

**AETNA
AVENUE®**

MICHIGAN PLAN GUIDE

Your Destination for Small Business SolutionsSM



For businesses with 2 - 50 eligible employees
Plans effective September 1, 2009

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We want you to know[®]



Health care is a journey ...

AETNA AVENUE IS THE WAY

IN THIS GUIDE:

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

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

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

CHOICE

For business owners and employees

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

Medical plans — supporting members on their health care journey

- Consumer-directed health plans (CDHP)
- HSA compatible plans
- Traditional plans

Dental, life and disability plans — providing valuable protection

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice
- Consumer-directed plan
- Preventive
- Basic term life insurance
- Packaged life and disability plans

EASE

Allowing you to focus on your business

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

Administration — making it work for your business

Aetna's plan designs automatically process health claim reimbursements, provide a password-protected website to keep track of accounts and are supported by knowledgeable service representatives. Our representatives are available to answer your questions and work with you when you need them.

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

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

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

- DocFind® to locate doctors in the neighborhood
- Track medical claims online
- Discount programs for eye, dental and other health care
- Personal Health Record providing a complete picture of health
- Temporary ID cards available for members to print as needed

REPUTATION

In business it's everything

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

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

AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

We know that small business owners' insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2 – 50 employees and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for your business and assist you through implementation.

AETNA'S MARKET MAP

Guiding your small business health care journey

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

**DO
YOU
VALUE ...**

Basic benefits for your employees
Limiting the expense to your business
Allowing employees to buy-up and share more of the cost

You might be a ...
Basic buyer

These plans fit ...
• PPO Split Copay plans
• PPO Consumer Directed plans

Employee responsibility
Consumerism's ability to make a difference
Tools and resources to support consumerism
Innovative plan design

You might be a ...
Value seeker

These plans fit ...
• PPO HSA plans
• PPO Consumer Directed plans
• PPO Split Coinsurance plans

Traditional benefits plans
Limiting the financial impact on employees

You might be a ...
Traditionalist

These plans fit ...
• PPO Split Copay plans

HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Consumer-directed health plans

YOUNG SINGLES

Includes singles and couples without children

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

ESTABLISHED FAMILIES

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

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

YOUNG FAMILIES

Traditional plans

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

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

EMPTY NESTERS

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

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

ESTABLISHED FAMILIES

Consumer-directed health plans
Split coinsurance plans

EMPTY NESTERS

Consumer-directed health plans

Aetna Avenue

MEDICAL OVERVIEW

Michigan provider network*

Alcona	Keweenaw
Alger	Lake
Allegan	Lapeer
Alpena	Leelanau
Antrim	Lenawee
Arenac	Livingston
Baraga	Luce
Barry	Mackinac
Bay	Macomb
Benzie	Manistee
Berrien	Marquette
Branch	Mason
Calhoun	Mecosta
Cass	Menominee
Charlevoix	Midland
Cheboygan	Missaukee
Chippewa	Monroe
Clare	Montcalm
Clinton	Montmorency
Crawford	Muskegon
Delta	Newaygo
Dickinson	Oakland
Eaton	Oceana
Emmet	Ogemaw
Genesee	Ontonagon
Gladwin	Osceola
Gogebic	Oscoda
Grand	Otsego
Traverse	Ottawa
Gratiot	Presque Isle
Hillsdale	Roscommon
Houghton	Saginaw
Huron	Saint Clair
Ingham	Saint Joseph
Ionia	Sanilac
Iosco	Schoolcraft
Iron	Shiawassee
Isabella	Tuscola
Jackson	Van Buren
Kalamazoo	Washtenaw
Kalkaska	Wayne
Kent	Wexford

*Network subject to change.

AETNA OPEN CHOICE PPO PLAN

The Aetna Open Choice PPO insurance plan offers members the freedom to go directly to any recognized provider for covered expenses, including specialists.

No referrals are required.

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

CONSUMER-DIRECTED HEALTH PLANS (CDHP)

Consumer-directed health insurance plans increase flexibility, control and choice for the employer and the employee by putting consumers in the center of the health care equation. Aetna offers this insurance plan option.

AETNA HIGH DEDUCTIBLE PPO PLAN (HSA-COMPATIBLE)

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

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

See page 9 for more details on the Aetna HealthFund® Health Savings Account.

AETNA INDEMNITY PLAN

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

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

HEALTH SAVINGS ACCOUNT (HSA)

No set-up or administrative fees

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



Administrative fees

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

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

The HRA and the HSA provide members with financial support for higher out-of-pocket health care expenses. Aetna’s consumer-directed health products and services give members the information and resources they need to help make informed health care decisions for themselves and their families while helping lower employers’ costs.

COBRA ADMINISTRATION

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

SECTION 125 CAFETERIA PLANS

Employees can reduce their taxable income, and employers can pay less in payroll taxes.

Premium Only Plans (POP)

Employees can pay for their portion of the group health insurance expenses on a pretax basis.

Flexible Savings Account (FSA)

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

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

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

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

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

PPO PLAN OPTIONS — SPLIT COPAY

Plan Options	MI PPO SPLIT COPAY 1.2*		MI PPO SPLIT COPAY 2.2*		MI PPO SPLIT COPAY 3.2*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$500 per member \$1,000 family	\$1,000 per member \$2,000 family	\$1,000 per member \$2,000 family	\$2,000 per member \$4,000 family	\$1,250 per member \$2,500 family	\$3,000 per member \$6,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$0 per member \$0 family	\$4,000 per member \$8,000 family	\$0 per member \$0 family	\$5,000 per member \$10,000 family	\$0 per member \$0 family	\$6,000 per member \$12,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	\$20 copay, ded. waived	80% after deductible	\$25 copay, ded. waived	80% after deductible	\$30 copay, ded. waived	80% after deductible
Specialist Office Visit	\$35 copay, ded. waived	80% after deductible	\$40 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	\$35 copay, ded. waived	80% after deductible	\$40 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	\$20 copay, ded. waived	Not Covered	\$25 copay, ded. waived	Not Covered	\$30 copay, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	\$20 copay, ded. waived	Not Covered	\$25 copay, ded. waived	Not Covered	\$30 copay, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	\$35 copay, ded. waived	80% after deductible	\$40 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	\$35 copay, ded. waived	Not Covered	\$40 copay, ded. waived	Not Covered	\$45 copay, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$35 copay, ded. waived	80% after deductible	\$40 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	\$35 copay, ded. waived	80% after deductible	\$40 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Inpatient Hospital	100% after deductible	80% after \$500 Copay and deductible	100% after deductible	80% after \$500 Copay and deductible	100% after deductible	80% after \$500 Copay and deductible
Outpatient Surgery	100% after deductible	80% after \$250 Copay and deductible	100% after deductible	80% after \$250 Copay and deductible	100% after deductible	80% after \$250 Copay and deductible
Emergency Room (Copay waived if admitted.)	\$125 copay, deductible waived		\$125 copay, deductible waived		\$125 copay, deductible waived	
Urgent Care	\$50 copay, ded. waived	80% after deductible	\$50 copay, ded. waived	80% after deductible	\$50 copay, ded. waived	80% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after \$500 Copay and deductible	50% after deductible	50% after \$500 Copay and deductible	50% after deductible	50% after \$500 Copay and deductible
Durable Medical Equipment	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription Drugs⁴	N/A		N/A		N/A	
Prescription Drug Deductible	N/A		N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	80% after \$15/\$35/\$50	\$15/\$35/\$50	80% after \$15/\$35/\$50	\$15/\$35/\$50	80% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — SPLIT COINSURANCE

Plan Options	MI PPO SPLIT COINSURANCE 1.2*		MI PPO SPLIT COINSURANCE 2.2*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	Professional: 90% after deductible Facility: 60% after deductible	60% after deductible	Professional: 90% after deductible Facility: 60% after deductible	60% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$1,000 per member \$2,000 family	\$4,000 per member \$8,000 family	\$1,500 per member \$3,000 family	\$4,000 per member \$8,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$4,000 per member \$8,000 family	\$8,000 per member \$16,000 family	\$4,000 per member \$8,000 family	\$8,000 per member \$16,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	\$30 copay, ded. waived	60% after deductible	\$30 copay, ded. waived	60% after deductible
Specialist Office Visit	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	90% deductible	60% after deductible	90% deductible	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	90% after deductible	60% after deductible	90% after deductible	60% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	\$30 copay, ded. waived	Not Covered	\$30 copay, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	\$30 copay, ded. waived	Not Covered	\$30 copay, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	\$45 copay, ded. waived	Not Covered	\$45 copay, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Inpatient Hospital	60% after deductible	60% after deductible	60% after deductible	60% after deductible
Outpatient Surgery	Professional: 90% after deductible Facility: 60% after deductible	60% after deductible	Professional: 90% after deductible Facility: 60% after deductible	60% after deductible
Emergency Room (Copay waived if admitted.)	\$125 copay, deductible waived		\$125 copay, deductible waived	
Urgent Care	\$50 copay, ded. waived	60% after deductible	\$50 copay, ded. waived	60% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after \$500 Copay and deductible	50% after deductible	50% after \$500 Copay and deductible
Durable Medical Equipment	90% after deductible	60% after deductible	90% after deductible	60% after deductible
Prescription Drugs⁴	N/A		N/A	
Prescription Drug Deductible	N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	60% after \$15/\$35/\$50	\$15/\$35/\$50	60% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

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PPO PLAN OPTIONS — CONSUMER DIRECTED				
Plan Options	MI PPO CONSUMER DIRECTED 1.2*		MI PPO CONSUMER DIRECTED 2.2*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$1,500 per member \$3,000 family	\$1,500 per member \$3,000 family	\$2,000 per member \$4,000 family	\$2,000 per member \$4,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$1,500 per member \$3,000 family	\$3,000 per member \$6,000 family	\$2,000 per member \$4,000 family	\$4,000 per member \$8,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Specialist Office Visit	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	80% after deductible	100%, ded. waived	80% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Inpatient Hospital	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Surgery	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Emergency Room	100% after deductible	100% after deductible	100% after deductible	100% after deductible
Urgent Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription Drugs⁴	N/A		N/A	
Prescription Drug Deductible	N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	80% after \$15/\$35/\$50	\$15/\$35/\$50	80% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — CONSUMER DIRECTED

Plan Options	MI PPO CONSUMER DIRECTED 3.2*		MI PPO CONSUMER DIRECTED 4.2*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$1,500 per member \$3,000 family	\$1,500 per member \$3,000 family	\$2,000 per member \$4,000 family	\$2,000 per member \$4,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$3,000 per member \$6,000 family	\$3,000 per member \$6,000 family	\$4,000 per member \$8,000 family	\$4,000 per member \$8,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Specialist Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	60% after deductible	100%, ded. waived	60% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Urgent Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs⁴				
Prescription Drug Deductible	N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	60% after \$15/\$35/\$50	\$15/\$35/\$50	60% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — CONSUMER DIRECTED				
Plan Options	MI PPO CONSUMER DIRECTED 5.2*		MI PPO CONSUMER DIRECTED 6.2*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$1,500 per member \$3,000 family	\$1,500 per member \$3,000 family	\$2,000 per member \$4,000 family	\$2,000 per member \$4,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$3,000 per member \$6,000 family	\$6,000 per member \$12,000 family	\$4,000 per member \$8,000 family	\$8,000 per member \$16,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	\$30 copay, ded. waived	80% after deductible	\$30 copay, ded. waived	80% after deductible
Specialist Office Visit	\$45 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	\$45 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$45 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	80% after deductible	100%, ded. waived	80% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$45 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	\$45 copay, ded. waived	80% after deductible	\$45 copay, ded. waived	80% after deductible
Inpatient Hospital	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Surgery	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Emergency Room	\$125 copay, ded waived	\$125 copay, ded waived	\$125 copay, ded waived	\$125 copay, ded waived
Urgent Care	\$50 copay, ded waived	80% after deductible	\$50 copay, ded waived	80% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription Drugs⁴	N/A		N/A	
Prescription Drug Deductible	N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	80% after \$15/\$35/\$50	\$15/\$35/\$50	80% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

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PPO PLAN OPTIONS — CONSUMER DIRECTED

Plan Options	MI PPO CONSUMER DIRECTED 7.2*		MI PPO CONSUMER DIRECTED 8.2+	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$2,500 per member \$5,000 family	\$2,500 per member \$5,000 family	\$3,500 per member \$7,000 family	\$3,500 per member \$7,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$5,000 per member \$10,000 family	\$10,000 per member \$20,000 family	\$7,000 per member \$14,000 family	\$14,000 per member \$28,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	\$30 copay, ded. waived	60% after deductible	\$30 copay, ded. waived	60% after deductible
Specialist Office Visit	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	60% after deductible	100%, ded. waived	60% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible	\$45 copay, ded. waived	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room	\$125 copay, ded waived	\$125 copay, ded waived	\$125 copay, ded waived	\$125 copay, ded waived
Urgent Care	\$50 copay, ded waived	60% after deductible	\$50 copay, ded waived	60% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs⁴	N/A		N/A	
Prescription Drug Deductible	N/A		N/A	
Retail: 30-day supply	\$15/\$35/\$50	60% after \$15/\$35/\$50	\$15/\$35/\$50	60% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

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²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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PPO PLAN OPTIONS — CONSUMER DIRECTED

Plan Options	MI PPO CONSUMER DIRECTED 9.2*	
Member Benefits	In-Network	Out-of-Network ¹
Plan Coinsurance	80% after deductible	60% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$5,000 per member \$10,000 family	\$5,000 per member \$10,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does apply.)	\$10,000 per member \$20,000 family	\$20,000 per member \$40,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	\$30 copay, ded. waived	60% after deductible
Specialist Office Visit	\$45 copay, ded. waived	60% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	\$45 copay, ded. waived	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	\$45 copay, ded. waived	60% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered
Preventive Care - Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	60% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	\$45 copay, ded. waived	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Emergency Room	\$125 copay, ded waived	\$125 copay, ded waived
Urgent Care	\$50 copay, ded waived	60% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prescription Drugs⁴	N/A	
Prescription Drug Deductible	N/A	
Retail: 30-day supply	\$15/\$35/\$50	60% after \$15/\$35/\$50
Mail Order: 31-90-day supply	\$30/\$70/\$100	Not Covered
Contraceptives and Diabetic Supplies	Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — HSA COMPATIBLE				
Plan Options	MI PPO HSA COMPATIBLE 1.1*		MI PPO HSA COMPATIBLE 2.1*	
Member Benefits	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Plan Coinsurance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network. All covered prescription drug and medical expenses, except in-network preventive care, apply to the deductible.)	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family	\$2,500 individual \$5,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. All amounts paid as deductible, copay and coinsurance for covered services and supplies do apply.)	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family	\$2,500 individual \$5,000 family	\$5,000 individual \$10,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Specialist Office Visit	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	80% after deductible	100%, ded. waived	80% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Inpatient Hospital	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Surgery	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Emergency Room	100% after deductible	100% after deductible	100% after deductible	100% after deductible
Urgent Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	100% after deductible	50% after deductible	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription Drugs⁴	Integrated medical/pharmacy deductible		Integrated medical/pharmacy deductible	
Prescription Drug Deductible	Integrated medical/pharmacy deductible		Integrated medical/pharmacy deductible	
Retail: 30-day supply	100% after deductible	80% after in-network deductible	100% after deductible	80% after in-network deductible
Mail Order: 31-90-day supply	100% after deductible	Not Covered	100% after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — HSA COMPATIBLE

Plan Options	MI PPO HSA COMPATIBLE 3.1*		MI PPO HSA COMPATIBLE 4.1*	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Member Benefits				
Plan Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network. All covered prescription drug and medical expenses, except in-network preventive care, apply to the deductible.)	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family	\$2,500 individual \$5,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. All amounts paid as deductible, copay and coinsurance for covered services and supplies do apply.)	\$3,000 individual \$6,000 family	\$3,000 individual \$6,000 family	\$5,000 individual \$10,000 family	\$5,000 individual \$10,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)		\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Specialist Office Visit	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	60% after deductible	100%, ded. waived	60% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Urgent Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs⁴				
Prescription Drug Deductible	Integrated medical/pharmacy deductible		Integrated medical/pharmacy deductible	
Retail: 30-day supply	80% after deductible	60% after in-network deductible	80% after deductible	60% after in-network deductible
Mail Order: 31-90-day supply	80% after deductible	Not Covered	80% after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included		Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

PPO PLAN OPTIONS — HSA COMPATIBLE		
Plan Options	MI PPO HSA COMPATIBLE 5.2*	
Member Benefits	In-Network	Out-of-Network ¹
Plan Coinsurance	100% after deductible	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network. All covered prescription drug and medical expenses, except in-network preventive care, apply to the deductible.)	\$5,000 individual \$10,000 family	\$5,000 individual \$10,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. All amounts paid as deductible, copay and coinsurance for covered services and supplies do apply.)	\$5,000 individual \$10,000 family	\$10,000 individual \$20,000 family
Lifetime Maximum Benefit	\$5,000,000 (In-network and out-of-network combined.)	
Primary Physician Office Visit	100% after deductible	80% after deductible
Specialist Office Visit	100% after deductible	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	100% after deductible	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	100% after deductible	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	100%, ded. waived	Not Covered
Preventive Care – Routine OB/GYN (1 annual exam and pap smear.)	100%, ded. waived	Not Covered
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40 +. In-network and out-of-network combined.)	100%, ded. waived	80% after deductible
Preventive Care – Routine Eye Exam (1 routine exam per 24 months. Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	100%, ded. waived	Not Covered
Chiropractic Services (20 visits per calendar year. In-network and out-of-network combined.)	100% after deductible	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined. In-network and out-of-network combined.)		
Inpatient Hospital		
Outpatient Surgery	100% after deductible	80% after deductible
Emergency Room		
Urgent Care		
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined. In-network and out-of-network combined.)	50% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Prescription Drugs⁴		
Prescription Drug Deductible	Integrated medical/pharmacy deductible	
Retail: 30-day supply	100% after deductible	80% after deductible
Mail Order: 31-90-day supply	100% after deductible	Not Covered
Contraceptives and Diabetic Supplies	Included	

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

INDEMNITY PLAN OPTION

Plan Options	MI INDEMNITY 1.2*
Member Benefits	Out-of-Network ¹
Plan Coinsurance	80% after deductible
Calendar Year Deductible² (Accumulates Separately In/Out-of-Network.)	\$500 per member \$1,000 family
Calendar Year Coinsurance Maximum³ (Accumulates Separately In/Out-of-Network. Deductible does not apply.)	\$1,000 per member \$2,000 family
Lifetime Maximum Benefit	\$5,000,000
Primary Physician Office Visit	80% after deductible
Specialist Office Visit	80% after deductible
Outpatient Services (Diagnostic/Lab/X-ray)	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible
Preventive Care – Well-Baby, Child and Adult Exams (7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter.)	80% after deductible
Preventive Care – Routine OB/GYN (1 annual exam and pap smear.)	80% after deductible
Preventive Care – Routine Mammography (1 baseline mammogram for covered females age 35-39 years old; and 1 annual mammogram for covered females age 40+.)	80% after deductible
Preventive Care – Routine Eye Exam (Note: Aetna Vision SM Discount program provides savings on contacts, frames, lenses and other eye care accessories.)	Not Covered
Chiropractic Services (20 visits per calendar year.)	80% after deductible
Outpatient Physical, Occupational, Speech Therapy (Limited to 60 visits per calendar year for speech, physical and occupational therapy combined.)	80% after deductible
Inpatient Hospital	80% after deductible
Outpatient Surgery	80% after deductible
Emergency Room	80% after deductible
Urgent Care	80% after deductible
Mental Health/Substance Abuse – Inpatient (30 days per calendar year for Inpatient Mental Health/Substance Abuse combined.)	50% after deductible
Durable Medical Equipment	80% after deductible
Prescription Drugs⁴	
Prescription Drug Deductible	N/A
Retail: 30-day supply	In-Network: \$15/\$35/\$50 Out-of-Network: 80% after \$15/\$35/\$50
Mail Order: 31-90-day supply	In-Network: \$30/\$70/\$100 Out-of-Network: Not Covered
Contraceptives and Diabetic Supplies	Included

*This is a partial description of benefits available; for more information, refer to the specific plan design summary. The dollar amount copayments indicate what the member is required to pay and the percentage amounts indicate what Aetna is required to pay.

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

²Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. No one family member may contribute more than the individual deductible amount to the family deductible.

³Once the coinsurance maximum is met, all family members will be considered as having met their coinsurance maximum for the remainder of the calendar year. No one family member may contribute more than the individual coinsurance maximum amount to the family coinsurance maximum. Certain member cost-sharing elements may not apply toward the coinsurance maximum: DME, mental health/substance abuse, infertility and prescription drug expenses; deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Out-of-Network pre-certification penalty amounts.

⁴"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 has expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the formulary guide. 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.

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

Note: For a summary list of Limitations and Exclusions, refer to pages 38-39. Please refer to Aetna's Producer World web site at www.aetna.com for more detailed small business benefit descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

Aetna Avenue

DENTAL OVERVIEW**AETNA DENTAL® PLANS**

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

The Mouth MattersSM

Research shows that more than 90 percent of all medical illnesses are detectable in the mouth and that 75 percent of people over the age of 35 have periodontal (gum) disease.¹ Untreated oral diseases can have a big impact on the quality of life. This means that a dentist may be the first health care provider to diagnose a health problem!

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

The Dental Maintenance Organization (DMO®)

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

Preferred Provider Organization (PPO) plan

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

¹ The professional entity, Academy of General Dentistry, 2007.
DMI may not be available in all states.

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

Freedom-of-Choice plan design option

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

Dual Option plan*

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

Voluntary Dental option

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

Aetna Dental Preventive CareSM Plan

The Preventive Care plan is a lower-cost dental plan that covers preventive and diagnostic procedures. Members pay nothing for these services and get a discount on the network dentist's charges for non-covered services when visiting an Aetna PPO dentist. This includes orthodontic work for adults and teeth whitening.

*Dual Option does not apply to Voluntary Dental plans.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees	Option 1 DMO Access	Option 2 Aetna Dental Preventive Care	Option 3 Freedom-of-Choice – Monthly selection between the DMO and PPO Max	
	Plan 42	PPO Plan 100/0/0	DMO Plan 100/90/60	PPO Plan 100/70/40
Office Visit Copay	\$5	N/A	\$5	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	None	\$50; 3X Family Maximum
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited	\$1,000
Diagnostic Services				
Oral Exams				
Periodic oral exam	No Charge	100%	100%	100%
Comprehensive oral exam	No Charge	100%	100%	100%
Problem-focused oral exam	No Charge	100%	100%	100%
X-rays				
Bitewing – single film	No Charge	100%	100%	100%
Complete series	No Charge	100%	100%	100%
Preventive Services				
Adult Cleaning	No Charge	100%	100%	100%
Child Cleaning	No Charge	100%	100%	100%
Sealants – per tooth	\$10	100%	100%	100%
Fluoride application – with cleaning	No Charge	100%	100%	100%
Space maintainers	\$100	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	\$32	Discounted Fee	90%	70%
Resin filling – 2 surfaces, anterior	\$55	Discounted Fee	90%	70%
Oral Surgery				
Extraction – exposed root or erupted tooth	\$30	Discounted Fee	90%	70%
Extraction of impacted tooth – soft tissue	\$80	Discounted Fee	90%	70%
*Major Services				
Complete upper denture	\$500	Discounted Fee	60%	40%
Partial upper denture (resin base)	\$513	Discounted Fee	60%	40%
Crown – Porcelain with noble metal	\$488	Discounted Fee	60%	40%
Pontic – Porcelain with noble metal	\$488	Discounted Fee	60%	40%
Inlay – Metallic (3 or more surfaces)	\$463	Discounted Fee	60%	40%
Oral Surgery				
Removal of impacted tooth – partially bony	\$175**	Discounted Fee	60%	40%
Endodontic Services				
Bicuspid root canal therapy	\$195	Discounted Fee	90%	40%
Molar root canal therapy	\$435**	Discounted Fee	60%	40%
Periodontic Services				
Scaling & root planing – per quadrant	\$65	Discounted Fee	90%	40%
Osseous surgery – per quadrant	\$445**	Discounted Fee	60%	40%
*Orthodontic Services	\$2300 copay	Discounted Fee	\$2300 copay	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

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

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

Fixed Dollar Copay amounts on the DMO in Plan Options 1 & 3 are the member's responsibility.

Access to negotiated discounts; On the PPO plans in Plan Options 2 – 8, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

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

Out-of-Network plan payments are limited by geographic area on Plan Options 2, 3, 5 & 6 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 8.

Plan Options 4 & 7; 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.

The DMO in Plan Option 1 can be offered with any one of the PPO plans in Plan Options 4 – 7 in a Dual Option package.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38-39.

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.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees	Option 4 PPO Max 1000		Option 5 Active PPO	
	PPO Max Plan 100/80/50	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	
Office Visit Copay	N/A	N/A	N/A	
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum	
Annual Maximum Benefit	\$1,000	\$1,500	\$1,000	
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	80%	100%	
Comprehensive oral exam	100%	80%	100%	
Problem-focused oral exam	100%	80%	100%	
X-rays				
Bitewing – single film	100%	100%	80%	
Complete series	100%	100%	80%	
Preventive Services				
Adult Cleaning	100%	100%	80%	
Child Cleaning	100%	100%	80%	
Sealants – per tooth	100%	100%	80%	
Fluoride application – with cleaning	100%	100%	80%	
Space maintainers	100%	100%	80%	
Basic Services				
Amalgam filling – 2 surfaces	80%	80%	60%	
Resin filling – 2 surfaces, anterior	80%	80%	60%	
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	60%	
Extraction of impacted tooth – soft tissue	80%	80%	60%	
*Major Services				
Complete upper denture	50%	50%	40%	
Partial upper denture (resin base)	50%	50%	40%	
Crown – Porcelain with noble metal	50%	50%	40%	
Pontic – Porcelain with noble metal	50%	50%	40%	
Inlay – Metallic (3 or more surfaces)	50%	50%	40%	
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	40%	
Endodontic Services				
Bicuspid root canal therapy	50%	50%	40%	
Molar root canal therapy	50%	50%	40%	
Periodontic Services				
Scaling & root planing – per quadrant	50%	50%	40%	
Osseous surgery – per quadrant	50%	50%	40%	
*Orthodontic Services				
Orthodontic Lifetime Maximum	Does not apply	\$1,000	\$1,000	

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

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

Fixed Dollar Copay amounts on the DMO in Plan Options 1 & 3 are the member's responsibility.

Access to negotiated discounts; On the PPO plans in Plan Options 2 – 8, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

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

Out-of-Network plan payments are limited by geographic area on Plan Options 2, 3, 5 & 6 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 8.

Plan Options 4 & 7; 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.

The DMO in Plan Option 1 can be offered with any one of the PPO plans in Plan Options 4 – 7 in a Dual Option package.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38-39.

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.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees	Option 6 PPO 1500	Option 7 PPO Max 1500	Option 8 PPO High
Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees	PPO Plan 100/80/50	PPO Max Plan 100/80/50	PPO Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum
Annual Maximum Benefit	\$1,500	\$1,500	\$1,500
Diagnostic Services			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Problem-focused oral exam	100%	100%	100%
X-rays			
Bitewing – single film	100%	100%	100%
Complete series	100%	100%	100%
Preventive Services			
Adult Cleaning	100%	100%	100%
Child Cleaning	100%	100%	100%
Sealants – per tooth	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%
Space maintainers	100%	100%	100%
Basic Services			
Amalgam filling – 2 surfaces	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%
Oral Surgery			
Extraction – exposed root or erupted tooth	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%
*Major Services			
Complete upper denture	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%
Crown – Porcelain with noble metal	50%	50%	50%
Pontic – Porcelain with noble metal	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%
Oral Surgery			
Removal of impacted tooth – partially bony	50%	50%	50%
Endodontic Services			
Bicuspid root canal therapy	50%	50%	50%
Molar root canal therapy	50%	50%	50%
Periodontic Services			
Scaling & root planing – per quadrant	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%
*Orthodontic Services			
Orthodontic Lifetime Maximum	\$1,000	Does not apply	\$1,000

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

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

Fixed Dollar Copay amounts on the DMO in Plan Options 1 & 3 are the member's responsibility.

Access to negotiated discounts; On the PPO plans in Plan Options 2 – 8, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

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

Out-of-Network plan payments are limited by geographic area on Plan Options 2, 3, 5 & 6 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 8.

Plan Options 4 & 7; 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.

The DMO in Plan Option 1 can be offered with any one of the PPO plans in Plan Options 4 – 7 in a Dual Option package.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38-39.

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.

AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 3 - 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 3 - 50 Eligible Employees	Voluntary Option 1 DMO Access	Voluntary Option 2 Freedom-of-Choice - Monthly selection between the DMO and PPO		Voluntary Option 3 PPO Max	Voluntary Option 4 Aetna Dental Preventive Care
	Plan 42	DMO Plan 100/90/60	PPO Max Plan 100/70/40	PPO Max Plan 100/80/50	PPO Plan 100/0/0
Office Visit Copay	\$10	\$10	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	None	None	\$75; 3X Family Maximum	\$75; 3X Family Maximum	None
Annual Maximum Benefit	Unlimited	Unlimited	\$1,000	\$1,000	Unlimited
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	\$10	100%	100%	100%	100%
Fluoride application – with cleaning	No Charge	100%	100%	100%	100%
Space maintainers	\$100	100%	100%	100%	100%
Basic Services					
Amalgam filling – 2 surfaces	\$32	90%	70%	80%	Discounted Fee
Resin filling – 2 surfaces, anterior	\$55	90%	70%	80%	Discounted Fee
Oral Surgery					
Extraction – exposed root or erupted tooth	\$30	90%	70%	80%	Discounted Fee
Extraction of impacted tooth – soft tissue	\$80	90%	70%	80%	Discounted Fee
*Major Services					
Complete upper denture	\$500	60%	40%	50%	Discounted Fee
Partial upper denture (resin base)	\$513	60%	40%	50%	Discounted Fee
Crown – Porcelain with noble metal	\$488	60%	40%	50%	Discounted Fee
Pontic – Porcelain with noble metal	\$488	60%	40%	50%	Discounted Fee
Inlay – Metallic (3 or more surfaces)	\$463	60%	40%	50%	Discounted Fee
Oral Surgery					
Removal of impacted tooth – partially bony	\$175**	60%	40%	50%	Discounted Fee
Endodontic Services					
Bicuspid root canal therapy	\$195	90%	40%	50%	Discounted Fee
Molar root canal therapy	\$435**	60%	40%	50%	Discounted Fee
Periodontic Services					
Scaling & root planing – per quadrant	\$65	90%	40%	50%	Discounted Fee
Osseous surgery – per quadrant	\$445**	60%	40%	50%	Discounted Fee
*Orthodontic Services	\$2400 copay	\$2400 copay	Not covered	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Voluntary Plan Options 1 & 2.

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

Fixed Dollar Copay amounts on the DMO in Plan Options 1 & 2 are the member's responsibility.

Access to negotiated discounts; On the PPO plans in Voluntary Plan Options 2, 3 & 4 members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Option 2.

Voluntary Plan Option 3; 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.

All voluntary plans require a minimum of 3 to enroll. Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only. A minimum of 5 employees must enroll.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38 – 39.

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.

AETNA SMALL GROUP DENTAL PLANS — OUT-OF-STATE PPO

Available With an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 10 - 50 Eligible Employees	Low Option No Ortho	Low Option Ortho	Medium Option No Ortho	Medium Option Ortho
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum	\$50; 3X Family Maximum
Annual Maximum Benefit	\$1,000	\$1,000	\$1,500	\$1,500
Diagnostic Services				
Oral Exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Adult Cleaning	100%	100%	100%	100%
Child Cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application – with cleaning	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic Services				
Amalgam filling – 2 surfaces	80%	80%	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%	80%	80%
Oral Surgery				
Extraction – exposed root or erupted tooth	80%	80%	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%	80%	80%
*Major Services				
Complete upper denture	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%
Crown – Porcelain with noble metal	50%	50%	50%	50%
Pontic – Porcelain with noble metal	50%	50%	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%	50%	50%
Oral Surgery				
Removal of impacted tooth – partially bony	50%	50%	50%	50%
Endodontic Services				
Bicuspid root canal therapy	50%	50%	50%	50%
Molar root canal therapy	50%	50%	50%	50%
Periodontic Services				
Scaling & root planing – per quadrant	50%	50%	50%	50%
Osseous surgery – per quadrant	50%	50%	50%	50%
*Orthodontic Services				
Orthodontic Lifetime Maximum	Does not apply	\$1,000	Does not apply	\$1,000

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Access to negotiated discounts; On all PPO Max plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.
PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area. Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only.
Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38-39.
For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.

AETNA SMALL GROUP DENTAL PLANS OUT-OF-STATE PPO VOLUNTARY

Available With an Aetna Medical Plan to Groups with 2 - 50 Eligible Employees Available Without Medical Plan (Dental Standalone) to Groups with 10 - 50 Eligible Employees	Option 1 No Ortho	Option 1 Ortho
	PPO Max Plan 100/80/50	PPO Max Plan 100/80/50
Office Visit Copay	N/A	N/A
Annual Deductible per Member (Does not apply to Diagnostic & Preventive Services)	\$75; 3X Family Maximum	\$75; 3X Family Maximum
Annual Maximum Benefit	\$1,000	\$1,000
Diagnostic Services		
Oral Exams		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
X-rays		
Bitewing – single film	100%	100%
Complete series	100%	100%
Preventive Services		
Adult Cleaning	100%	100%
Child Cleaning	100%	100%
Sealants – per tooth	100%	100%
Fluoride application – with cleaning	100%	100%
Space maintainers	100%	100%
Basic Services		
Amalgam filling – 2 surfaces	80%	80%
Resin filling – 2 surfaces, anterior	80%	80%
Oral Surgery		
Extraction – exposed root or erupted tooth	80%	80%
Extraction of impacted tooth – soft tissue	80%	80%
*Major Services		
Complete upper denture	50%	50%
Partial upper denture (resin base)	50%	50%
Crown – Porcelain with noble metal	50%	50%
Pontic – Porcelain with noble metal	50%	50%
Inlay – Metallic (3 or more surfaces)	50%	50%
Oral Surgery		
Removal of impacted tooth – partially bony	50%	50%
Endodontic Services		
Bicuspid root canal therapy	50%	50%
Molar root canal therapy	50%	50%
Periodontic Services		
Scaling & root planing – per quadrant	50%	50%
Osseous surgery – per quadrant	50%	50%
*Orthodontic Services		
Orthodontic Lifetime Maximum	Does not apply	\$1,000

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

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.

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to pages 38-39.

For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, New Mexico, South Dakota, Vermont, Wyoming.

*Aetna Avenue***LIFE AND DISABILITY OVERVIEW**

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

LIFE INSURANCE

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

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

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

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

Giving you (and your employees) what you want

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

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

Accelerated death benefit —

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

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

Optional dependent life — This feature allows employees to add optional additional coverage for eligible spouses and children for employers with 10 or more employees.

Our fresh approach to life

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

AD&D ULTRA®

AD&D Ultra coverage is standardly included with our small group life and disability package and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. It includes extra, no-cost features, such as coverage for education or child-care expenses that make this protection even more valuable.

Benefits include:

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

DISABILITY INSURANCE

Disability insurance coverage is standardly included with our small group life and disability package. Finding disability services for you and your employees isn't difficult. Many companies offer them. The challenge is finding the right plan ... one that will meet the distinct needs of your business. Aetna understands this.

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

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

INTEGRATED HEALTH AND DISABILITY

Integrated health and disability coverage is standardly included with our small group life and disability package. With our Integrated Health and Disability program, we can link medical and disability data to help anticipate concerns, take action and get your employees back to work sooner:

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

For a summary list of Limitations and Exclusions, refer to pages 38-39.

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 even if only 2 classes are offered
Premium Waiver Provision	Premium Waiver 60	Premium Waiver 60
Age Reduction Schedule	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75	Original Life Amount reduces to 65% at age 65; 40% at age 70; 25% at age 75
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Guaranteed Issue	\$20,000	10-25 employees \$75,000 26-50 employees \$100,000
Participation Requirements	100%	100% on non-contributory plans; With Medical — 70% on contributory plans Standalone (26-50) — 75% on contributory plans
Contribution Requirements	100% Employer Contribution	Minimum 50% Employer Contribution
AD&D ULTRA®		
AD&D Schedule	Matches Life Benefit	Matches Life Benefit
Additional Features	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	\$5,000
Child Amount	Not Available	\$2,000

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

Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees

Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees

DISABILITY PLAN OPTIONS

SHORT TERM BENEFITS	Plan Option 1	Plan Option 2
Plan Amount	Choice of flat \$100 increments to a maximum of \$500 weekly	Choice of flat \$100 increments to a maximum of \$500 weekly
Benefits Start — Accident	1 Day	8 Days
Benefits Start — Illness	8 Days	8 Days
Maximum Benefit Period	26 Weeks	26 Weeks
Maternity Benefit	Maternity treated same as any other disability but is subject to pre-existing. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.	Maternity treated same as any other disability but is subject to pre-existing. If pregnant before the effective date, the pregnancy is not covered unless she has prior creditable coverage.
Pre-Existing Conditions Rule	3/12	3/12
Actively at Work Rule	Applies	Applies
Other Income Offset Integration	N/A	N/A
Other Income Offset Integration	Earnings Loss of 20% or more	Earnings Loss of 20% or more
Definition of Disability	Earnings Loss of 20% or more	Earnings Loss of 20% or more
Class Schedules	Up to 3 classes (with a minimum requirement of 3 employees in each class) available for groups of 10 or more employees. The benefit amount of the highest class cannot be more than 5 times the benefit amount of the lowest class even if only two classes are offered.	

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

Available With an Aetna Dental Plan to Groups with 10-50 Eligible Employees

Available Standalone (Without Medical or Dental Plans) to Groups with 26-50 Eligible Employees

PACKAGED LIFE AND DISABILITY PLAN OPTIONS

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

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

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

For groups with 2 to 50 eligible employees on or after September 1, 2009 effective date, Michigan

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

Census Data	<ul style="list-style-type: none"> ▪ Census data must be provided on all eligible, including COBRA and Retiree eligible employees. Include name, age/date of birth, date of hire, gender, dependent status, and residence zip code. ▪ COBRA eligibles should be included on the census and noted as COBRA.
Case Submission	<ul style="list-style-type: none"> ▪ All new business submissions must be received in our Jacksonville Underwriting office by end of business day on the requested effective date. ▪ Any cases 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 date.
Dependent Eligibility	<ul style="list-style-type: none"> ▪ Eligible dependents include an employee’s spouse and unmarried children up to age 19. Unmarried child(ren) who are dependent solely on the employee for support include natural, stepchildren, foster, legally adopted children, proposed adoptive children, and a child under court order. Coverage may be extended to age 25 if they are attending school on a full-time basis and dependent solely on the employee for support. ▪ Domestic Partners are not considered eligible dependents. ▪ If both husband and wife work for the same company, they may enroll together or separately. Children can only be covered under one parent’s plan. ▪ For dependent life, dependents are eligible from 14 days to age 19, or to age 25 if in school. ▪ Dependents are not eligible for AD&D or Disability coverage. ▪ For Medical and Dental, dependents must enroll in the same benefits as the employee (participation is not required). ▪ Employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical Plan. See product-specific Life/AD&D and Disability guidelines under Product Specifications.
Pick-A-Plan 3	<ul style="list-style-type: none"> ▪ Allows employers to offer up to three medical plans to the employees. ▪ The group must have 5 enrolled employees for any combination of up to 3 plans for Pick-A-Plan 3. One must enroll in each plan. ▪ Employees who choose to enroll in the richer plan are responsible for the difference in premium. ▪ The plans are priced based on full census of the group so actual enrollment in each plan will not cause the rates to change; however, if the sold case has a different overall census than the quote they will need to be rerated (i.e. a case quoted with 20 employees but sold with 17 employees would need to be rerated with the new census).
Effective Date	<ul style="list-style-type: none"> ▪ 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. ▪ When replacing an employer sponsored group plan, the effective date must coincide with the premium date of the other carrier, without regard to the grace period. For example, if the other plan has a premium date of the 1st. The Aetna plan will be effective on the 1st and not the 15th.

Employee Eligibility	<ul style="list-style-type: none"> ▪ An eligible employee is an employee who works 30 or more hours a week for a given employer. ▪ Employers who do not meet the definition of a small employer are not eligible for coverage. ▪ The employer may choose to count employees who work 17.5 hours to 30 hours per week as full-time employees as long as this criterion is applied uniformly among all of the employer's employees and without regard to health status. If this criteria is elected the employer's actual definition must be provided in writing on the Employer Application at the time of new business submission. ▪ Employees reported on the IRS 1099 forms who meet Aetna's standard criteria for determining 1099 status may be considered, and only if all 1099 employees are offered coverage, and as long as the 1099 employees comprise less than 25% of total eligibles in the group. ▪ Part-time, temporary, or substitute employees are not eligible. ▪ Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement or excluded class of non-management/non-salaried employees. While they must be included in the count in determining whether or not the group is a small employer, the employer may carve out these employees as an excluded class. ▪ Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa. <p>Retirees</p> <ul style="list-style-type: none"> ▪ Coverage is available to retirees for groups with 20 to 50 eligible employees. ▪ Retirees cannot comprise more than 10% of the group. ▪ The retiree must be currently covered with present carrier (must be shown on the bill roster or provide a copy of the ID card). If there were no retirees covered by the prior carrier, the employee must be covered as an employee on the bill roster and on the quarterly wage and tax statement. ▪ The Retiree Questionnaire must be completed. <p>COBRA continuees</p> <ul style="list-style-type: none"> ▪ COBRA eligible enrollees are required to be included on the census for medical and dental (if applicable), however are not eligible for Life or Disability. ▪ Health questions must be answered. <p>Note: Employees reported on the IRS 1099 forms, COBRA and Retirees are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, 1099 employees and COBRA continuees and Retirees can be included for coverage subject to normal underwriting guidelines.</p>
Employer Eligibility	<ul style="list-style-type: none"> ▪ Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business that, on at least 50% of its working days during the preceding and current calendar years employed at least 2 but not more than 50 eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. ▪ Employers who do not meet the definition of a small employer are not eligible for coverage. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage. ▪ Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms and closed groups are not eligible. ▪ Dental and Disability have ineligible industries which are listed separately under Product Specifications. ▪ The dental ineligible industry list does not apply when dental is sold in combination with medical.
Initial Premium Check	<ul style="list-style-type: none"> ▪ The initial premium check should be in the amount of the first month's premium and drawn on a company check. ▪ The initial premium check is not a binder check. ▪ 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.
Live/Work	<ul style="list-style-type: none"> ▪ Live or work is allowed for PPO plans as long as the employee residence zip is located within 60 miles of the business location for one of the following contiguous states — Ohio and Indiana.
Plan Change Ancillary Additions	<ul style="list-style-type: none"> ▪ Package Life / Disability must be requested 30 days prior to the desired effective date. ▪ Dental plans must be requested 30 days prior to the desired effective date. ▪ The future renewal date of the ancillary products will be the same as the medical plan renewal. Non-packaged plan changes are available upon renewal.
Replacing Other Group Coverage	<ul style="list-style-type: none"> ▪ Provide a copy of the current billing statement that includes the account summary. ▪ The employer should be told not to cancel any existing Medical coverage until they have been notified of approval from the Aetna Underwriting unit.

<p>Tax Documentation</p>	<ul style="list-style-type: none"> ▪ The employer must provide a copy of the most recent Quarterly Wage and Tax Statement (QWTS) that must contain the names, salaries, etc., of all employees of the employer group. <ul style="list-style-type: none"> – Employees who have terminated, work part-time or are newly hired should be noted accordingly on the QWTS. – Any handwritten comments added to the QWTS must be signed and dated by the employer. This may be requested at the discretion of the underwriter. – Newly hired employees not listed on the QWTS must provide a copy of the first and last payroll stub for each employee and letter from employer verifying the number of hours worked. ▪ Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941. ▪ Proprietors, Partners or Officers of the business who do not appear on the QWTS must submit one of the following identified documents: <table border="1" data-bbox="349 420 1494 850"> <tr> <td data-bbox="349 420 820 546"> <p>Sole Proprietor</p> <ul style="list-style-type: none"> ▪ Franchise ▪ Limited Liability Company (operating as a Sole Proprietor) </td> <td data-bbox="820 420 1494 546"> <ul style="list-style-type: none"> ▪ IRS Form 1040 along with Schedule C (Form 1040) ▪ IRS Form 1040 along with Schedule SE (Form 1040) ▪ IRS Form 1040 along with Schedule F (Form 1040) ▪ IRS 1040 along with Schedule K1 (Form 1065) </td> </tr> <tr> <td data-bbox="349 546 820 661"> <p>Partner</p> <ul style="list-style-type: none"> ▪ Partnership ▪ Limited Liability Partnership </td> <td data-bbox="820 546 1494 661"> <ul style="list-style-type: none"> ▪ IRS Form 1065 Schedule K-1 ▪ IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) ▪ Partnership agreement - eligible partners must be listed on agreement </td> </tr> <tr> <td data-bbox="349 661 820 850"> <p>Corporate Officer</p> <ul style="list-style-type: none"> ▪ Limited Liability Company (operating as C Corp) ▪ C-Corporation ▪ Personal Service Corporation ▪ S-Corporation </td> <td data-bbox="820 661 1494 850"> <ul style="list-style-type: none"> ▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040) ▪ IRS Form 1120 W (C-Corp & Personal Service Corp) ▪ 1040 ES (Estimated Tax) (S-Corp) ▪ IRS Form 8832 (Entity classification as a corporation) ▪ W2 ▪ Articles of Incorporation - corporate officers must be listed </td> </tr> </table> 	<p>Sole Proprietor</p> <ul style="list-style-type: none"> ▪ Franchise ▪ Limited Liability Company (operating as a Sole Proprietor) 	<ul style="list-style-type: none"> ▪ IRS Form 1040 along with Schedule C (Form 1040) ▪ IRS Form 1040 along with Schedule SE (Form 1040) ▪ IRS Form 1040 along with Schedule F (Form 1040) ▪ IRS 1040 along with Schedule K1 (Form 1065) 	<p>Partner</p> <ul style="list-style-type: none"> ▪ Partnership ▪ Limited Liability Partnership 	<ul style="list-style-type: none"> ▪ IRS Form 1065 Schedule K-1 ▪ IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040) ▪ Partnership agreement - eligible partners must be listed on agreement 	<p>Corporate Officer</p> <ul style="list-style-type: none"> ▪ Limited Liability Company (operating as C Corp) ▪ C-Corporation ▪ Personal Service Corporation ▪ S-Corporation 	<ul style="list-style-type: none"> ▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040) ▪ IRS Form 1120 W (C-Corp & Personal Service Corp) ▪ 1040 ES (Estimated Tax) (S-Corp) ▪ IRS Form 8832 (Entity classification as a corporation) ▪ W2 ▪ Articles of Incorporation - corporate officers must be listed
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<p>Corporate Officer</p> <ul style="list-style-type: none"> ▪ Limited Liability Company (operating as C Corp) ▪ C-Corporation ▪ Personal Service Corporation ▪ S-Corporation 	<ul style="list-style-type: none"> ▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040) ▪ IRS Form 1120 W (C-Corp & Personal Service Corp) ▪ 1040 ES (Estimated Tax) (S-Corp) ▪ IRS Form 8832 (Entity classification as a corporation) ▪ W2 ▪ Articles of Incorporation - corporate officers must be listed 						
<p>Two Separate Companies</p>	<p>Single employer groups with multiple Employer Tax ID Numbers may be considered together as long as:</p> <ul style="list-style-type: none"> ▪ There are 50 or fewer employees in the combined employer groups. ▪ One owner controls the majority of each separate business. For example: <ul style="list-style-type: none"> – Business 1 – John owns 75% and Mike owns 25% – Business 2 – John owns 55% and Mike owns 45% – Both businesses can be written as one group since John has controlling interest in both companies. ▪ Businesses with equal controlling interest may be considered if the owners of the company designate one individual to act on behalf of all the groups. ▪ A copy of current 1120 S (Schedule K-1 Form) must be provided; and ▪ A copy of most recent Quarterly Wage and Tax Statement for all companies must be provided; and ▪ A letter from the plan sponsor stating that they are a single employer under IRS and not a MEWA under ERISA. The Employer should consult with their counsel to be sure they qualify as one group. ▪ The two or more groups may have different Standard Industrial Classification Codes (SIC), however, rates will be based on the SIC code for the group with the majority of employees. 						
<p>Waiting Period</p>	<ul style="list-style-type: none"> ▪ At initial submission of the group, the benefit waiting period may be waived upon the employer's request. This should be checked on the Employer Application. ▪ Only one benefit waiting period is allowed. ▪ Benefit waiting periods must be consistently applied to all employees, including newly hired key employees. ▪ The benefit waiting period for future employees may be 0, 30, 60, 90, 120, or 180 days. ▪ The eligibility date for new hires will be the first day of the policy month following the waiting period. <ul style="list-style-type: none"> – Example: <ul style="list-style-type: none"> – Group A – effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period. – Group B – effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period. ▪ A change to the waiting period can only be made on the anniversary date. ▪ No retroactive changes will be allowed. 						

	Medical	Dental	Life/AD&D Life Packaged Plans	Disability
Product Availability	<ul style="list-style-type: none"> 2 to 50 eligibles may be written standalone or with ancillary coverages as noted in the following columns. 	<p>Standard</p> <ul style="list-style-type: none"> 2 to 50 eligibles <ul style="list-style-type: none"> All plans available if packaged with medical 3 to 50 eligibles <ul style="list-style-type: none"> All plans available if packaged with medical Standalone available <p>Voluntary</p> <ul style="list-style-type: none"> 2 eligibles <ul style="list-style-type: none"> Not available 3 to 50 eligibles <ul style="list-style-type: none"> All plans available if packaged with medical Standalone available Voluntary Dual Option <ul style="list-style-type: none"> Not permitted <p>Standard and Voluntary</p> <ul style="list-style-type: none"> Orthodontic coverage is available to dependent children only for groups of 10 or more eligible employees with a minimum of 5 enrolled. 	<p>Term Life</p> <ul style="list-style-type: none"> 2-50 eligibles <ul style="list-style-type: none"> If packaged with medical 10-50 eligibles <ul style="list-style-type: none"> If packaged with dental 26-50 eligibles <ul style="list-style-type: none"> Standalone basis <p>Packaged Life and Disability</p> <ul style="list-style-type: none"> 2-50 eligibles <ul style="list-style-type: none"> If packaged with medical 10-50 eligibles <ul style="list-style-type: none"> If packaged with dental 10-50 eligibles <ul style="list-style-type: none"> Standalone basis <p>Term Life/Packaged Life and Disability</p> <p>A plan sponsor cannot purchase both Life and Packaged Life and Disability plans.</p>	<ul style="list-style-type: none"> 2-9 eligible <ul style="list-style-type: none"> If packaged with medical 10-25 eligibles <ul style="list-style-type: none"> If packaged with medical or dental 26-50 eligibles <ul style="list-style-type: none"> Standalone basis. 10-50 eligible <ul style="list-style-type: none"> If packaged life and disability Groups are ineligible for coverage if 60% or more of eligible employees or 60% or more of eligible payroll are for employees over 50 years old. Employees may elect Disability coverage even if they do not elect medical coverage. A plan sponsor cannot purchase both Disability and Packaged Life and Disability plans. Available to employees only.
Employer Contribution	<ul style="list-style-type: none"> No minimum employer contribution is required. 	<p>Standard</p> <ul style="list-style-type: none"> 2 to 50 eligibles <ul style="list-style-type: none"> 25% of the total cost of the plan or 50% of the cost of employee only coverage. <p>Voluntary</p> <ul style="list-style-type: none"> Employer contribution of less than 50% of employee only premium. Employee pay all plans are permitted. <p>Standard and Voluntary</p> <ul style="list-style-type: none"> Coverage can be denied based on inadequate contributions. 	<ul style="list-style-type: none"> 2 to 9 eligibles <ul style="list-style-type: none"> 100% of the total cost 10 to 50 eligibles <ul style="list-style-type: none"> At least 50% of the total cost (excluding Optional Dependent Term Life) Coverage can be denied based on inadequate contributions. 	<ul style="list-style-type: none"> 2 to 9 eligibles <ul style="list-style-type: none"> 100% of the total cost 10 to 50 eligibles <ul style="list-style-type: none"> At least 50% of total cost of the plan Coverage can be denied based on inadequate contributions.
Excluded Class/Carve Outs	<ul style="list-style-type: none"> Union employees may be excluded. Provide the union name and local number. Union employees are included in the total count of eligible employees in determining the case size. Non-Management or nonsalaried employees may be carved-out / excluded, provided the following are met: <ul style="list-style-type: none"> The group must have 10+ eligibles in the management or salaried group. QWTS – the employer must note each employee's designation next to their name (management vs nonmanagement or salaried vs non-salaried) and sign/ date the form. 100% participation is required less spousal group waivers. Spousal waivers are the only valid waiver. 	<ul style="list-style-type: none"> Union 	<ul style="list-style-type: none"> Union 	<ul style="list-style-type: none"> Union

MICHIGAN PLAN GUIDE

	Medical	Dental	Life/AD&D Life Packaged Plans	Disability
Medical Underwriting	<ul style="list-style-type: none"> ▪ A Michigan group with 2 to 50 eligibles cannot be denied based on medical conditions; however, rates may be adjusted for known medical conditions. ▪ Employees residing outside the state cannot be denied based on medical conditions; however, may have rates adjusted to the maximum allowed in that state. 	<ul style="list-style-type: none"> ▪ Not applicable. 	<ul style="list-style-type: none"> ▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested. ▪ Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts listed below will be required to submit Evidence of Insurability (EOI) which means they must complete an individual health statement and may have to submit 	<ul style="list-style-type: none"> ▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested and/or they are late entrants.
Late Applicants	<ul style="list-style-type: none"> ▪ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee. Applicants without a qualifying life event (i.e. marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below: ▪ Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to enroll. ▪ Life late enrollee example: Group has \$50,000 life with \$20,000 guarantee issue limit. Late enrollee enrolling for \$50,000 would not automatically get the \$20,000. Since the applicant is late they must medically qualify for the entire \$50,000. 			
	<ul style="list-style-type: none"> ▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. 	<ul style="list-style-type: none"> ▪ An employee or dependent may enroll at any time, however, coverage is limited to Preventive & Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics). ▪ Late Entrant provision does not apply to enrollees less than age 5. 	<ul style="list-style-type: none"> ▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. ▪ The applicant will be required to complete an individual health statement/questionnaire and provide EOI. 	<ul style="list-style-type: none"> ▪ Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date. ▪ The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).
Out-of-state employees (residing outside Michigan)	<ul style="list-style-type: none"> ▪ Out-of-State employees may enroll in a PPO plan if available, otherwise in an Indemnity plan. ▪ PPO is not available in the following states: AL, HI, ID, MN, MT, ND, NM, RI, UT, VT, WI, WY. ▪ Indemnity is not available in HI or VT. 	<ul style="list-style-type: none"> ▪ Out-of-state employees must be enrolled in a PPO dental plan if available, otherwise an indemnity dental plan. ▪ OOS PPO Dental is not available in the following states: AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, VT, WY. 	<ul style="list-style-type: none"> ▪ Out of state employees are eligible for the same benefit, same rates as elected by the home office. ▪ Note: The home office would have to be situated in a state that we offer Life and/or Packaged Life/DI. 	<ul style="list-style-type: none"> ▪ Out of state employees are eligible for the same benefit, same rates as elected by the home office except out-of-state employees residing in NY, NJ, HI, CA, RI and PR. ▪ Note: The home office would have to be situated in a state that we offer Disability and/or Packaged Life/DI.

	Medical	Dental	Life/AD&D Life Packaged Plans	Disability
Participation	<ul style="list-style-type: none"> ▪ Non-contributory plans, 100% participation is required, excluding valid waivers. ▪ 2 to 3 eligibles 100% of the eligible employees seeking health care coverage through the small employer. ▪ 4 to 25 eligibles 70% of the eligible employees seeking health care coverage through the small employer. ▪ 26 to 50 eligibles 50% of the eligible employees seeking health care coverage through the small employer. ▪ Seeking coverage means those employees that choose to seek group coverage through their employer. If an employee has their own individual coverage, has coverage through a spouse, simply cannot afford the employee share of the premium, or just chooses to not be covered by health insurance, they are not included with the employees seeking coverage and must complete a waiver. ▪ The employer size is based on the number of eligible employees, regardless of how many employees are seeking coverage through the employer. <ul style="list-style-type: none"> – Example: 26 eligibles 19 are seeking coverage 50% (not 70% applies noting there are 26 eligibles) of the employees seeking coverage must enroll. Waivers or enrollment forms are needed on all 26 employees $19 \times 50\% = 9.5 = 10$ must enroll 	<ul style="list-style-type: none"> ▪ Non-contributory plans, 100% participation is required, excluding those with other qualifying dental coverage. <p>Standard</p> <ul style="list-style-type: none"> ▪ 2 to 3 eligibles 100% participation is required excluding those with other qualifying dental coverage. <ul style="list-style-type: none"> – Example: 3 eligibles, 1 spousal dental $3 \text{ minus } 1 = 2 \times 100\% = 2$ 2 must enroll ▪ 4 to 50 eligibles 70% participation is required excluding those with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the dental plan. <p>Voluntary</p> <ul style="list-style-type: none"> ▪ 3 to 50 eligibles 25% participation, excluding those with other qualifying existing dental coverage, or a minimum of 3 enrollees (5 enrollees for orthodontia coverage), whichever is greater. <ul style="list-style-type: none"> – Example 1: 6 eligibles 2 spousal dental $6 \text{ minus } 2 = 4 \times 25\% = 1$ 1 is below minimum of 3 so 3 must enroll to meet minimum. – Example 2: 20 eligibles 2 spousal dental $20 \text{ minus } 2 = 18 \times 25\% = 4.5$ 5 must enroll <p>Standalone</p> <ul style="list-style-type: none"> ▪ 75% participation is required excluding those with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the dental plan. <p>All Plans</p> <ul style="list-style-type: none"> ▪ Employees may select coverage for eligible dependents under the Dental plan even if they elected single coverage on the Medical Plan or vice versa. ▪ Coverage can be denied based on inadequate participation. 	<ul style="list-style-type: none"> ▪ Non-contributory plans, 100% participation is required. ▪ 2 to 9 eligibles 100% participation is required. ▪ 10 to 50 eligibles 70% must participate if packaged with medical. ▪ Standalone life – 75% participation is required. ▪ COBRA continuees are not eligible for Life. ▪ 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. <ul style="list-style-type: none"> – Example: 9 employees 3 waiving medical 9 must enroll for Life 	<ul style="list-style-type: none"> ▪ Non-contributory plans, 100% participation is required. ▪ 2 to 9 employees 100% participation is required. ▪ 10 to 50 employees 75% participation is required. ▪ COBRA continuees are not eligible for Disability. ▪ Employees may elect Disability coverage even if they do not elect medical coverage and the group must meet the required participation percentage. If not, then Disability will be declined for the group. <ul style="list-style-type: none"> – Example: 9 employees 3 waiving medical 9 must enroll for Disability

MICHIGAN PLAN GUIDE

	Medical	Dental	Life/AD&D Life Packaged Plans	Disability																																																																																																																																
<p>Standard Industrial Classification Code (SIC)</p>	<ul style="list-style-type: none"> All industries are eligible The employer should provide the SIC code (four digit number) or NAIC state code 6 (digit code) filed with the state on the business tax return and/or the Workers' Compensation form. 	<p>The following industries are not eligible when Dental is sold standalone or packaged only with Life.</p> <ul style="list-style-type: none"> This list does not apply when Dental is sold in combination with Medical. 	<ul style="list-style-type: none"> Basic Term Life All industries are eligible. Packaged Life and Disability The following industries are not eligible: 	<ul style="list-style-type: none"> The following industries are not eligible: 																																																																																																																																
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DENTAL ONLY

<p>Coverage Waiting Period</p>	<ul style="list-style-type: none"> For Major and Orthodontic Services employees must be an enrolled member of the employer's plan for 1 year before eligible (not applicable to DMO). The coverage waiting period is waived separately for major or Orthodontics Services for employees who were covered by the group's immediately preceding dental plan. To waive the waiting period for orthodontic services, the immediately preceding group plan must have included orthodontic coverage. To waive the waiting period for Major Services, the group's immediately preceding plan must have included Major Services. Virgin group (no prior coverage) – The waiting periods apply to employees at case inception as well as any future hires. Takeover/Replacement cases (prior coverage) – If a group's prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a dental plan in place that covered Major (and Ortho, if applicable) immediately preceding our takeover of the business. – Example: Prior Major coverage but no Ortho coverage. Aetna plan has coverage for both Major and Ortho. The Waiting Period is waived for Major services but not for Ortho services
<p>Product Packaging</p>	<p>Voluntary</p> <ul style="list-style-type: none"> Dental Dual Option sales are not permitted. All voluntary plans must be a single plan sold. Must have a minimum of 3 enrolled. Orthodontic coverage for dependent children only is available on the DMO in Plan Options 1 & 2 for groups with 10 or more eligibles and a minimum of 5 enrolled employees. <p>Standard</p> <ul style="list-style-type: none"> DMO can either be sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 3 enrolled. PPO can be sold standalone or packaged with DMO as a Dual Option with a minimum of 3 enrolled. Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold. Orthodontic coverage for dependent children only is available only to groups with 10 or more eligibles and a minimum of 5 enrolled employees.
<p>Open Enrollment</p>	<ul style="list-style-type: none"> 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.
<p>Option Sales</p>	<ul style="list-style-type: none"> Option sales alongside another Dental carrier are not allowed. All Dental plans must be sold on a full replacement basis.

LIFE AND DISABILITY ONLY

<p>Job Classification (Position) Schedules</p>	<ul style="list-style-type: none"> Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to 3 separate classes are allowed with a minimum requirement of 3 employees in each class. Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five (5) times the benefit of the class with the lowest benefit even if only two classes are offered. For example, a schedule may be structured as follows: <table border="1" data-bbox="344 1306 1484 1449"> <thead> <tr> <th>Position/Job Class</th> <th>Basic Term Life Amount</th> <th>STD</th> <th>Packaged Life/Disability</th> </tr> </thead> <tbody> <tr> <td>Executives</td> <td>\$50,000</td> <td>Flat \$500 (8/8)</td> <td>High</td> </tr> <tr> <td>Managers, Supervisors</td> <td>\$20,000</td> <td>Flat \$300 (8/8)</td> <td>Medium</td> </tr> <tr> <td>All other Employees</td> <td>\$10,000</td> <td>Flat \$200 (8/8)</td> <td>Low</td> </tr> </tbody> </table>	Position/Job Class	Basic Term Life Amount	STD	Packaged Life/Disability	Executives	\$50,000	Flat \$500 (8/8)	High	Managers, Supervisors	\$20,000	Flat \$300 (8/8)	Medium	All other Employees	\$10,000	Flat \$200 (8/8)	Low
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<p>Guaranteed Issue Coverage</p>	<ul style="list-style-type: none"> 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. 																
<p>Actively-at-work (Non-Replacement)</p>	<ul style="list-style-type: none"> Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day. 																
<p>Continuity of Coverage (Replacement - no loss/no gain)</p>	<ul style="list-style-type: none"> The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers. If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable. 																

LIMITATIONS AND EXCLUSIONS

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

The following is a partial list of services and supplies that are generally not covered. However, the plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

MEDICAL

Aetna Open Choice PPO Plan

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

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

DENTAL

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

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

Specific service limitations

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

AD&D ULTRA

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

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

DISABILITY

No benefits are payable if the disability:

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

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

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

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

*For Presale Quote
Requests, e-mail
IL-MI-Quotes
@aetna.com
or fax to
1-866-692-3531.*

MICHIGAN PLAN GUIDE

GROUP ENROLLMENT CHECKLIST

Effective dates may be the 1st or the 15th of the month only.

All new business submissions must be received in our Jacksonville Underwriting office 5 business days prior to the requested effective date.

Send paperwork to:

Aetna Small Group
PO Box 2510
Jacksonville, FL 32231

OR

Aetna New Business Underwriting
Third Floor, F434
841 Prudential Drive
Jacksonville, FL 32207

STEP 1

Complete/Review Employer Application

- Complete all pages of application in ink.
- Employer signature must be an owner or corporate officer.
- Alterations are allowed as long as all changes are initialed and dated by the employee.
- Applications cannot be more than 60 days old.
- Plan options indicated.

STEP 2

Complete/Review Employee Enrollment/Change Form

- Completely filled out by each employee in ink.
- Alterations are allowed as long as all changes are initialed and dated by the employee.
- Waivers/Declinations of coverage section completed.
 - Required for employees — indicate reason for waiving.
 - Required for dependents — indicate other group coverage — list dependent(s) name(s) and reason for declining.

STEP 3

Provide the following information

- ❑ Copy of most recent Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc. of all employees of the employer group.
 - Employees who have terminated or work part-time must be noted accordingly on the QWTS. Terminated employees must have the date of termination listed on the QWTS.
 - Newly hired employees not listed on the QWTS must provide the first and last payroll stub for each employee on a payroll register.
 - Any handwritten comment added to the QWTS must be signed and dated by the employer. This may be requested at the discretion of the underwriter.
- ❑ Sole Proprietor, Partners or Corporate Officers not reported on the Quarterly Wage and Tax form must submit a copy of their prior year tax return.

STEP 4

Complete/Review Initial Premium Check

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

STEP 5

Provide documentation of previous coverage with last premium statement

- ❑ If group coverage currently exists, a copy of the most recent prior carrier bill must be provided. Individuals contained on the bill should match those listed on the wage and tax statement. If not, please indicate on the bill why they are not on the tax and wage statement.

STEP 6

Complete/Review Agent and General Agent information

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

A large blue square containing the text "AETNA AVENUE" in white, bold, sans-serif capital letters. The word "AETNA" is on the top line and "AVENUE" is on the bottom line, with a registered trademark symbol (®) to the right of "AVENUE".

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