50 copay | $50 copay | $40 copay, deductible waived | $50 copay, deductible waived | 30% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | | 30% | 30% | 30%, deductible waived | 50%, deductible waived | 30% after deductible |
| **Prescription Drug Deductible** | | Not applicable | Not applicable | Not applicable | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | | $20/$50/$75 | $20/$50/$75 | Rx option 1: $10/$40/$75 Rx option 2: $20/$50/$75 | $20/$50/$75 | $20/$50/$75 |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs |
| **Outpatient Surgery: Hospital Outpatient Facility** | | $500 copay | 30% | 30% after deductible | 50% after deductible | 30% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | | $250 copay | 30% | 30% after deductible | 50% after deductible | 30% after deductible |
| **Emergency Room** | | 30% | 30% | 30%, deductible waived | 50%, deductible waived | $100 copay + 30% after deductible |
| **Inpatient Hospital Facility** | | $500 copay per day, 5-day copay max per admission | 30% | 30% after deductible | 50% after deductible | 30% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST) | | $20 copay | $20 copay | $20 copay, deductible waived | $20 copay, deductible waived | 30% after deductible |

Refer to pages 30–31 for important plan provisions.

# Consumer-Directed — HMO and HNOnly HSA-Compatible Plans

| Plan Name | NJ Silver HMO 2000 100% HSA* | NJ Silver HNOnly 2000 HSA* | NJ Silver HNOnly 2000 90% HSA* | NJ Bronze HMO 2500 50% HSA*<br>NJ Bronze HNOnly 2500 50% HSA* |
|---|---|---|---|---|
| **Member Benefits** | In-network providers | In-network providers | In-network providers | In-network providers |
| **Benefit Year Deductible** | $2,000 Individual/ $4,000 Family | $2,000 Individual/ $4,000 Family | $2,000 Individual/ $4,000 Family | $2,500 Individual/ $5,000 Family |
| **Benefit Year Maximum Out-of-Pocket** | $6,350 Individual/ $12,700 Family | $4,000 Individual/ $8,000 Family | $6,350 Individual/ $12,700 Family | $6,350 Individual/ $12,700 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation**[2] | Non-embedded | Non-embedded | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses | Noncovered expenses | Noncovered expenses | Noncovered expenses |
| **Primary Care Physician Office Visit** | 0% after deductible | $30 copay after deductible | 10% after deductible | 50% after deductible |
| **Specialist Office Visit** | 0% after deductible | $50 copay after deductible | 10% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | 0% after deductible | $30 copay after deductible | 10% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per benefit year) | 0% after deductible | 25% after deductible | 10% after deductible | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived | 0%, deductible waived | 0%, deductible waived |
| **Diagnostic Testing: Lab** | 0% after deductible | $15 copay after deductible | 10% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | 0% after deductible | $50 copay after deductible | 10% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 0% after deductible | 30% after deductible | 10% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible | Integrated with medical deductible | Integrated with medical deductible | Integrated with medical deductible |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 after deductible | Rx option 1: $10/$40/$75 after deductible<br>Rx option 2: $20/$50/$75 after deductible | $20/$50/$75 after deductible | 50% after deductible |
| **Aetna Specialty CareRx℠ Drugs**[3] (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs |
| **Outpatient Surgery: Hospital Outpatient Facility** | 0% after deductible | $200 copay after deductible | 10% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 0% after deductible | $200 copay after deductible | 10% after deductible | 50% after deductible |
| **Emergency Room** | 0% after deductible | 30% after deductible | 10% after deductible | 50% after deductible |
| **Inpatient Hospital Facility** | 0% after deductible | $400 copay per day, 5-day copay max per admission, after deductible | 10% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per benefit year, PT/OT combined, and 30 visits per benefit year, ST) | 0% after deductible | $20 copay after deductible | 10% after deductible | 50% after deductible |

*Benefit year: Plans are available on a calendar-year (CY) or plan-year (PY) basis.

Refer to pages 30–31 for important plan provisions.

# Traditional – QPOS Plan

| Plan Name | NJ Silver QPOS 2000 70/50 | |
|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $2,000 Individual/ $4,000 Family | $5,000 Individual/ $10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $5,000 Individual/ $10,000 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Embedded | Embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | 30% after deductible | 50% after deductible |
| **Specialist Office Visit** | 30% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | 30% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per calendar year. In-network and out-of-network combined.) | 30% after deductible | 50% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | 30% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | 30% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | 30% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 30% after deductible | 50% after deductible |
| **Emergency Room** (Copay is waived if admitted.) | $100 copay plus 30% after deductible | |
| **Inpatient Hospital Facility** | 30% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | 30% after deductible | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Traditional – HNOption Plans

| Plan Name | NJ Gold HNOption 100/60 300D | | NJ Gold HNOption 100/50 500D | |
|---|---|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $0 Individual/<br>$0 Family | $3,000 Individual/<br>$6,000 Family | $0 Individual/<br>$0 Family | $5,000 Individual/<br>$10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/<br>$12,000 Family | $10,000 Individual/<br>$20,000 Family | $6,000 Individual/<br>$12,000 Family | $10,000 Individual/<br>$20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | $20 copay | 40% after deductible | $30 copay | 50% after deductible |
| **Specialist Office Visit** | $40 copay | 40% after deductible | $50 copay | 50% after deductible |
| **Walk-In Clinic Visit** | $20 copay | 40% after deductible | $30 copay | 50% after deductible |
| **Chiropractic Services**<br>(30 visits per calendar year. In-network and out-of-network combined.) | 25% | 25% after deductible | 25% | 25% after deductible |
| **Preventive Care/Screenings/Immunizations**<br>(Age and frequency schedules may apply.) | $0 copay | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) | $0 copay | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | $15 copay | 40% after deductible | $15 copay | 50% after deductible |
| **Diagnostic Testing: X-ray** | $40 copay | 40% after deductible | $50 copay | 50% after deductible |
| **Imaging**<br>(CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% | 40% after deductible | 30% | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]:<br>Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | Not covered | $20/$50/$75 | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]**<br>(Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | $300 copay | 40% after deductible | $500 copay | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | $150 copay | 40% after deductible (Maximum benefit of $2,000 per member per calendar year.) | $250 copay | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) |
| **Emergency Room** | 30% | | 30% | |
| **Inpatient Hospital Facility** | $300 copay per day, 5-day copay max per admission | 40% after deductible | $500 copay per day, 5-day copay max per admission | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)**<br>(30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | $20 copay | 40% after deductible | $20 copay | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Traditional – HNOption Plans

| Plan Name | NJ Gold HNOption 70/50 | | NJ Silver HNOption 1500 70/50 | |
|---|---|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $0 Individual/ $0 Family | $5,000 Individual/ $10,000 Family | $1,500 Individual/ $3,000 Family | $5,000 Individual/ $10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/ $12,000 Family | $10,000 Individual/ $20,000 Family | $6,000 Individual/ $12,000 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | $30 copay | 50% after deductible | $35 copay, deductible waived | 50% after deductible |
| **Specialist Office Visit** | $50 copay | 50% after deductible | $50 copay, deductible waived | 50% after deductible |
| **Walk-In Clinic Visit** | $30 copay | 50% after deductible | $35 copay, deductible waived | 50% after deductible |
| **Chiropractic Services** (30 visits per calendar year. In-network and out-of-network combined.) | 25% | 25% after deductible | 25%, deductible waived | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | $0 copay | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) | $0 copay, deductible waived | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | $10 copay | 50% after deductible | $15 copay, deductible waived | 50% after deductible |
| **Diagnostic Testing: X-ray** | $50 copay | 50% after deductible | $50 copay, deductible waived | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% | 50% after deductible | 50%, deductible waived | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | Not covered | $20/$50/$75 | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | 30% | 50% after deductible | 30% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 30% | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) | 30% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) |
| **Emergency Room** | 30% | | 50%, deductible waived | |
| **Inpatient Hospital Facility** | 30% | 50% after deductible | 30% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | $20 copay | 50% after deductible | $20 copay, deductible waived | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Traditional – HNOption Plans

| Plan Name | NJ Silver HNOption 2000 60/50 | |
|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $2,000 Individual/ $4,000 Family | $5,000 Individual/ $10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/ $12,000 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | $30 copay, deductible waived | 50% after deductible |
| **Specialist Office Visit** | $50 copay, deductible waived | 50% after deductible |
| **Walk-In Clinic Visit** | $30 copay, deductible waived | 50% after deductible |
| **Chiropractic Services** (30 visits per calendar year. In-network and out-of-network combined.) | 25%, deductible waived | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | $0 copay, deductible waived | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | $15 copay, deductible waived | 50% after deductible |
| **Diagnostic Testing: X-ray** | $50 copay, deductible waived | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 50%, deductible waived | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | 40% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 40% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) |
| **Emergency Room** | 50%, deductible waived | |
| **Inpatient Hospital Facility** | 40% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | $20 copay, deductible waived | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Consumer-Directed – HNOption HSA-Compatible Plans

| Plan Name | NJ Silver HNOption 2000 HSA* | | NJ Silver HNOption 2000 90/50 HSA* | |
|---|---|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] | In-network providers | Out-of-network providers[1] |
| **Benefit Year Deductible** | $2,000 Individual/ $4,000 Family | $4,000 Individual/ $8,000 Family | $2,000 Individual/ $4,000 Family | $5,000 Individual/ $10,000 Family |
| **Benefit Year Maximum Out-of-Pocket** | $4,000 Individual/ $8,000 Family | $8,000 Individual/ $16,000 Family | $6,350 Individual/ $12,700 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | $30 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Specialist Office Visit** | $50 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | $30 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per benefit year. In-network and out-of-network combined.) | 25% after deductible | 25% after deductible | 10% after deductible | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | $0 copay, deductible waived | 0%, deductible waived. ($500 maximum per year for ages 1+ or $750 maximum per year from birth until the end of the benefit year in which the child attains age 1.) | 0%, deductible waived | 0%, deductible waived. ($500 maximum per year for ages 1+ or $750 maximum per year from birth until the end of the benefit year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | $15 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | $50 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible | Not applicable | Integrated with medical deductible | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | Rx option 1: $10/$40/$75 after deductible<br>Rx option 2: $20/$50/$75 after deductible | Not covered | $20/$50/$75 after deductible | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | $200 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | $200 copay after deductible | 50% after deductible (Maximum benefit of $2,000 per member per benefit year.) | 10% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per benefit year.) |
| **Emergency Room** | 30% after deductible | | 10% after deductible | |
| **Inpatient Hospital Facility** | $400 copay per day, 5 day copay max per admission, after deductible | 50% after deductible | 10% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per benefit year, PT/OT combined, and 30 visits per benefit year, ST. In-network and out-of-network combined.) | $20 copay after deductible | 50% after deductible | 10% after deductible | 50% after deductible |

*Benefit year: Plans are available on a calendar-year (CY) or plan-year (PY) basis.

Refer to pages 30–31 for important plan provisions.

# Consumer-Directed – HNOption HSA-Compatible Plans

| Plan Name | NJ Bronze HNOption 2500 50/50 HSA* | |
|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] |
| **Benefit Year Deductible** | $2,500 Individual/ $5,000 Family | $5,000 Individual/ $10,000 Family |
| **Benefit Year Maximum Out-of-Pocket** | $6,350 Individual/ $12,700 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | 50% after deductible | 50% after deductible |
| **Specialist Office Visit** | 50% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | 50% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per benefit year. In-network and out-of-network combined.) | 25% after deductible | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived. ($500 maximum per year for ages 1+ or $750 maximum per year from birth until the end of the benefit year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | 50% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | 50% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 50% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | 50% after deductible | Not covered |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Not covered |
| **Outpatient Surgery: Hospital Outpatient Facility** | 50% after deductible | N/A |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 50% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per benefit year.) |
| **Emergency Room** | 50% after deductible | |
| **Inpatient Hospital Facility** | 50% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per benefit year, PT/OT combined, and 30 visits per benefit year, ST. In-network and out-of-network combined.) | 50% after deductible | 50% after deductible |

*Benefit year: Plans are available on a calendar-year (CY) or plan-year (PY) basis.
Refer to pages 30–31 for important plan provisions.

# Traditional – OA EPO Plans

| Plan Name | NJ Gold OAEPO 500D | NJ Gold OAEPO 1500 70% | NJ Silver OAEPO 2000 70% |
|---|---|---|---|
| **Member Benefits** | In-network providers | In-network providers | In-network providers |
| **Calendar Year Deductible** | $0 Individual/<br>$0 Family | $1,500 Individual<br>$3,000 Family | $2,000 Individual/<br>$4,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/<br>$12,000 Family | $3,500 Individual/<br>$7,000 Family | $5,000 Individual/<br>$10,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation**[2] | Non-embedded | Non-embedded | Embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses | Noncovered expenses | Noncovered expenses |
| **Primary Care Physician Office Visit** | $30 copay | $20 copay, deductible waived | 30% after deductible |
| **Specialist Office Visit** | $50 copay | $40 copay, deductible waived | 30% after deductible |
| **Walk-In Clinic Visit** | $30 copay | $20 copay, deductible waived | 30% after deductible |
| **Chiropractic Services**<br>(30 visits per calendar year) | 25% | 25%, deductible waived | 30% after deductible |
| **Preventive Care/Screenings/Immunizations**<br>(Age and frequency schedules may apply.) | $0 copay | $0 copay, deductible waived | 0%, deductible waived |
| **Diagnostic Testing: Lab** | $15 copay | $5 copay, deductible waived | 30% after deductible |
| **Diagnostic Testing: X-ray** | $50 copay | $40 copay, deductible waived | 30% after deductible |
| **Imaging**<br>(CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% | 30%, deductible waived | 30% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]:<br>Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | $10/$40/$75 | $20/$50/$75 |
| **Aetna Specialty CareRx℠ Drugs**[3]<br>(Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs |
| **Outpatient Surgery: Hospital Outpatient Facility** | $500 copay | 30% after deductible | 30% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | $250 copay | 30% after deductible | 30% after deductible |
| **Emergency Room**<br>(Copay is waived if admitted.) | 30% | 30%, deductible waived | $100 copay + 30% after deductible |
| **Inpatient Hospital Facility** | $500 copay per day,<br>5-day copay max per admission | 30% after deductible | 30% after deductible |
| **Rehabilitation Services (PT/OT/ST)**<br>(30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST) | $20 copay | $20 copay, deductible waived | 30% after deductible |

Refer to pages 30–31 for important plan provisions.

# Consumer-Directed – OA EPO HSA-Compatible Plan

| Plan Name | NJ Bronze OAEPO 2500 50% HSA* |
|---|---|
| **Member Benefits** | In-network providers |
| **Benefit Year Deductible** | $2,500 Individual/ $5,000 Family |
| **Benefit Year Maximum Out-of-Pocket** | $6,350 Individual/ $12,700 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation**[2] | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses |
| **Primary Care Physician Office Visit** | 50% after deductible |
| **Specialist Office Visit** | 50% after deductible |
| **Walk-In Clinic Visit** | 50% after deductible |
| **Chiropractic Services** (30 visits per benefit year) | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived |
| **Diagnostic Testing: Lab** | 50% after deductible |
| **Diagnostic Testing: X-ray** | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 50% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | 50% after deductible |
| **Aetna Specialty CareRx℠ Drugs**[3] (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs |
| **Outpatient Surgery: Hospital Outpatient Facility** | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 50% after deductible |
| **Emergency Room** | 50% after deductible |
| **Inpatient Hospital Facility** | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per benefit year, PT/OT combined, and 30 visits per benefit year, ST) | 50% after deductible |

*Benefit year: Plans are available on a calendar-year (CY) or plan-year (PY) basis.
Refer to pages 30–31 for important plan provisions.

# Traditional – Managed Choice (MC) Plan

| Plan Name | NJ Silver MC 2000 70/50 | |
|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $2,000 Individual/ $4,000 Family | $5,000 Individual/ $10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $5,000 Individual/ $10,000 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Embedded | Embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | 30% after deductible | 50% after deductible |
| **Specialist Office Visit** | 30% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | 30% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per calendar year. In-network and out-of-network combined.) | 30% after deductible | 50% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | 30% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | 30% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | 50% |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | |
| **Outpatient Surgery: Hospital Outpatient Facility** | 30% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 30% after deductible | 50% after deductible |
| **Emergency Room** (Copay is waived if admitted.) | $100 copay plus 30% after deductible | |
| **Inpatient Hospital Facility** | 30% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | 30% after deductible | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Traditional – Open Access Managed Choice (OAMC) Plans

| Plan Name | NJ Gold OAMC 100/50 500D | | NJ Silver OAMC 1500 70/50 | |
|---|---|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] | In-network providers | Out-of-network providers[1] |
| **Calendar Year Deductible** | $0 Individual/ $0 Family | $5,000 Individual/ $10,000 Family | $1,500 Individual/ $3,000 Family | $5,000 Individual/ $10,000 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/ $12,000 Family | $10,000 Individual/ $20,000 Family | $6,000 Individual/ $12,000 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | $30 copay | 50% after deductible | $35 copay, deductible waived | 50% after deductible |
| **Specialist Office Visit** | $50 copay | 50% after deductible | $50 copay, deductible waived | 50% after deductible |
| **Walk-In Clinic Visit** | $30 copay | 50% after deductible | $35 copay, deductible waived | 50% after deductible |
| **Chiropractic Services** (30 visits per calendar year. In-network and out-of-network combined.) | 25% | 25% after deductible | 25%, deductible waived | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | $0 copay | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) | $0 copay, deductible waived | 0%, deductible waived. ($500 annual maximum for ages 1+ or $750 annual maximum from birth until the end of the calendar year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | $15 copay | 50% after deductible | $15 copay, deductible waived | 50% after deductible |
| **Diagnostic Testing: X-ray** | $50 copay | 50% after deductible | $50 copay, deductible waived | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 30% | 50% after deductible | 50%, deductible waived | 50% after deductible |
| **Prescription Drug Deductible** | Not applicable | Not applicable | Not applicable | Not applicable |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | $20/$50/$75 | 50% | $20/$50/$75 | 50% |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | | Applicable cost as noted above for generic or brand drugs | |
| **Outpatient Surgery: Hospital Outpatient Facility** | $500 copay | 50% after deductible | 30% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | $250 copay | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) | 30% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per calendar year.) |
| **Emergency Room** | 30% | | 50%, deductible waived | |
| **Inpatient Hospital Facility** | $500 copay per day, 5 day copay max per admission | 50% after deductible | 30% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST. In-network and out-of-network combined.) | $20 copay | 50% after deductible | $20 copay, deductible waived | 50% after deductible |

Refer to pages 30–31 for important plan provisions.

# Consumer-Directed – Open Access Managed Choice (OAMC) HSA-Compatible Plan

| Plan Name | NJ Bronze OAMC 2500 50/50 HSA* | |
|---|---|---|
| **Member Benefits** | In-network providers | Out-of-network providers[1] |
| **Benefit Year Deductible** | $2,500 Individual/ $5,000 Family | $5,000 Individual/ $10,000 Family |
| **Benefit Year Maximum Out-of-Pocket** | $6,350 Individual/ $12,700 Family | $10,000 Individual/ $20,000 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Non-embedded | Non-embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | 50% after deductible | 50% after deductible |
| **Specialist Office Visit** | 50% after deductible | 50% after deductible |
| **Walk-In Clinic Visit** | 50% after deductible | 50% after deductible |
| **Chiropractic Services** (30 visits per benefit year. In-network and out-of-network combined.) | 25% after deductible | 25% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived. ($500 maximum per year for ages 1+ or $750 maximum per year from birth until the end of the benefit year in which the child attains age 1.) |
| **Diagnostic Testing: Lab** | 50% after deductible | 50% after deductible |
| **Diagnostic Testing: X-ray** | 50% after deductible | 50% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 50% after deductible | 50% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible | Integrated with medical deductible |
| **Prescription Drugs** (up to 30-day supply)[3]: Generic drugs/Preferred brand drugs/Non-preferred brand drugs. Two times the 30-day supply cost sharing for up to 90-day supply. | 50% after deductible | 50% after deductible |
| **Aetna Specialty CareRx℠ Drugs[3]** (Self-injectable, infused and oral specialty drugs) | Applicable cost as noted above for generic or brand drugs | |
| **Outpatient Surgery: Hospital Outpatient Facility** | 50% after deductible | 50% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 50% after deductible | 50% after deductible (Maximum benefit of $2,000 per member per benefit year.) |
| **Emergency Room** | 50% after deductible | |
| **Inpatient Hospital Facility** | 50% after deductible | 50% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per benefit year, PT/OT combined, and 30 visits per benefit year, ST. In-network and out-of-network combined.) | 50% after deductible | 50% after deductible |

*Benefit year: Plans are available on a calendar-year (CY) or plan-year (PY) basis.

Refer to pages 30–31 for important plan provisions.

# Traditional – Indemnity Plans

| Plan Name | NJ Gold Indemnity 500 80% | NJ Silver Indemnity 1200 70% |
|---|---|---|
| **Member Benefits** | Out-of-network providers[1] | Out-of-network providers[1] |
| **Calendar Year Deductible** | $500 Individual/ $1,000 Family | $1,200 Individual/ $2,400 Family |
| **Calendar Year Maximum Out-of-Pocket** | $6,000 Individual/ $12,000 Family | $6,350 Individual/ $12,700 Family |
| **Deductible and Maximum Out-of-Pocket Accumulation[2]** | Embedded | Embedded |
| **Not Included In Maximum Out-of-Pocket** | Noncovered expenses, balance-billed charges and failure to precertify penalties | |
| **Primary Care Physician Office Visit** | 20% after deductible | 30% after deductible |
| **Specialist Office Visit** | 20% after deductible | 30% after deductible |
| **Walk-In Clinic Visit** | 20% after deductible | 30% after deductible |
| **Chiropractic Services** (30 visits per calendar year) | 20% after deductible | 30% after deductible |
| **Preventive Care/Screenings/Immunizations** (Age and frequency schedules may apply.) | 0%, deductible waived | 0%, deductible waived |
| **Diagnostic Testing: Lab** | 20% after deductible | 30% after deductible |
| **Diagnostic Testing: X-ray** | 20% after deductible | 30% after deductible |
| **Imaging** (CT, CTA, MRI, MRA, MRS, PET and nuclear medicine, including nuclear cardiology) | 20% after deductible | 30% after deductible |
| **Prescription Drug Deductible** | Integrated with medical deductible | Integrated with medical deductible |
| **Prescription Drugs** | 20% after deductible | 30% after deductible |
| **Aetna Specialty CareRx℠ Drugs** | 20% after deductible | 30% after deductible |
| **Outpatient Surgery: Hospital Outpatient Facility** | 20% after deductible | 30% after deductible |
| **Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility** | 20% after deductible | 30% after deductible |
| **Emergency Room** | $100 copay + 20% after deductible | $100 copay + 30% after deductible |
| **Inpatient Hospital Facility** | 20% after deductible | 30% after deductible |
| **Rehabilitation Services (PT/OT/ST)** (30 visits per calendar year, PT/OT combined, and 30 visits per calendar year, ST) | 20% after deductible | 30% after deductible |

Refer to pages 30–31 for important plan provisions.

# Important plan provisions

**[1]QPOS, HNOption, MC and OAMC plans:**

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays — and what you may have to pay — for your out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "allowed" amount. This amount is a standard amount based on data about what providers charge. A third-party organization compiles that data sent to it by Aetna and other insurers.

Aetna will pay the higher amount of benefits for prosthetic and orthotic appliances. It does not matter if you get this appliance from an in-network or out-of-network provider. We will pay the higher of:

- Aetna's contracted rate with the network provider, or
- The federal Medicare reimbursement schedule

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "allows." Your doctor may bill you for the dollar amount that Aetna doesn't "allow." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "allowed amount" counts toward your deductible or maximum out-of-pocket. To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign in to your Aetna Navigator member site.

This way of paying out-of-network doctors and hospitals applies when you choose to get out-of-network care. When you have no choice, we will pay the bill as if you got in-network care. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

**[1]Indemnity plans:**

Providers* will be paid based on either the "allowed charges" or the provider's actual billed charges for covered services and supplies. The "allowed charge" means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or another state when services or supplies are provided in such state. The maximum allowed charge will be based on the 80$^{th}$ percentile of the PHCS profile.

Aetna reimburses a percentage of the allowed charges for covered services and supplies as defined in the plan. You may have to pay the difference between the provider's billed charge. and the allowed charges, plus any applicable copayment, coinsurance and deductible due under the plan. Note that any amount the provider bills you above allowed charges does not count toward your deductible or maximum out-of-pocket amounts.

*Aetna will pay benefits for prosthetic and orthotic appliances at the same reimbursement rate for such appliances under the federal Medicare reimbursement schedule.

**Note:** Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain prior approval for certain services. For a summary list of limitations and exclusions, refer to page 70. Please refer to Aetna's Producer World® website at **www.aetna.com** for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

[2]**Embedded deductible:** Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the benefit year. No one family member may contribute more than the individual deductible amount to the family deductible. All covered expenses accumulate separately toward the in-network and out-of-network deductibles for QPOS and MC plans.

[2]**Non-embedded deductible:** The individual deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible can be met by a combination of family members or by any single individual within the family. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the benefit year. All covered expenses accumulate separately toward the in-network and out-of-network deductibles for HNOption and OAMC plans.

[2]**Embedded maximum out-of-pocket:** Once the family maximum out-of-pocket is met, all family members will be considered as having met their maximum out-of-pocket for the remainder of the benefit year. No one family member may contribute more than the individual maximum out-of-pocket to the family maximum out-of-pocket. All amounts paid as deductible, copayment and coinsurance for covered medical services and supplies and prescription drugs apply toward the maximum out-of-pocket. All covered expenses accumulate separately toward the in-network and out-of-network maximum out-of-pocket for QPOS and MC plans.

[2]**Non-embedded maximum out-of-pocket:**
The individual maximum out-of-pocket can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family maximum out-of-pocket can be met by a combination of family members or by any single individual within the family. Once the family maximum out-of-pocket is met, all family members will be considered as having met their maximum out-of-pocket for the remainder of the benefit year. All amounts paid as deductible, copayment and coinsurance for covered medical services and supplies and prescription drugs apply toward the maximum out-of-pocket. All covered expenses accumulate separately toward the in-network and out-of-network maximum out-of-pocket for HNOption and OAMC plans.

[3]**Rx plan provisions (all plans, except indemnity plans):**

If a physician prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies “dispense as written” (DAW), the member will pay the cost sharing for the brand-name prescription drug. If a physician does not specify “DAW” and the member requests a covered brand-name prescription drug where a generic prescription drug equivalent is available, the member will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing.

Performance drugs or supplies for the treatment of erectile dysfunction, impotence or sexual dysfunction/inadequacy are not covered.

Transition of coverage for prior authorizations helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group’s initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the Preferred Drug List. Members, who have claims paid for a drug requiring prior authorization during the transition-of-coverage period may continue to receive this drug after the 90 calendar days and will not be required to obtain a prior authorization for this drug.

Preferred generic contraceptives and certain preferred brand contraceptives are covered without member copayment. Certain religious organizations or religious employers may be exempt from offering contraceptive services.

D

# Aetna Dental Plans

Dental coverage is sure to put a smile on an employee's face. Our affordable plan design options make it possible for you to add this valuable benefit to your package.

# Dental
## Overview

### The Mouth Matters℠

Research suggests that serious gum disease, known as periodontitis, may be associated with many health problems. This is especially true if gum disease continues without treatment.[1] Now, here's the good news. Researchers are discovering that a healthy mouth may be important to your overall health.[1]

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

### The Dental Maintenance Organization (DMO®)

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

### 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 covered 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 usual and prevailing 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 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.

### Aetna Dental Preventive Care℠ plan

The Preventive Care plan is a lower cost dental plan that covers preventive and diagnostic procedures. Members pay nothing for these services when visiting an Aetna PPO dentist.

[1]MayoClinic.com. "Oral health: A window to your overall health." **www.mayoclinic.com/health/dental/DE00001** [article online]. February 5, 2011. Accessed August 2013.

*DMI may not be available in all states.

**Dual Option does not apply to preventive plans or Voluntary Dental 3 – 9 size plans

Note: For groups with 25 or more eligible employees, the DMO cannot be sold on a stand-alone basis.

D

# Aetna Small Group Dental Plans 2 – 9

| | **Option 2** | **Option 3 Freedom-of-Choice —** Monthly selection between the DMO and PPO Max | | **Option 4** | **Option 5 Active PPO High–Option Plan** | |
|---|---|---|---|---|---|---|
| | DMO Plan 100/80/50 | DMO Plan 100/90/60 | PPO Max Plan 100/70/40 | PPO Max Plan 100/80/50 | Preferred Plan 100/80/50 | Non-preferred Plan 80/60/40 |
| **Office Visit Copay** | $5 | $5 | None | None | None | None |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | None | None | $50; 3X Family maximum | $50; 3X Family maximum | $50; 3X Family maximum | $50; 3X Family maximum |
| **Annual Maximum Benefit** | None | None | $1,000 | $1,500 | $1,500 | $1,000 |
| **Diagnostic Services** | | | | | | |
| **Oral Exams** | | | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% | 100% | 80% |
| Comprehensive oral exam | 100% | 100% | 100% | 100% | 100% | 80% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% | 100% | 80% |
| **X-rays** | | | | | | |
| Bitewing – single film | 100% | 100% | 100% | 100% | 100% | 80% |
| Complete series | 100% | 100% | 100% | 100% | 100% | 80% |
| **Preventive Services** | | | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% | 100% | 80% |
| Child cleaning | 100% | 100% | 100% | 100% | 100% | 80% |
| Sealants – per tooth | 100% | 100% | 100% | 100% | 100% | 80% |
| Fluoride application – with cleaning | 100% | 100% | 100% | 100% | 100% | 80% |
| Space maintainers | 100% | 100% | 100% | 100% | 100% | 80% |
| **Basic Services** | | | | | | |
| Amalgam filling – 2 surfaces | 80% | 90% | 70% | 80% | 80% | 60% |
| Resin filling – 2 surfaces, anterior | 80% | 90% | 70% | 80% | 80% | 60% |
| **Oral Surgery** | | | | | | |
| Extraction – exposed root or erupted tooth | 80% | 90% | 70% | 80% | 80% | 60% |
| Extraction of impacted tooth – soft tissue | 80% | 90% | 70% | 80% | 80% | 60% |
| **Major Services*** | | | | | | |
| Complete upper denture | 50% | 60% | 40% | 50% | 50% | 40% |
| Crown – Porcelain with noble metal[1] | 50% | 60% | 40% | 50% | 50% | 40% |
| Pontic – Porcelain with noble metal[1] | 50% | 60% | 40% | 50% | 50% | 40% |
| Inlay – Metallic (3 or more surfaces) | 50% | 60% | 40% | 50% | 50% | 40% |
| **Oral Surgery** | | | | | | |
| Removal of impacted tooth – partially bony | 50% | 60% | 40% | 50% | 50% | 40% |
| **Endodontic Services** | | | | | | |
| Bicuspid root canal therapy | 80% | 90% | 40% | 50% | 80% | 60% |
| Molar root canal therapy | 50% | 60% | 40% | 50% | 50% | 40% |
| **Periodontic Services** | | | | | | |
| Scaling and root planing – per quadrant | 80% | 90% | 40% | 50% | 80% | 60% |
| Osseous surgery – per quadrant | 50% | 60% | 40% | 50% | 50% | 40% |
| **Orthodontic Services** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Orthodontic Lifetime Maximum** | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply |

Refer to page 44 for footnotes.

# Aetna Small Group Dental Plans 2 – 9

| | Option 6 | Option 7.1 Preventive Dental | Option 8 Freedom-of-Choice — Monthly selection between the DMO and PPO | | Option 9 | Option 10 |
|---|---|---|---|---|---|---|
| | PPO 1500 Plan 100/80/50 | Preventive/PPO Max 100/0/0 | DMO Plan 100/90/60 | PPO 1500 Plan 100/80/50 | PPO 2000 Plan 100/80/50 | DMO Plan 41 |
| **Office Visit Copay** | None | None | $5 | None | None | $5 |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | $50; 3X Family maximum | None | None | $50; 3X Family maximum | $50; 3X Family maximum | None |
| **Annual Maximum Benefit** | $1,500 | None | None | $1,500 | $2,000 | None |
| **Diagnostic Services** | | | | | | |
| **Oral Exams** | | | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% | 100% | No charge |
| Comprehensive oral exam | 100% | 100% | 100% | 100% | 100% | No charge |
| Problem-focused oral exam | 100% | 100% | 100% | 100% | 100% | No charge |
| **X-rays** | | | | | | |
| Bitewing – single film | 100% | 100% | 100% | 100% | 100% | No charge |
| Complete series | 100% | 100% | 100% | 100% | 100% | No charge |
| **Preventive Services** | | | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% | 100% | No charge |
| Child cleaning | 100% | 100% | 100% | 100% | 100% | No charge |
| Sealants – per tooth | 100% | 100% | 100% | 100% | 100% | $10 |
| Fluoride application – with cleaning | 100% | 100% | 100% | 100% | 100% | No charge |
| Space maintainers | 100% | 100% | 100% | 100% | 100% | $100 |
| **Basic Services** | | | | | | |
| Amalgam filling – 2 surfaces | 80% | Not covered | 90% | 80% | 80% | $32 |
| Resin filling – 2 surfaces, anterior | 80% | Not covered | 90% | 80% | 80% | $55 |
| **Oral Surgery** | | | | | | |
| Extraction – exposed root or erupted tooth | 80% | Not covered | 90% | 80% | 80% | $30 |
| Extraction of impacted tooth – soft tissue | 80% | Not covered | 90% | 80% | 80% | $80 |
| **Major Services*** | | | | | | |
| Complete upper denture | 50% | Not covered | 60% | 50% | 50% | $500 |
| Crown – Porcelain with noble metal[1] | 50% | Not covered | 60% | 50% | 50% | $513 |
| Pontic – Porcelain with noble metal[1] | 50% | Not covered | 60% | 50% | 50% | $488 |
| Inlay – Metallic (3 or more surfaces) | 50% | Not covered | 60% | 50% | 50% | $463 |
| **Oral Surgery** | | | | | | |
| Removal of impacted tooth – partially bony | 50% | Not covered | 60% | 50% | 80% | $175 |
| **Endodontic Services** | | | | | | |
| Bicuspid root canal therapy | 50% | Not covered | 90% | 50% | 80% | $195 |
| Molar root canal therapy | 50% | Not covered | 60% | 50% | 80% | $435 |
| **Periodontic Services** | | | | | | |
| Scaling and root planing – per quadrant | 50% | Not covered | 90% | 50% | 80% | $65 |
| Osseous surgery – per quadrant | 50% | Not covered | 60% | 50% | 80% | $445 |
| **Orthodontic Services** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Orthodontic Lifetime Maximum** | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply |

Refer to page 44 for footnotes.

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# Aetna Small Group Voluntary Dental Plans 3 – 9

| | **Voluntary Option 2** | **Option 3 Freedom-of-Choice —** Monthly selection between the DMO and PPO Max | | **Voluntary Option 4** | **Voluntary Option 5** | **Voluntary Option V7.1 Preventive Dental** |
|---|---|---|---|---|---|---|
| | DMO Plan 100/80/50 | DMO Plan 100/90/60 | PPO Max Plan 100/70/40 | PPO Max Plan 100/80/50 | DMO Plan 41 | Preventive/PPO Max 100/0/0 |
| **Office Visit Copay** | $10 | $10 | N/A | N/A | $10 | N/A |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | None | None | $75; 3X Family maximum | $75; 3X Family maximum | None | N/A |
| **Annual Maximum Benefit** | None | None | $1,000 | $1,500 | None | Unlimited |
| **Diagnostic Services** | | | | | | |
| **Oral Exams** | | | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% | No charge | 100% |
| Comprehensive oral exam | 100% | 100% | 100% | 100% | No charge | 100% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% | No charge | 100% |
| **X-rays** | | | | | | |
| Bitewing – single film | 100% | 100% | 100% | 100% | No charge | 100% |
| Complete series | 100% | 100% | 100% | 100% | No charge | 100% |
| **Preventive Services** | | | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% | No charge | 100% |
| Child cleaning | 100% | 100% | 100% | 100% | No charge | 100% |
| Sealants – per tooth | 100% | 100% | 100% | 100% | $10 | 100% |
| Fluoride application – with cleaning | 100% | 100% | 100% | 100% | No charge | 100% |
| Space maintainers | 100% | 100% | 100% | 100% | $100 | 100% |
| **Basic Services** | | | | | | |
| Amalgam fillings | 80% | 90% | 70% | 80% | $32 | Not covered |
| Resin fillings, anterior | 80% | 90% | 70% | 80% | $55 | Not covered |
| **Oral Surgery** | | | | | | |
| Extraction – exposed root or erupted tooth | 80% | 90% | 70% | 80% | $30 | Not covered |
| Extraction of impacted tooth – soft tissue | 80% | 90% | 70% | 80% | $80 | Not covered |
| **Major Services*** | | | | | | |
| Complete upper denture | 50% | 60% | 40% | 50% | $500 | Not covered |
| Partial upper denture (resin base) | 50% | 60% | 40% | 50% | $513 | Not covered |
| Crown – Porcelain with noble metal[1] | 50% | 60% | 40% | 50% | $488 | Not covered |
| Pontic – Porcelain with noble metal[1] | 50% | 60% | 40% | 50% | $488 | Not covered |
| Inlay – Metallic (3 or more surfaces) | 50% | 60% | 40% | 50% | $463 | Not covered |
| **Oral Surgery** | | | | | | |
| Removal of impacted tooth – partially bony | 50% | 60% | 40% | 50% | $175 | Not covered |
| **Endodontic Services** | | | | | | |
| Bicuspid root canal therapy | 80% | 90% | 40% | 50% | $195 | Not covered |
| Molar root canal therapy | 50% | 60% | 40% | 50% | $435 | Not covered |
| **Periodontic Services** | | | | | | |
| Scaling and root planing – per quadrant | 80% | 90% | 40% | 50% | $65 | Not covered |
| Osseous surgery – per quadrant | 50% | 60% | 40% | 50% | $445 | Not covered |
| **Orthodontic Services** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Orthodontic Lifetime Maximum** | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply |

Refer to page 44 for footnotes.

# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | Option 1A DMO Fixed Copay 42 | Option 1B DMO Fixed Copay 53 | Option 2A DMO 100/80/50 | Option 3A DMO Fixed Copay 64 | Option 4A DMO 100/100/60 | Option 4B DMO 100/100/60 B |
|---|---|---|---|---|---|---|
| | Plan code 42 | Plan code 53 | DMO Plan 100/80/50 | Plan code 64 | DMO Plan 100/100/60 | DMO Plan 100/100/60 |
| **Office Visit Copay** | $5 | $5 | $5 | $5 | $5 | $5 |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | None | None | None | None | None | None |
| **Annual Maximum Benefit** | None | None | None | None | None | None |
| **Diagnostic Services** | | | | | | |
| **Oral Exams** | | | | | | |
| Periodic oral exam | No charge | No charge | 100% | No charge | 100% | 100% |
| Comprehensive oral exam | No charge | No charge | 100% | No charge | 100% | 100% |
| Problem-focused oral exam | No charge | No charge | 100% | No charge | 100% | 100% |
| **X-rays** | | | | | | |
| Bitewing – single film | No charge | No charge | 100% | No charge | 100% | 100% |
| Complete series | No charge | No charge | 100% | No charge | 100% | 100% |
| **Preventive Services** | | | | | | |
| Adult cleaning | No charge | $8 | 100% | No charge | 100% | 100% |
| Child cleaning | No charge | $7 | 100% | No charge | 100% | 100% |
| Sealants – per tooth | $10 | $8 | 100% | No charge | 100% | 100% |
| Fluoride application | No charge | No charge | 100% | No charge | 100% | 100% |
| Space maintainers (fixed) | $100 | $65 | 100% | $75 | 100% | 100% |
| **Basic Services** | | | | | | |
| Amalgam filling – 2 surfaces | $32 | $24 | 80% | $12 | 100% | 100% |
| Resin filling – 2 surfaces, anterior | $55 | $35 | 80% | $21 | 100% | 100% |
| **Endodontic Services** | | | | | | |
| Bicuspid root canal therapy | $195 | $140 | 80% | $109 | 100% | 100% |
| **Periodontic Services** | | | | | | |
| Scaling and root planing – per quadrant | $65 | $50 | 80% | $51 | 100% | 100% |
| **Oral Surgery** | | | | | | |
| Extraction – exposed root or erupted tooth | $30 | $15 | 80% | $11 | 100% | 100% |
| Extraction of impacted tooth – soft tissue | $80 | $60 | 80% | $46 | 100% | 100% |
| **Major Services*** | | | | | | |
| Complete upper denture | $500 | $300 | 50% | $275 | 60% | 60% |
| Crown – Porcelain with noble metal[1] | $488 | $260 | 50% | $255 | 60% | 60% |
| Pontic – Porcelain with noble metal[1] | $488 | $260 | 50% | $255 | 60% | 60% |
| Inlay – Metallic (3 or more surfaces) | $463 | $220 | 50% | $195 | 60% | 60% |
| **Oral Surgery** | | | | | | |
| Removal of impacted tooth – partially bony | 175** | $72 | 50% | $58 | 60% | 60% |
| **Endodontic Services** | | | | | | |
| Molar root canal therapy | 435** | $260 | 50% | $280 | 60% | 60% |
| **Periodontic Services** | | | | | | |
| Osseous surgery – per quadrant | $445** | $325 | 50% | $300 | 60% | 60% |
| **Orthodontic Services** (Optional)* | $2,300 copay | $2,300 copay | $2,300 copay | $2,300 copay | $2,300 copay | $1,750 copay |
| **Orthodontic Lifetime Maximum** | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply |

Refer to page 45 for footnotes.

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# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | **Option 5A DMO Fixed Copay 56** | **Option 6A Freedom-of-Choice – PPO Max Low —** Monthly selection between the DMO and PPO Max | | **Option 7A Freedom-of-Choice – PPO Max High —** Monthly selection between the DMO and PPO Max | |
|---|---|---|---|---|---|
| | Plan code 56 | DMO Plan 100/90/60 | PPO Max Plan 100/70/40 | DMO Plan 100/100/60 | PPO Max Plan 100/80/50 |
| **Office Visit Copay** | $5 | $5 | None | $5 | None |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | None | None | $50; 3X family maximum | None | $50; 3X family maximum |
| **Annual Maximum Benefit** | None | None | $1,000 | None | $1,000 |
| **Diagnostic Services** | | | | | |
| **Oral Exams** | | | | | |
| Periodic oral exam | No charge | 100% | 100% | 100% | 100% |
| Comprehensive oral exam | No charge | 100% | 100% | 100% | 100% |
| Problem-focused oral exam | No charge | 100% | 100% | 100% | 100% |
| **X-rays** | | | | | |
| Bitewing – single film | No charge | 100% | 100% | 100% | 100% |
| Complete series | No charge | 100% | 100% | 100% | 100% |
| **Preventive Services** | | | | | |
| Adult cleaning | No charge | 100% | 100% | 100% | 100% |
| Child cleaning | No charge | 100% | 100% | 100% | 100% |
| Sealants – per tooth | No charge | 100% | 100% | 100% | 100% |
| Fluoride application | No charge | 100% | 100% | 100% | 100% |
| Space maintainers (Fixed) | No charge | 100% | 100% | 100% | 100% |
| **Basic Services** | | | | | |
| Amalgam filling – 2 surfaces | No charge | 90% | 70% | 100% | 80% |
| Resin filling – 2 surfaces, anterior | No charge | 90% | 70% | 100% | 80% |
| **Endodontic Services** | | | | | |
| Bicuspid root canal therapy | No charge | 90% | 70% | 100% | 80% |
| **Periodontic Services** | | | | | |
| Scaling and root planing – per quadrant | $25 | 90% | 70% | 100% | 80% |
| **Oral Surgery** | | | | | |
| Extraction – exposed root or erupted tooth | No charge | 90% | 70% | 100% | 80% |
| Extraction of impacted tooth – soft tissue | No charge | 90% | 70% | 100% | 80% |
| **Major Services*** | | | | | |
| Complete upper denture | $185 | 60% | 40% | 60% | 50% |
| Crown – Porcelain with noble metal[1] | $150 | 60% | 40% | 60% | 50% |
| Pontic – Porcelain with noble metal[1] | $150 | 60% | 40% | 60% | 50% |
| Inlay – Metallic (3 or more surfaces) | $150 | 60% | 40% | 60% | 50% |
| **Oral Surgery** | | | | | |
| Removal of impacted tooth – partially bony | $45 | 60% | 40% | 60% | 50% |
| **Endodontic Services** | | | | | |
| Molar root canal therapy | $125 | 60% | 40% | 60% | 50% |
| **Periodontic Services** | | | | | |
| Osseous surgery – per quadrant | $140 | 60% | 40% | 60% | 50% |
| **Orthodontic Services** (Optional)* | $2,300 copay | $2,300 copay | 40% | $2,300 copay | 50% |
| **Orthodontic Lifetime Maximum** | Does not apply | Does not apply | $1,000 | Does not apply | $1,000 |

Refer to page 45 for footnotes.

# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | **Option 8A Freedom-of-Choice – PPO Low 80th —** Monthly selection between the DMO and PPO | | **Option 9A Freedom-of-Choice – PPO 1000 80th —** Monthly selection between the DMO and PPO | | **Option 10A Freedom-of-Choice – PPO 2000 80th —** Monthly selection between the DMO and PPO | |
|---|---|---|---|---|---|---|
| | DMO Plan 100/100/60 | PPO Plan 100/80/50 | Plan code 56 | PPO Plan 100/80/50 | DMO Plan 100/100/60 | PPO Plan 100/80/50 |
| **Office Visit Copay** | $5 | None | $5 | None | $5 | None |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | None | $50; 3X family maximum | None | $50; 3X family maximum | None | $50; 3X family maximum |
| **Annual Maximum Benefit** | None | $1,000 | None | $1,000 | None | $2,000 |
| **Diagnostic Services** | | | | | | |
| **Oral Exams** | | | | | | |
| Periodic oral exam | 100% | 100% | No charge | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | No charge | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | No charge | 100% | 100% | 100% |
| **X-rays** | | | | | | |
| Bitewing – single film | 100% | 100% | No charge | 100% | 100% | 100% |
| Complete series | 100% | 100% | No charge | 100% | 100% | 100% |
| **Preventive Services** | | | | | | |
| Adult cleaning | 100% | 100% | No charge | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | No charge | 100% | 100% | 100% |
| Sealants – per tooth | 100% | 100% | No charge | 100% | 100% | 100% |
| Fluoride application | 100% | 100% | No charge | 100% | 100% | 100% |
| Space maintainers (fixed) | 100% | 100% | No charge | 100% | 100% | 100% |
| **Basic Services** | | | | | | |
| Amalgam filling – 2 surfaces | 100% | 80% | No charge | 80% | 100% | 80% |
| Resin filling – 2 surfaces, anterior | 100% | 80% | No charge | 80% | 100% | 80% |
| **Endodontic Services** | | | | | | |
| Bicuspid root canal therapy | 100% | 80% | No charge | 80% | 100% | 80% |
| **Periodontic Services** | | | | | | |
| Scaling and root planing – per quadrant | 100% | 80% | $25 | 80% | 100% | 80% |
| **Oral Surgery** | | | | | | |
| Extraction – exposed root or erupted tooth | 100% | 80% | No charge | 80% | 100% | 80% |
| Extraction of impacted tooth – soft tissue | 100% | 80% | No charge | 80% | 100% | 80% |
| **Major Services*** | | | | | | |
| Complete upper denture | 60% | 50% | $185 | 50% | 60% | 50% |
| Crown – Porcelain with noble metal[1] | 60% | 50% | $150 | 50% | 60% | 50% |
| Pontic – Porcelain with noble metal[1] | 60% | 50% | $150 | 50% | 60% | 50% |
| Inlay – Metallic (3 or more surfaces) | 60% | 50% | $150 | 50% | 60% | 50% |
| **Oral Surgery** | | | | | | |
| Removal of impacted tooth – partially bony | 60% | 50% | $45 | 50% | 60% | 80% |
| **Endodontic Services** | | | | | | |
| Molar root canal therapy | 60% | 50% | $125 | 50% | 60% | 80% |
| **Periodontic Services** | | | | | | |
| Osseous surgery – per quadrant | 60% | 50% | $140 | 50% | 60% | 80% |
| **Orthodontic Services** (Optional)* | $2,300 copay | 50% | $2,300 copay | 50% | $2,300 copay | 50% |
| **Orthodontic Lifetime Maximum** | Does not apply | $1,000 | Does not apply | $1,000 | Does not apply | $1,000 |

Refer to page 45 for footnotes.

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# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | Option 11A PPO Max 1500 | Option 11B PPO Max 1500 Plus | Option 11C PPO Max 1000 | Option 12A PPO 1000 80th |
|---|---|---|---|---|
| | PPO Max 1500 Plan 100/80/50 | PPO Max 1500 Plan 100/80/50 | PPO Max 1000 Plan 100/80/50 | PPO 1000 Plan 100/80/50 |
| **Office Visit Copay** | None | None | None | None |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum |
| **Annual Maximum Benefit** | $1,500 | $1,500 | $1,000 | $1,000 |
| **Diagnostic Services** | | | | |
| **Oral Exams** | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% |
| **X-rays** | | | | |
| Bitewing – single film | 100% | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% | 100% |
| **Preventive Services** | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% | 100% |
| Sealants – per tooth | 100% | 100% | 100% | 100% |
| Fluoride application | 100% | 100% | 100% | 100% |
| Space maintainers (Fixed) | 100% | 100% | 100% | 100% |
| **Basic Services** | | | | |
| Amalgam filling – 2 surfaces | 80% | 80% | 80% | 80% |
| Resin filling – 2 surfaces, anterior | 80% | 80% | 80% | 80% |
| **Endodontic Services** | | | | |
| Bicuspid root canal therapy | 80% | 80% | 80% | 80% |
| **Periodontic Services** | | | | |
| Scaling and root planing – per quadrant | 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% |
| 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% | 80% | 80% |
| **Endodontic Services** | | | | |
| Molar root canal therapy | 50% | 50% | 80% | 80% |
| **Periodontic Services** | | | | |
| Osseous surgery – per quadrant | 50% | 50% | 80% | 80% |
| **Orthodontic Services** (Optional)* | 50% | 50% | 50% | 50% |
| **Orthodontic Lifetime Maximum** | $1,000 | $1,000 | $1,000 | $1,000 |

Refer to page 45 for footnotes.

# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | **Option 12B PPO 1000 90th** | **Option 13A PPO 1500 80th** | **Option 13B PPO 1500 80th Plus** | **Option 13C PPO 1500 90th** |
|---|---|---|---|---|
| | PPO 1000 Plan 100/80/50 | PPO 1500 Plan 100/80/50 | PPO 1500 Plan 100/80/50 | PPO 1500 Plan 100/80/50 |
| **Office Visit Copay** | None | None | None | None |
| **Annual Deductible per Member** (does not apply to diagnostic and 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% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% |
| **X-rays** | | | | |
| Bitewing – single film | 100% | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% | 100% |
| **Preventive Services** | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% | 100% |
| Sealants – per tooth | 100% | 100% | 100% | 100% |
| Fluoride application | 100% | 100% | 100% | 100% |
| Space maintainers (Fixed) | 100% | 100% | 100% | 100% |
| **Basic Services** | | | | |
| Amalgam filling – 2 surfaces | 80% | 80% | 80% | 80% |
| Resin filling – 2 surfaces, anterior | 80% | 80% | 80% | 80% |
| **Endodontic Services** | | | | |
| Bicuspid root canal therapy | 80% | 80% | 80% | 80% |
| **Periodontic Services** | | | | |
| Scaling and root planing – per quadrant | 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% |
| 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 | 80% | 80% | 80% | 80% |
| **Endodontic Services** | | | | |
| Molar root canal therapy | 80% | 80% | 80% | 80% |
| **Periodontic Services** | | | | |
| Osseous surgery – per quadrant | 80% | 80% | 80% | 80% |
| **Orthodontic Services** (Optional)* | 50% | 50% | 50% | 50% |
| **Orthodontic Lifetime Maximum** | $1,000 | $1,000 | $1,000 | $1,000 |

Refer to page 45 for footnotes.

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# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | **Option 14A PPO 2000 90th** | **Option 15A Active PPO 80th A** | | **Option 15B Active PPO 80th B** | |
|---|---|---|---|---|---|
| | PPO 2000 Plan 100/80/50 | Preferred Plan 100/80/50 | Non-preferred Plan 80/60/50 | Preferred Plan 100/80/50 | Non-preferred Plan 80/60/50 |
| **Office Visit Copay** | None | N/A | N/A | N/A | N/A |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum |
| **Annual Maximum Benefit** | $2,000 | $1,500 | $1,000 | $1,500 | $1,000 |
| **Diagnostic Services** | | | | | |
| **Oral Exams** | | | | | |
| Periodic oral exam | 100% | 100% | 80% | 100% | 80% |
| Comprehensive oral exam | 100% | 100% | 80% | 100% | 80% |
| Problem-focused oral exam | 100% | 100% | 80% | 100% | 80% |
| **X-rays** | | | | | |
| Bitewing – single film | 100% | 100% | 80% | 100% | 80% |
| Complete series | 100% | 100% | 80% | 100% | 80% |
| **Preventive Services** | | | | | |
| Adult cleaning | 100% | 100% | 80% | 100% | 80% |
| Child cleaning | 100% | 100% | 80% | 100% | 80% |
| Sealants – per tooth | 100% | 100% | 80% | 100% | 80% |
| Fluoride application | 100% | 100% | 80% | 100% | 80% |
| Space maintainers (Fixed) | 100% | 100% | 80% | 100% | 80% |
| **Basic Services** | | | | | |
| Amalgam filling – 2 surfaces | 80% | 80% | 60% | 80% | 60% |
| Resin filling – 2 surfaces, anterior | 80% | 80% | 60% | 80% | 60% |
| **Endodontic Services** | | | | | |
| Bicuspid root canal therapy | 80% | 80% | 60% | 80% | 60% |
| **Periodontic Services** | | | | | |
| Scaling and root planing – per quadrant | 80% | 80% | 60% | 80% | 60% |
| **Oral Surgery** | | | | | |
| Extraction – exposed root or erupted tooth | 80% | 80% | 60% | 80% | 60% |
| Extraction of impacted tooth – soft tissue | 80% | 80% | 60% | 80% | 60% |
| **Major Services*** | | | | | |
| Complete upper denture | 50% | 50% | 50% | 50% | 50% |
| Crown – Porcelain with noble metal[1] | 50% | 50% | 50% | 50% | 50% |
| Pontic – Porcelain with noble metal[1] | 50% | 50% | 50% | 50% | 50% |
| Inlay – Metallic (3 or more surfaces) | 50% | 50% | 50% | 50% | 50% |
| **Oral Surgery** | | | | | |
| Removal of impacted tooth – partially bony | 80% | 80% | 60% | 80% | 60% |
| **Endodontic Services** | | | | | |
| Molar root canal therapy | 80% | 80% | 60% | 80% | 60% |
| **Periodontic Services** | | | | | |
| Osseous surgery – per quadrant | 80% | 80% | 60% | 80% | 60% |
| **Orthodontic Services** (Optional)* | 50% | 50% | 50% | 50% | 50% |
| **Orthodontic Lifetime Maximum** | $1,500 | $1,000 | $1,000 | $1,500 | $1,500 |

Refer to page 45 for footnotes.

# Aetna Standard and Voluntary Dental Plan Selections 10–50

| | **Option 16A Active PPO 1500 80th A** | | **Option 16B Active PPO 1500 80th B** | |
|---|---|---|---|---|
| | Preferred Plan 100/80/50 | Non-preferred Plan 80/60/50 | Preferred Plan 100/80/50 | Non-preferred Plan 80/60/50 |
| **Office Visit Copay** | N/A | N/A | N/A | N/A |
| **Annual Deductible per Member** (does not apply to diagnostic and preventive services) | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum | $50; 3X family maximum |
| **Annual Maximum Benefit** | $1,500 | $1,500 | $1,500 | $1,500 |
| **Diagnostic Services** | | | | |
| **Oral Exams** | | | | |
| Periodic oral exam | 100% | 80% | 100% | 80% |
| Comprehensive oral exam | 100% | 80% | 100% | 80% |
| Problem-focused oral exam | 100% | 80% | 100% | 80% |
| **X-rays** | | | | |
| Bitewing – single film | 100% | 80% | 100% | 80% |
| Complete series | 100% | 80% | 100% | 80% |
| **Preventive Services** | | | | |
| Adult cleaning | 100% | 80% | 100% | 80% |
| Child cleaning | 100% | 80% | 100% | 80% |
| Sealants – per tooth | 100% | 80% | 100% | 80% |
| Fluoride application | 100% | 80% | 100% | 80% |
| Space maintainers (Fixed) | 100% | 80% | 100% | 80% |
| **Basic Services** | | | | |
| Amalgam filling – 2 surfaces | 80% | 60% | 80% | 60% |
| Resin filling – 2 surfaces, anterior | 80% | 60% | 80% | 60% |
| **Endodontic Services** | | | | |
| Bicuspid root canal therapy | 80% | 60% | 80% | 60% |
| **Periodontic Services** | | | | |
| Scaling and root planing – per quadrant | 80% | 60% | 80% | 60% |
| **Oral Surgery** | | | | |
| Extraction – exposed root or erupted tooth | 80% | 60% | 80% | 60% |
| Extraction of impacted tooth – soft tissue | 80% | 60% | 80% | 60% |
| **Major Services*** | | | | |
| Complete upper denture | 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 | 80% | 60% | 80% | 60% |
| **Endodontic Services** | | | | |
| Molar root canal therapy | 80% | 60% | 80% | 60% |
| **Periodontic Services** | | | | |
| Osseous surgery – per quadrant | 80% | 60% | 80% | 60% |
| **Orthodontic Services** (Optional)* | 50% | 50% | 50% | 50% |
| **Orthodontic Lifetime Maximum** | $1,000 | $1,000 | $1,500 | $1,500 |

Refer to page 45 for footnotes.

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# Dental plans
## Footnotes

### Aetna Small Group dental plans 2 – 9

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan option 10.

Fixed dollar copay amounts on the DMO in plan options 2, 3, 8 and 10 are the member's responsibility.

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in plan options 2, 3, 8 and 10 or the PPO in plan option 7.1.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 2, 3, 8 and 10 and the PPO in plan option 5. All oral surgery, endodontic and periodontic services are covered as basic services on PPO in plan option 9.

The DMO in plan options 2 and 10 can be offered with any of the PPO plans in plan options 4 – 6 and 9 in a Dual Option package.

For plan options 3, 4 and 7.1 (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.

Out-of-network plan payments are limited by geographic area on plan options 5, 6 and 8 to the prevailing fees at the 80$^{th}$ percentile and the 90$^{th}$ percentile on plan option 9.

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 70.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

### Aetna voluntary Small Group dental plans 3 – 9

*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in voluntary plan options 2, 3 and 5 or the PPO in plan option V7.1.

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in voluntary option 5.

Fixed dollar copay amounts on the DMO in voluntary options 2, 3 and 5 are the member's responsibility.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in voluntary plan options 2, 3 and 5.

For voluntary plan options 3, 4 and V7.1( 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.

Voluntary Dual Option plans are not available.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 70.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

## Aetna standard and voluntary dental plans 10 – 50

### Voluntary plans

*Coverage waiting period applies to voluntary PPO plans: 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 DMO or standard plans.

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.

### Standard and voluntary plans:

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

[1]There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures for the DMO in plan options 1A, 1B, 3A, 5A and 9A.

Fixed dollar copay amounts on the DMO, including office visit and ortho copays, are the member responsibility in plan options 1A, 1B, 2A – 4A, 4B, 5A – 10A.

Note: For New Jersey groups with 25 or more eligible employees, the DMO in plan options 1A, 1B, 2A – 4A, 4B and 5A cannot be sold on a stand-alone basis to a customer with primary business location in New Jersey. It must be part of a Dual Option sale packaged with one of the PPO plans in plan options 11A, 11B, 11C, 12A, 12B, 13A, 13B, 13C, 14A – 16A and 16B. For groups with fewer than 25 eligible employees, the DMO in plan options 1A, 1B, 2A – 4A, 4B and 5A can be offered with any of the PPO plans in plan options 11A, 11B, 11C, 12A, 12B, 13A, 13B, 13C, 14A – 16A and 16B in a Dual Option package.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 1A – 10A, and on the PPO in plan options 6A – 9A and 11A/B. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan option 13A/B. General anesthesia along with all oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan options 10A, 12A and 14A.

Coverage for Implants is included as a major service on the PPO in plan options 10A and 14A.

Out-of-network plan payments are limited by geographic area on the PPO in plan options 8A – 10A, 12A and 13A, 13B, 15A, 15B, 16A and 16B to the prevailing fees at the 80$^{th}$ percentile and the 90$^{th}$ percentile on plan options 12B, 13C and 14A.

For plan options 6A, 7A, 11A, 11B and 11C (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.

For plan options 11B and 13B: The calendar year maximum does not apply to preventive services.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Orthodontic coverage is available for dependent children only.

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 70.

# Aetna Life & Disability

With Aetna as your insurer, you can round out your employee benefits package with even more coverage. Our group life and disability is an affordable way to offer your employees — and their families — the extra financial protection of life insurance and disability benefits.

# Life & Disability
## Overview

**For groups of 2 to 50**, Aetna Life Insurance Company (Aetna) Small Group packaged life and disability insurance plans include a range of flat-dollar insurance options bundled together in one monthly per-employee rate. These products are easy to understand and offer affordable benefits to help your employees protect their families in the event of illness, injury or death. You'll benefit from streamlined plan installation, administration and claims processing, and all of the benefits of our stand-alone life and disability products for small groups. Or, simply choose from our portfolio of group basic term life and disability insurance plans.

### Life insurance

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

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

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

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

#### Giving you (and your employees) what you want

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

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

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

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

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

#### Our fresh approach to life

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

L&D

## AD&D Ultra®

AD&D Ultra is standardly included with our small group term life plans and in our packaged life and disability plans, and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. This includes extra benefits at no additional cost to your members, such as coverage for education or child care expenses, that make this protection even more valuable.

Covered losses include:

- Death
- Dismemberment
- Loss of sight
- Loss of speech
- Loss of hearing
- Third-degree burns
- Paralysis
- Coma
- Total disability
- Exposure and disappearance

Extra benefits for the following:

- Passenger restraint use and airbag deployment*
- Education assistance for dependent child and/or spouse*
- Child care*
- Repatriation of mortal remains*

## Disability insurance

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

Our in-depth approach to disability helps give us a clear understanding of what you and your employees need — and then helps meet those needs. You'll get the right resources, the right support and the right care for your employees at the right time:

- Our clinically based disability model ensures claims and duration guidelines are fact-based with objective benchmarks.
- We offer a holistic approach that takes the whole person into account.
- We give you 24-hour access to claims information.
- We provide return-to-work programs to help ensure employees are back to work as soon as it's medically safe to do so.
- We employ vocational rehabilitation and ergonomic specialists who can help restore employees back to health and productive employment.

## Integrated health and disability

With our Integrated Health and Disability program, we can link medical and disability data to help anticipate concerns, take action and get your employees back to work sooner:

- Predictive modeling identifies medical members most likely to experience a disability, potentially preventing a disability from occurring or minimizing the impact for better outcomes.
- The program is compliant with the Health Insurance Portability and Accountability Act (HIPAA) so medical and disability staff can share clinical information and work jointly with the employee to help address medical and disability issues.
- Referrals between health case managers and their disability counterparts help ensure better consistency and integration.
- The Integrated Health and Disability program is available at no additional cost when a member has both medical and disability coverage from Aetna.

For a summary list of limitations and exclusions, refer to pages 70–71.

*Only available if insured loses life.

Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

# Term Life Plan Options

| | 2–9 Employees | 10–50 Employees |
|---|---|---|
| **Basic Life Schedule** | Flat $10,000, $15,000, $20,000, $50,000 | Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000 |
| **Class Schedules** | Not available | Up to 3 classes (with a minimum requirement of 3 employees in each class) — the benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class |
| **Premium Waiver Provision** | Premium Waiver 60 | Premium Waiver 60 |
| **Age Reduction Schedule** | Original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75 | Original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75 |
| **Accelerated Death Benefit** | Up to 75% of life amount for terminal illness | Up to 75% of life amount for terminal illness |
| **Guaranteed Issue** | $20,000 | 10–25 employees $75,000<br>26–50 employees $100,000 |
| **Participation Requirements** | 100% | 100% on non-contributory plans;<br>75% on contributory plans |
| **Contribution Requirements** | 100% employer contribution | Minimum 50% employer contribution |
| **AD&D Ultra®** | | |
| **AD&D Ultra Schedule** | Matches life benefit | Matches life benefit |
| **AD&D Ultra Extra Benefits** | Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains. | Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains. |
| **Optional Dependent Term Life** | | |
| **Spouse Amount** | Not available | $5,000 |
| **Child Amount** | Not available | $2,000 |

L&D

# Packaged Life and Disability Plan Options

| Basic Life Plan Design | Low Option | Medium Option | High Option |
|---|---|---|---|
| **Benefit** | Flat $10,000 | Flat $20,000 | Flat $50,000 |
| **Guaranteed Issue** | | | |
| **2–9 Lives** | $10,000 | $20,000 | $20,000 |
| **10–50 Lives** | $10,000 | $20,000 | $50,000 |
| **Reduction Schedule** | Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75 | Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75 | Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75 |
| **Disability Provision** | Premium Waiver 60 | Premium Waiver 60 | Premium Waiver 60 |
| **Conversion** | Included | Included | Included |
| **Accelerated Death Benefit** | Up to 75% of benefit; 24-month acceleration | Up to 75% of benefit; 24-month acceleration | Up to 75% of benefit; 24-month acceleration |
| **Dependent Life** | Spouse $5,000; Child $2,000 | Spouse $5,000; Child $2,000 | Spouse $5,000; Child $2,000 |
| **AD&D Ultra®** | | | |
| **AD&D Ultra® Schedule** | Matches basic life benefit | Matches basic life benefit | Matches basic life benefit |
| **AD&D Ultra® Extra Benefits** | Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains. | | |
| **Disability Plan Design** | | | |
| **Monthly Benefit** | Flat $500; No offsets | Flat $1,000; Offsets are workers' compensation, any state disability plan, and primary and family social security benefits. | |
| **Elimination Period** | 30 days | 30 days | 30 days |
| **Definition of Disability** | Own occupation: Earnings loss of 20% or more. | Own occupation: Earnings loss of 20% or more. | First 24 months of benefits: Own occupation: Earnings loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss. |
| **Benefit Duration** | 24 months | 24 months | 60 months |
| **Pre-Existing Condition Limitation** | 3/12 | 3/12 | 3/12 |
| **Types of Disability** | Occupational & non-occupational | Occupational & non-occupational | Occupational & non-occupational |
| **Separate Periods of Disability** | 15 days during elimination period 6 months thereafter | 15 days during elimination period 6 months thereafter | 15 days during elimination period 6 months thereafter |
| **Mental Health/Substance Abuse** | Duration same as all other conditions | Duration same as all other conditions | Duration same as all other conditions |
| **Waiver of Premium** | Included | Included | Included |
| **Other Plan Provisions** | | | |
| **Eligibility** | Active full-time employees | Active full-time employees | Active full-time employees |
| **Rate Guarantee** | 1 year | 1 year | 1 year |
| **Rates PEPM** | $8.00 | $15.00 | $27.00 |

# Underwriting guidelines

In business, nothing is more critical to success than the health and well-being of employees.

# Underwriting guidelines

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

Note: State and federal legislation/regulations, including Small Group Reform and ACA, take precedence over any and all underwriting rules. Exceptions to underwriting rules require approval of the regional underwriting manager. This information is the property of Aetna and its affiliates ("Aetna"), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing. All underwriting guidelines below are subject to change without notice.

| | |
|---|---|
| **Case Submission Dates** | • New business case submissions must be received by Aetna on the 25th of the previous month for 1st of the month effective dates and by the 10th of the month for 15th of the month effective dates.<br>• Any case received after the cut-off date will be considered on an exception basis only, as approved by the Underwriting Unit manager. If not approved, the effective date will be moved to the next available effective date with potential rate impact. |
| **Census Data** | • Census data must be provided on all eligible employees, including enrolled, waivers and COBRA/state continuation.<br>• Include name, date of birth and gender for each employee, spouse and child, date of hire, dependent status, residence ZIP Code and employee work location ZIP Code.<br>• Retirees are not eligible.<br>• New business rating will be based on final enrollment.<br>• COBRA/state continuation enrollees should be included on the census and noted as COBRA/state continuation. |
| **COBRA/State Continuation Enrollees** | • COBRA coverage will be extended in accordance with federal legislation/regulations.<br>• Employers with fewer than 20 employees (full- and part-time) are eligible to offer state continuation.<br>• Employers with 20 or more employees (full- and part-time) are eligible to offer COBRA coverage.<br>• COBRA applies to employers who employed 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.<br>- Include: full-time, part-time, seasonal, temporary, union, owners, partners, officers<br>- Exclude: self-employed persons, independent contractors (1099), directors<br>- Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours a part-time employee worked divided by the hours an employee must work to be considered full-time.<br>• Because COBRA is directed at employers, the decision to comply with COBRA should be made by the employer. In situations where it may appear the employer is not subject to COBRA, for example, a three-life group requesting COBRA, Aetna will ask the employer to "validate" the number of employees in the prior calendar year in order to determine the number of employees for COBRA purposes.<br>• Life, disability and/or voluntary dental: COBRA/state continuation enrollees are not eligible.<br>• Eligible enrollees are required to be included on the census.<br>• Provide the qualifying event, length, start date and end date.<br>• Note: COBRA/state continuation enrollees are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined, according to the law applicable to the group, COBRA/state continuation enrollees can be included for coverage subject to normal underwriting guidelines. |

**Dependent Eligibility**

Eligible dependents include:

- Spouse, domestic partner and same-sex civil union partner:
  - If both employee and spouse/partner work for the same company, they may enroll together or separately.
  - If an employee and spouse/partner work for the same company, refer to Employee Eligibility section.
- Children:
  - Medical and dental:
    - Dependent children are eligible, as defined in plan documents, in accordance with applicable state and federal laws up to age 26, regardless of financial dependency, employment, eligibility of other coverage, student status, marital status, tax dependency or residency. This requirement applies to natural and adopted children, stepchildren and children subject to legal guardianship.
    - Children can only be covered under one parent's plan when both parents work for the same company.
    - When the child works for the same company as the parent, the child may enroll separately as an employee OR as a dependent under the parent's plan.
    - Grandchildren are eligible if court ordered. A copy of the court papers must be submitted.
    - At the election of the employer, dependents beyond age 26 may remain on their parent's New Jersey fully insured medical plan through age 30, until their 31st birthday. To be eligible, the parents of the overage dependent must be actively covered under a New Jersey-issued group health contract. This does NOT apply to small groups sitused in another state, regardless of where the employee resides. Eligible dependents must be the insured's child (by blood or by law) and must meet the following criteria:
    - Is younger than 31 years of age
    - Is unmarried
    - Has no dependents
    - Is a resident of New Jersey OR is enrolled as a full-time student
    - Is not provided coverage as a named subscriber, enrollee or covered person under any other health plan (cannot be entitled to Medicare)
    - Elects coverage before their 30th birthday
    - The employee completes the New Jersey mandated form to enroll dependents up to the age of 31.
  - Life – dependent children are eligible from 14 days up to their 19th birthday or 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 not required).
- Employees may select coverage for eligible dependents under the dental plan, even if they selected 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 a dependent under the same plan.

**Dual Option and Triple Option** (medical only)

- Dual and Triple option offerings are available.
- One person must enroll in each plan.
- Calendar-year and plan-year deductible plans are not available together. If multiple HSA plans are offered within a group, they must all be calendar-year or plan-year plans.

**Effective Date**

- The effective date must be the 1st or the 15th of the month.
- The effective date requested by the employer may be up to 60 days in advance.

**Electronic Funds Transfer (EFT)**

- Payment for the first month's premium at new business can be processed via an electronic funds transfer/ACH.
- Once the group is issued, customers can pay their monthly premiums online or by calling an automated phone number, **1-866-350-7644**, using their checking account and routing number. There is no extra charge for this service.

**Employee Eligibility**

- Employee means a full-time bona fide employee working 25 hours per week. Partners, proprietors, and independent contractors will be treated like employees, if they meet all of this policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be employees.
- If the employer's employee eligibility criteria definition differs from the above definition (more than 25 hours), the employer's actual definition must be provided on the Aetna Employer Application at the time of new business submission. Note: The normal workweek cannot be less than 25 hours.
- Note: Participation is based on the number of employees working 25 hours or more.
- A small employer may elect to cover all independent contractors or none. There must be at least two eligible W-2 employees working for the company.
- Employees in the waiting period are considered when determining the group size.
- If an employee and dependent work for the same company and elect to enroll as employee and dependent, applicable documentation to determine dependent's actual employee eligibility status must be provided as any other employee of the group (that is WR-30, partnership document, W-2 and payroll stub).
- Union employees who have collectively bargained for their health plan are excluded as eligible employees for the purpose of health coverage.
- Employees not eligible for coverage include leased, part-time, temporary, seasonal or substitute employees, uncompensated employees, employees making less than equivalent minimum wage, volunteers, inactive owners, directors, shareholders, officers, outside consultants, managing members who are not active, investors or silent partners.
- For life and disability only: 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.
- An employee can waive medical coverage and still enroll for dental, life/AD&D and disability.

**Retirees**

- Retirees are not eligible.
- Medicare-eligible retirees who are enrolled in an Aetna Medicare plan are eligible to enroll in standard dental plans in accordance with the dental underwriting guidelines.

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| **Employer Eligibility** | • Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership or political subdivision that is actively engaged in business that employed an average of at least 2 but not more than 50 eligible employees on business days during the preceding calendar year and that employs at least 2 eligible employees on the first day of the plan year, and the majority of the eligible employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 will be treated as one employer. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer will be based on the average number of eligible employees that it is expected the employer will employ on business days in the current calendar year.<br>• Groups that do not meet the above definition of a small employer are not eligible for coverage.<br>• Medical plans can be offered to groups of 2 to 50 eligible employees.<br>• Organizations must not be formed solely for the purpose of obtaining health coverage.<br>• Medical plans can be offered to sole proprietorships with two or more eligible employees, partnerships or corporations.<br>• Associations, Taft-Hartley groups, professional employers organization (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible.<br>• Dental and disability have ineligible industries that are listed separately under the Product Specifications section. The dental ineligible list does not apply when dental is sold in combination with medical. |
| **Initial Premium** | • The initial premium should be in the amount of the first month's premium and may be in the form of a check or electronic funds transfer (EFT).<br>• Submit a "copy" of the initial premium check payable to Aetna Inc. or complete the ACH/EFT form.<br>• If the EFT method is selected, the initial premium will be withdrawn from the checking account when the group is approved. This is a one-time authorization for the first month's premium only. If a copy of the check is provided, once coverage is approved, you will be advised where to mail the initial premium check.<br>• The initial premium check is not a binder check and does not bind Aetna to provide coverage.<br>• 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.<br>• If the initial premium check is returned by the bank for non-sufficient funds, the standard termination process will be followed. |
| **Licensed, Appointed Producers** | • Only appropriately licensed agents/producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna products.<br>• License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted. |
| **Medicare (MSP) for CMS Reporting** | • Each year, all carriers must report to CMS (Centers for Medicare & Medicaid Services) the number of Medicare Secondary Payer (MSP) groups and the number of employees, based on the number of employees provided by the employer.<br>• Medicare Secondary – 20 or more employees: Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the Aetna plan would pay primary to Medicare for active employees and would pay first when there are 20 or more total employees (full- and part-time) for 20 or more weeks during this calendar year or prior calendar year.<br>• Both full- and part-time employees are counted based on the number the employer employed for at least 20 or more calendar weeks during the current or prior calendar year.<br>- Include: full-time, part-time, seasonal, temporary, union, owners, partners, officers<br>- Exclude: self-employed persons, independent contractors (1099), directors, leased employees |

**Municipalities and Townships**

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

**Underwriting requirements**

1. Quarterly Wage and Tax Statement (QWTS).
2. W-2 – 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 W-2 and must provide a copy of their W-2.
3. 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 that participation will be maintained.

**Newly Formed Business**
(in operation less than 3 months)

Newly formed businesses must provide the following documentation:

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| **Sole proprietor** | A copy of the business license (not a professional license). |
| **Partnership or limited liability partnership** | A copy of the Articles of organization or the operating agreement to include the signature page(s) of all officers. |
| **Limited liability company** | A copy of the articles of incorporation that includes the signature page(s) of all officers |

Each newly formed business must also provide:

- Proof of employer identification number/federal tax ID number; and
- Quarterly Wage and Tax Statement. If not available, provide the date when will one be filed; and
- Four most recent payroll records that include hours worked, taxes withheld, check numbers and wages earned; or
- A letter from an attorney or CPA with the following information:
  1. A list of all employees, to include owners, partners, officers (full-time and part-time)
  2. Number of hours worked by each employee
  3. Weekly salary for each employee
  4. Date of hire for each employee
  5. Have payroll records been established?
  6. Will a Quarterly Wage and Tax Statement be filed? If so, when?

**PEO (Professional Employer Organization) groups covered under a PEO**

- As long as the PEO provides payroll specific to the 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.

**Plan Change Ancillary Additions**

- Requests to add or change ancillary benefits must be requested by the desired effective date.
- The future renewal date of the ancillary products will be the same as the medical plan renewal date.

**Prior Aetna Coverage**

- Groups that have been terminated for non-payment by Aetna may require six months of premium with application and must pay all premiums still owed on the prior Aetna plan before the new plan will be issued.

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| **Rating** | • Rates are tabular and based on final enrollment based on information provided on enrollment forms.<br>• If any of the information Aetna receives is determined to be incomplete or incorrect, we reserve the right to adjust rates. |
| **Replacing Other Group Coverage** | • Provide a copy of the current billing statement that includes the account summary.<br>• For dental, also provide a copy of the benefit summary to verify major and orthodontic coverage.<br>• The employer should be told not to cancel any existing coverage until they have been notified of approval from Aetna Underwriting. |
| **Signature Dates** | • The Aetna Employer Application and all employee applications must be signed and dated prior to and within 90 days of the requested effective date.<br>• All employee applications must be completed by the employee himself/herself. |
| **Spin-Off Groups** (current Aetna customers leaving an Aetna group only) | Aetna will consider the group with the following:<br>• 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.<br>• Ownership documents showing that the spin-off company is a newly formed separate entity. |
| **Tax Information/ Documents** | **Groups with 2 to 5 enrolling**<br>Employees must provide a copy of the most recent Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc., of all employees of the employer group.<br>• Newly hired employees should be written in on the Quarterly Wage and Tax Statement<br>• Employees who have terminated or work part-time must be noted accordingly on the QWTS.<br>• Reconciled QWTS must be signed and dated by the employer.<br>• If a QWTS is not available, explain why and provide a copy of payroll records. |

**Tax Information/ Documents** (continued)

**Groups with 6 to 50 enrolling employees**

- QWTS not required.
- Seasonal industries such as lawn and garden services, construction, concrete and paving, golf courses, farm laborers, etc., Must provide four consecutive quarters of wage and tax reports to verify consistent, continuous employment of eligible employees.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours, that must match the totals on Form 941.
- Sole proprietors, partners and corporate officers not listed on the QWTS need to complete Aetna's Small Group Proof of Eligibility Form (located at **www.aetna.com/employer-plans/small-business/index-smallgroup.html**) and submit one of the following identified documents. This list is not all inclusive. The employer may provide any other documentation to establish eligibility.
- 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.

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| **Sole proprietor**<br>• Franchise<br>• Limited liability company (operating as a sole proprietor) | • IRS Form 1040 along with Schedule C (Form 1040)<br>• IRS Form 1040 along with Schedule SE (Form 1040)<br>• IRS Form 1040 along with Schedule F (Form 1040)<br>• IRS Form 1040 along with Schedule K-1 (Form 1065)<br>• Any other documentation the owner would like to provide to help determine eligibility |
| **Partner**<br>• Partnership<br>• Limited liability partnership | • IRS Form 1065 (Schedule K-1)<br>• IRS Form 1120 (S Schedule K-1) along with Schedule E (Form 1040)<br>• Partnership agreement if established within two years listing eligible partners<br>• Any other documentation the owner would like to provide to help determine eligibility |
| **Corporate officer**<br>• Limited liability company (operating as C corp)<br>• C corporation<br>• Personal service corporation<br>• S corporation | • RS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)<br>• IRS Form 1120 W (C Corp and personal service corp)<br>• IRS Form1040 ES (Estimated Tax) (S corp)<br>• IRS Form 8832 (Entity classification as a corporation)<br>• W-2 Form<br>• Articles of incorporation if established within two years listing corporate officers<br>• Any other documentation the owner would like to provide to help determine eligibility |

**Total Average Employees**

- For new business sold cases, be sure and answer the question on the Aetna Employer Application.
- For any states where the question is not included on the Aetna Employer Application, please complete the Addendum to New Business Input Document (Total Average Employee form) available on Producer World® at **www.aetna.com/employer-plans/small-business/index-smallgroup.html**.
- The prior year form must be completed. For example, on January 1, 2014, we will require the 2013 form. We cannot accept the 2012 form.

**Two or More Companies — Affiliated, Associated or Multiple Companies, Common Ownership**

Employers that have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following are met:

- One owner has controlling interest of all business to be included; or
- The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, and 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 will be considered a single 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, as long as you have one decision maker and the total eligible for all groups does not exceed 50. If the request is for only two of the three businesses to be enrolled, the group will be considered a carve-out.
- There are 50 or fewer employees in the combined employer groups.
- A completed Common Ownership Associated Companies 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. Please have a Multiple Companies form completed.
- Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case basis.

**Example**

One owner has controlling interest of all companies to be included:
Company 1 – Jim owns 75 percent and Jack owns 25 percent.
Company 2 – Jim owns 55 percent and Jack owns 45 percent.
Both companies can be written as one group since Jim has controlling interest in both.

**Waiting Period**

- The employer decides whether or not to impose a waiting period.
- The benefit waiting period (BWP) for future employees may be the 1st or 15th of the month following 0, 30, 60, or exactly 90 days following the date of hire.
- Changes to waiting period are allowed on anniversary only.
- No retroactive changes will be allowed.
- Aetna does not have a date of hire BWP.
- One or two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer, such as management versus non-management, hourly versus salaried, etc.
- Benefit waiting periods must be consistently applied to all employees, including newly hired key employees.

**Waiting Period** (continued)

- For new hires, the eligibility date will be the first day of the policy month following the waiting period, not to exceed 90 days following the date of hire.
  - If "0" days is selected and the employee is hired on the 1st of the month, the effective date will be the date of hire.
  - If "Exactly 90 Days" is selected, the enrollment eligibility date will begin 90 calendar days from the date of hire.

| Examples | 1st of the month following the BWP | 15th of the month following the BWP |
|---|---|---|
| **0 days** | Date of hire: 4/1<br>Effective date: 4/1<br><br>Date of hire: 4/18<br>Effective date: 5/1 | Date of hire: 4/1<br>Effective date: 4/15<br><br>Date of hire: 4/18<br>Effective date: 5/15 |
| **30 days** | Date of hire: 4/18<br>Effective date: 6/1 | Date of hire: 4/18<br>Effective date: 6/15 |
| **60 days** | Date of hire: 4/18<br>Effective date: 7/1 | Date of hire: 4/18<br>Effective date: 7/15 |
| **90 days** | Date of hire: 4/18<br>Effective date: 7/16 not 8/1 –<br>exactly 90 days from the date of hire | Date of hire: 4/18<br>Effective date: 7/16 not 8/15 –<br>exactly 90 days from the date of hire |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Product Availability** | • May be written stand-alone or with ancillary coverage as noted in the following columns. | **1 life**<br>• Not available.<br>**2 eligible employees**<br>• Standard dental available with medical.<br>• Voluntary dental not available.<br>**3 to 50 eligible employees**<br>• Standard and voluntary available with or without medical.<br>• Stand-alone available.<br>• Stand-alone dental has ineligible industries that are listed separately under the SIC Codes section of the guidelines.<br>**Orthodontic coverage**<br>• Available for standard and voluntary plans with 10 or more eligible employees with a minimum of 5 enrolled employees for dependent children only. | • Must meet the qualifications of a small business.<br>• The same employer eligibility guidelines that apply to medical will apply to basic term life and packaged life/ disability coverage.<br>• Employees may elect basic term life or the packaged life/ disability coverage even if they do not elect medical coverage.<br>• Basic term life and packaged life/disability cannot be offered as a dual option.<br>**Term life**<br>• 1 life not available.<br>• 2 to 9 eligible employees – available if sold with medical.<br>• 10 to 50 eligible employees – available if sold with medical or dental.<br>• 26 to 50 eligible employees on a stand-alone basis.<br>**Packaged life and disability**<br>• 2 to 50 eligible employees if sold with medical.<br>• 10 to 50 eligible employees on a stand-alone basis.<br>• A plan sponsor cannot purchase both life and packaged life and disability plans.<br>• Product packaging rule is a group level requirement. Employees will be able to individually elect life or packaged life and disability insurance even if they do not elect medical coverage. |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Carve-Out/ Excluded Class** | • Employees covered under a union-sponsored plan cannot be included as eligible employees.<br>• Carve-outs are permitted provided minimum participation and eligibility requirements are met.<br>• Groups that do not meet participation criteria are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. | • Union employees if packaged/ sold with medical | • Union employees if packaged/ sold with medical |
| **Employer Contribution** | • 10% of the annual cost of the health benefits plan.<br>• Groups that do not meet contribution are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. | • 25% of the total cost of the plan or 50% of the cost of employee-only coverage.<br>• If the employer pays 100%, the group is not eligible for a voluntary plan and would get a standard plan.<br>• Coverage can be denied based on inadequate contributions. | • 2 to 9 eligible employees – 100% of the total cost of the basic life plan excluding optional dependent term life.<br>• 10 to 50 eligible employees – At least 50% of the total cost of the plans excluding optional dependent life.<br>• 2 to 50 eligible employees – Coverage can be denied based on inadequate contributions. |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Late Applicants** | • An employee or dependent enrolling for coverage more than 31 days from the date first eligible or more than 31 days from the qualifying event is considered a late enrollee. Applicants without a qualifying life event (that is, marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below.<br>• 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. | | |
| | • 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. | • An employee or dependent may enroll at any time; however, coverage is limited to preventive and diagnostic services for the first 12 months.<br>• No coverage for most basic and major services for the first 12 months (24 months for orthodontics).<br>• Late Entrant provision does not apply to enrollees less than age 5. | • 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.<br>• The applicant will be required to complete an individual health statement/ questionnaire and provide EOI.<br>• Life late enrollee example:<br>• 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, he/ she must medically qualify for the entire $50,000. |
| **Live/Work Situs** | • Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA and VA (the situs region) will receive the same rates and benefits as the headquarter's location.<br>• Situs does not apply to Savings Plus plans. | • Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA and VA (the situs region) will receive the same rates and benefits as the headquarter's location. | • Not applicable. |
| **Out-of-State Employees** | • Any employee located in CT, DC, DE, MD, NJ, NY, PA, VA (situs area) but not residing in an Aetna Health Network Only (HNOnly)/Health Network Option (HNOption) and/or Open Access Elect Choice (OA EPO)/ Open Access Managed Choice (OA MC) network will be enrolled in an indemnity benefit plan. | • Members who reside out of state (OOS) will receive the same plan as in-state members (based on state rules and network availability). This applies to DMO, PPO and FOC dental plans.<br>• If an OOS member resides in a state that does not allow the in-state plan, those members will be placed into an available PPO or indemnity plan. | • Employees are eligible for the same life plan selected by the employer. |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Out-of-State Employees** (continued) | • Any active employee who lives and works in a state other than within the group situs area (CT, DC, DE, MD, NJ, NY, PA, VA), is considered an out-of-state employee.<br>• Out-of-state employees must be enrolled in an OA EPO/OA MC/MC plan if available; otherwise, an indemnity plan.<br>• No indemnity or PPO products are available in HI or VT.<br>• Louisiana residents – employees residing in Louisiana are required to have a separate plan quoted and sold based on Louisiana rates and benefits. These employees are still underwritten as part of the group; however, the plans and rates for the Louisiana members will not be based on where the employer is located. This will require a Louisiana employer and employee applications to be completed. | | |
| **Participation** | • 75% of eligible employees must enroll, rounding up, including those covered under a spouse's group health benefits plan, Medicare, NJ Family Care, or Medicaid. In calculating participation, individuals with these types of other coverages must be counted as participating.<br>**Example**<br>22 lives,<br>2 covered under spouse<br>22 x 75% = 16.5<br>= 17 rounding up<br>17 – 2 (covered under spouse)<br>= 15 must enroll to meet participation | **Noncontributory plans**<br>• 100% participation is required, excluding those with other qualifying dental coverage.<br>**Standard contributory with medical or stand-alone (round to the nearest)**<br>• 2 to 3 – 100% excluding valid waivers. Minimum of 2 eligible employees must enroll<br>• 4 to 50 – 75% excluding valid waivers. Minimum of 2 and 50% of total eligible employees must enroll. | **2 to 9 eligible employees**<br>• 100% participation<br>**10 to 50 eligible employees**<br>• Noncontributory – 100% participation<br>• Contributory – 75% participation<br>**Stand-alone Life**<br>• 75% participation is required. |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Participation** (continued) | • Groups that do not meet participation are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date.<br>• Dependent participation is not required.<br>• Employees waiving must complete the waiver section.<br>• Other group coverage sponsored by the same employer will not count towards satisfying the 75% participation requirement. | **Voluntary contributory with medical or stand-alone (round to the nearest)**<br>• 3 to 50 – minimum 30% excluding valid waivers with a minimum of 3 enrolled.<br>• If a group does not qualify for a standard plan and has 30% or more participation, then group qualifies for voluntary.<br>**Standard and Voluntary**<br>• Employees may select coverage for eligible dependents under the dental plan even if they elected single coverage on the medical plan or vice versa.<br>• Coverage can be denied based on inadequate participation. | **All**<br>• COBRA and state continuees are not eligible.<br>• Retirees are not eligible.<br>• Employees may elect life insurance even if they do not elect medical coverage, and the group must meet the required participation percentage. If not, then life will be declined for the group.<br>• Coverage can be denied based on inadequate participation. |
| **Plan Change Group Level** | • Plan anniversary date only. | • Dental plans must be requested 30 days prior to the desired effective date.<br>• The future renewal date of the change will be the same as the medical plan anniversary date. | • Packaged life/disability must be requested 30 days prior to the desired effective date.<br>• Non-packaged plans are only available on the plan anniversary date.<br>• The future renewal date of the change will be the same as the medical plan anniversary date. |
| **Plan Change Employee Level** | • Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events). | • Freedom-of-Choice – May change from DMO to PPO and vice versa at any time but must be received in Aetna Underwriting by the 15th to be effective the next month | • Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events). |
| **Rate Guarantee** | • Medical rates are guaranteed for one year (12 months). | • Dental rates are guaranteed for one year (12 months) unless the anniversary date of the dental is different than the medical. If the dental product is added off the original medical anniversary date, this does not apply. | • Life rates are guaranteed for 1 year (12 months). |

# Product Specifications

| | Medical | Dental | Basic Life/AD&D, Packaged Life and Disability |
|---|---|---|---|
| **Standard Industrial Classification (SIC) Codes** | • All industries are eligible. | • All industries are eligible if sold with medical.<br>• The following industries are not eligible when dental is sold stand-alone or packaged only with life.<br>7933 – 7933 Bowling Centers<br>8611 – 8611 Business Associations<br>7911 – 7911 Dance Studios, Schools<br>7361 – 7363 Employment Agencies<br>7999 – 7999 Miscellaneous Amusement/ Recreation<br>8699 – 8699 Miscellaneous Membership Org<br>8999 – 8999 Miscellaneous Services<br>7991 – 7991 Physical Fitness Facilities<br>8811 – 8811 Private Households<br>8621 – 8651 Professional Membership Organizations, Labor Unions, Civic Social and Fraternal Orgs, Political Orgs<br>7941 – 7948 Professional Sports Clubs & Producers, Race Tracks<br>7992 – 7997 Public Golf Courses, Amusements, Membership Sports & Recreation Clubs<br>8661 – 8661 Religious Organizations<br>7922 – 7929 Theatrical Producers, Bands, Orchestras, Actors | • Basic term life – All industries are eligible.<br>• Packaged life/disability and/or disability only – The following industries are not eligible.<br>3291 – 3292 Asbestos Products<br>7500 – 7599 Automotive Repairs/ Services<br>8010 – 8043 Doctor's Offices Clinics<br>2892 – 2899 Explosives, Bombs & Pyrotechnics<br>3480 – 3489 Fire Arms & Ammunition<br>5921 Liquor Stores<br>8600 – 8699 Membership Associations<br>1000 – 1499 Mining<br>7800 – 7999 Motion Picture/ Amusement & Recreation<br>9999 Non-classified Establishments<br>3310 – 3329 Primary Metal Industries<br>6531 Real Estate – Agents<br>6211 Security Brokers<br>7381 Service – Detective Services<br>8800 – 8899 Service – Private Household |

# Dental Only

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|---|---|
| **Coverage Waiting Period** | **Standard 2 to 9 eligible employees and Voluntary 3 to 50 eligible employees**<br>• PPO and indemnity plans – For major and orthodontic services employees must be an enrolled member of the employer's plan for one year before becoming eligible.<br>• DMO – there is no waiting period.<br>• Discount plans do not qualify as previous coverage.<br>• Future hires – waiting period applies regardless if takeover for voluntary plans.<br>• Virgin group (no prior coverage) – the waiting periods apply to employees at case inception as well as any future hires.<br>• Takeover/replacement cases (prior coverage) – provide a copy of the last billing statement and schedule of benefits in order to provide credit. If a group's prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a dental plan in place that covered major (and orthodontic, if applicable) immediately preceding our takeover of the business.<br>**Example**<br>Prior major coverage but no orthodontic coverage.<br>Aetna plan has coverage for both major and orthodontic.<br>The waiting period is waived for major services but not for orthodontic services.<br>**Standard 10 to 50 eligible employees**<br>• No waiting period |
| **Product Packaging** | • Refer to dental footnotes page for plan availability. |
| **Open Enrollment** | An open enrollment is a period when any employee can elect to join the dental plan without penalty, regardless if they previously declined coverage during the first 31 days of initial eligibility.<br>**Standard with medical or stand-alone**<br>• 2 to 9 eligible employees – no open enrollment. An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible unless a qualifying life event has occurred or the enrollee is less than age 5.<br>• 10 to 50 eligible employees – employees/dependents who do not enroll when initially eligible are now eligible to enroll during a subsequent open enrollment period without being subject to the late entrant provision.<br>**Voluntary with medical or stand-alone**<br>• Not allowed. An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible unless a qualifying life event has occurred or the enrollee is less than age 5. |
| **Reinstatement** (applies to voluntary plans only) | • Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the coverage waiting period. |

# Life and Packaged Life & Disability Only

**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 for a maximum of 12 months from the policy effective date, except no benefits are payable if the prior plan is liable. If the employee has not returned to active work prior to the end of the 12-month period, conversion must be offered.

**Job Classification (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 three 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 even if only two classes are offered. For example, a schedule may be structured as follows:

| Position/Job Class | Basic Term Life Amount | Packaged Life & Disability |
|---|---|---|
| **Executives** | $50,000 | High Option |
| **Managers, supervisors** | $20,000 | Medium Option |
| **All other employees** | $10,000 | Low Option |

**Evidence of Insurability (EOI)**

Evidence of insurability (EOI) means the person must complete an individual health statement and may have to submit medical evidence via medical records at their expense. EOI is required when one or more of the following conditions exist:

1. Life insurance coverage amounts requested are above the guaranteed standard issue limit.
2. Late entrant – coverage is not requested within 31 days of eligibility for contributory coverage.
3. New coverage is requested during the anniversary period.
4. Coverage is requested outside of the employer's anniversary period due to qualifying life event (that is marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).
5. Reinstatement or restoration of coverage is requested.
6. Dependent coverage option was initially refused by employee but requested later. The dependent would be considered a late entrant and subject to EOI, and may be declined for medical reasons.
7. Requesting life or disability at the individual level and person is a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the guarantee issue limit.

   **Example**

   Group has $50,000 life with $20,000 guarantee issue limit.
   Late enrollee enrolling for $50,000 would not automatically get the $20,000.
   Since the applicant is late, he/she must medically qualify for the entire $50,000.

**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.

# Life and Packaged Life & Disability Only

**Guaranteed Issue Coverage**

- Aetna provides certain amounts of life insurance to all timely entrants without requiring an employee to answer any medical questions. These insurance amounts are called "guaranteed issue."
- Employees wishing to obtain increased insurance amounts will be required to submit evidence of insurability, which means they must complete a medical questionnaire and may be required to provide medical records.
- On-time enrollees who do not meet the requirements of evidence of insurability will receive the guaranteed issue life amount.
- Late enrollees must qualify for the entire amount and are not guaranteed any coverage.

**Medical Underwriting**

**New business medical evaluation**

- At new business time, any dependents enrolling for coverage are guaranteed issue and not subject to EOI.
- Employees wishing to obtain insurance amounts above the guaranteed issue amounts listed below will be required to submit evidence of insurability (EOI), which means they must complete an individual health statement/questionnaire.

**Guarantee issue amounts**

| Case Size | Basic Term Life Amount |
|---|---|
| **2 to 9 eligible employees** | $20,000 |
| **10 to 25 eligible employees** | $75,000 |
| **26 to 50 eligible employees** | $100,000 |

- Only those employees who have an unacceptable medical condition will be reduced to the guaranteed issue amount. The rest of the employees will be issued the higher amount if they medically qualify.

**Example**

Applying for $50,000
54-year-old male
Heart attack 6 months ago, no surgery
Reduced to $20,000 life
All other employees will be issued $50,000

**New Hire – On-Time**

- New hires wishing to obtain insurance amounts above the guaranteed issue amounts will be required to submit evidence of insurability (EOI), which means they must complete a medical questionnaire.
- If the employee has unacceptable medical conditions, the employee will be reduced to the guaranteed issue amount.

**New Hire – Late Enrollee**

- 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).
- Late enrollees must qualify for the entire amount and are not guaranteed any coverage.

**Life late enrollee example**

Group has $50,000 life with $20,000 guaranteed issue limit.
Late enrollee enrolling for $50,000 would not automatically get the $20,000.
Since the applicant is late, he/she must medically qualify for the entire $50,000.

# Limitations and exclusions

### Medical

These plans do not cover all health care expenses and include exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered.

- All medical and hospital services not specifically covered in, or that are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage terminates
- Custodial care
- Dental care or treatment, including appliances and dental implants, except as otherwise stated in the contract
- Donor egg retrieval
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the contract
- Eye surgery, such as radial keratotomy or LASIK surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)
- Immunizations for travel or work
- Non-medically necessary services or supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Services or supplies furnished in connection with any procedures to enhance fertility that involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:
  - Procedures: in vitro fertilization, embryo transfer, embryo freezing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), donor sperm and surrogate motherhood
  - Prescription drugs not eligible under the prescription drugs section of the contract
- Services or supplies related to cosmetic surgery, except as otherwise stated in the policy; complications of cosmetic surgery; and drugs prescribed for cosmetic purposes

### Dental, AD&D Ultra and Disability

The Dental, AD&D Ultra and Disability plans include limitations, exclusions, and charges or services that these plans do not cover. For a complete listing of all limitations and exclusions or charges and services that are not covered, please refer to your Aetna group plan documents. Limitations, exclusions, and charges or services may vary by state or group size.

### Dental

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by the physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges for the following services or supplies are limited or may be excluded:

- Dental services or supplies that are primarily used to alter, improve or enhance appearance
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost, missing or stolen appliances and certain damaged appliances
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- Specific service limitations:
  - DMO plans: Oral exams (4 per year)
  - PPO plans: Oral exams (2 routine and 2 problem-focused per year)
  - All plans:
    - Bitewing X-rays (1 set per year)
    - Complete series X-rays (1 set every 3 years)
    - Cleanings (2 per year)
    - Fluoride (1 per year; children under 16)
    - Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)
    - Scaling and root planing (4 quadrants every 2 years)
    - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in your plan documents

### Employee and Dependent Life Insurance

The plan may not pay a benefit for deaths caused by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of the person's coverage. If death occurs after two years of the effective date but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

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.

## AD&D Ultra

Not all events that may be ruled accidental are covered by this plan. No benefits are payable for a loss caused or contributed to by:

- 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)
- Bodily or mental infirmity
- Commission of or attempt to commit a criminal act
- Illness, ptomaine or bacterial infection*
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Ligature strangulation resulting from auto-erotic asphyxiation
- Intentionally self-inflicted injury
- Medical or surgical treatment*
- Third-degree burns resulting from sunburn
- Use of alcohol
- Use of drugs, except as prescribed by a physician
- Use of intoxicants
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident the employee or covered dependent was:
  - Operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
  - Operating the motor vehicle while under the influence of an intoxicant or illegal drug; or
  - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician; or
  - Operating the motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions
- Suicide or attempted suicide (while sane or insane)
- War or any act of war (declared or not declared)

*These do not apply if the loss is caused by:
- An infection which results directly from the injury.
- Surgery needed because of the injury.

The injury must not be one which is excluded by the terms of this section.

## Disability

Disability coverage also does not cover any disability that:

- Is due to an occupational illness or occupational injury except in the case of sole proprietors or partners who cannot be covered by workers' compensation
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion
- Is due to intentionally self-inflicted injury (while sane or insane)
- Is due to war or any act of war (declared or not declared).
- Results from the commission of, or attempt to commit a criminal act
- Results from a motor vehicle accident caused by operating the vehicle while under the influence of alcohol. A motor vehicle accident will be deemed to be caused by the use of alcohol if it is determined that at the time of the accident the employee was operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter

Disability coverage does not cover any disability on any day that the employee is confined in a penal or correctional institution for conviction of a criminal act or other public offense. He/she will not be considered to be disabled, and no benefits will be payable.

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

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Health/Dental benefits, health/dental insurance, life and disability insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health/dental services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. 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. Investment services are independently offered through HealthEquity, Inc. While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. Not all health, dental, disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. 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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