AETNA AVE

Aetna Avenue® — Your Destination for Small Business Solutions®

NEW JERSEY PLAN GUIDE

PLANS EFFECTIVE OCTOBER 1, 2010

For businesses with 2-50 eligible employees

64.10.300.1-NJ (6/10)

Health care is a journey …

AETNA AVENUE IS THE WAY

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

Small businesses need health benefits and insurance 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.

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Health/dental benefits and health/dental insurance plans, life and disability insurance/policies plans are offered, underwritten and/or administered by Aetna Health Inc.; Aetna Health Insurance Company; Aetna Dental Inc. and/or Aetna Life Insurance Company (Aetna).

CHOICE

For business owners and employees

At Aetna, we provide employers a choice of health 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

- Traditional plans
- Cost-sharing plans
- Consumer-directed health plans

Dental, life and disability plans — providing valuable protection

- DMO®
- PPO
- PPO Max
- Freedom-of-Choice plan design
- 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 health 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. Secure and online, Aetna Enroll℠ makes managing health benefits easy and eliminates time-consuming, expensive paper-based processes.

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

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

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

- Look up rates for providers, facilities and hospitals for common services and treatments.
- Simple Steps To A Healthier Life®, an online health and wellness program
- 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.

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AETNA AVENUE'S COMMITMENT TO SMALL BUSINESS EMPLOYERS

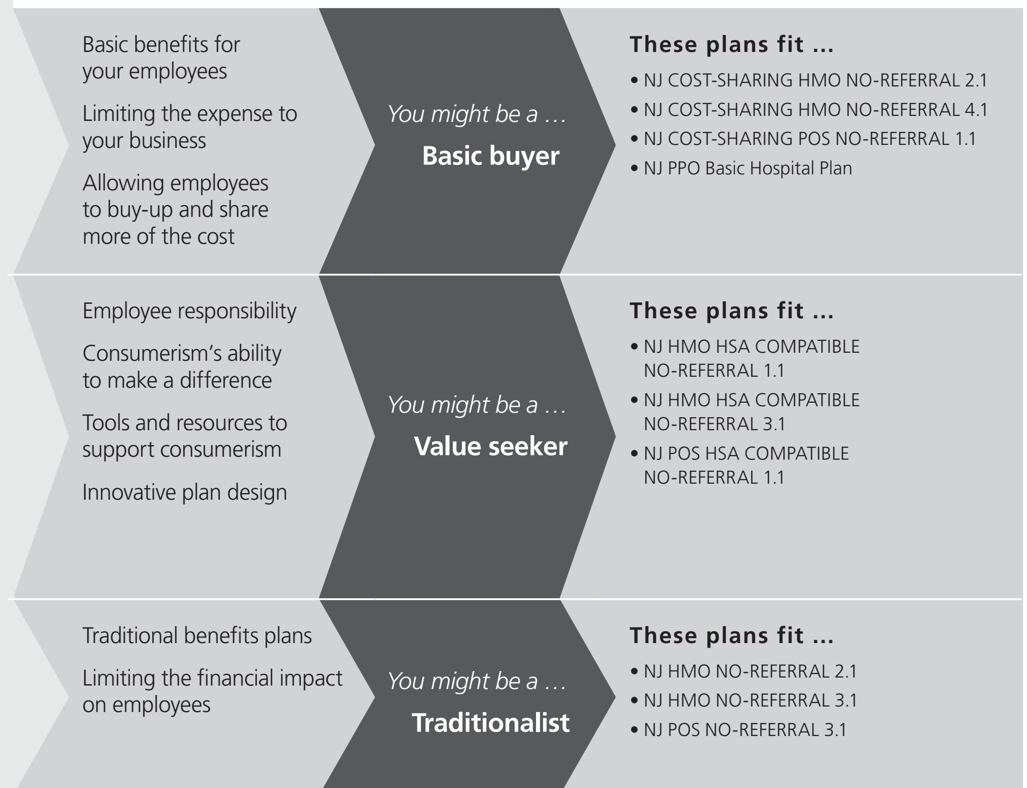
We know that small business owners' health insurance benefits needs are often different than a larger employer. Aetna Avenue focuses on employers with 2-50 employees and our insurance benefits programs are designed to work for this size group. We'll work with you to determine the right plans for your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



HEALTH INSURANCE BENEFITS FOR EVERY STAGE OF LIFE

YOUNG SINGLES

Cost-sharing plans
Consumer-directed health plans

YOUNG FAMILIES

Traditional plans
Consumer-directed health plans

ESTABLISHED FAMILIES

Cost-sharing plans
Consumer-directed health plans

EMPTY NESTERS

Cost-sharing plans
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.

YOUNG FAMILIES

Includes married couples and single parents with young children and teens

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

ESTABLISHED FAMILIES

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

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

EMPTY NESTERS

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

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

Aetna Avenue

MEDICAL OVERVIEW

New Jersey provider network*

All plans are available in all New Jersey counties.

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

Bergen
Essex
Hudson
Hunterdon
Middlesex
Monmouth
Morris
Ocean
Passaic
Somerset
Sussex
Union
Warren

Mid-Atlantic Small Group Sales Support Center: 1-877-28-AETNA (2-3862)

Atlantic
Burlington
Camden
Cape May
Cumberland
Gloucester
Mercer
Salem

*Network subject to change.

WELLNESS ON US℠

Wellness for employees means a healthier business for employers. Our small business plans in New Jersey offer $0 copays for network eye exams on top of $0 copay for network preventive care. It's one more way for us to help employees get a step closer to better health.

See what employees can get for $0*

Immunizations	$0 copay
Routine vision exams	$0 copay
Routine physicals	$0 copay
Child wellness visits	$0 copay
Routine mammogram	$0 copay
Routine ob/gyn visits	$0 copay

PRODUCT OVERVIEW

Product Name	Product Description	PCP Required	Referrals Required	Network
Aetna HMO	A Health Maintenance Organization (HMO) uses a network of participating providers. Each family member selects a primary care physician (PCP) participating in our network. The PCP provides routine and preventive care and helps coordinate the member's total health care. The PCP refers members to participating specialists and facilities for medically necessary specialty care. Only services provided or referred by the PCP are covered except for emergency, urgently needed care or direct access benefits, unless approved by the HMO in advance of receiving services.	Yes	Yes	HMO
Aetna HMO No-Referral	A Health Maintenance Organization (HMO) uses a network of participating providers. Each family member may select a primary care physician (PCP) participating in our network to provide routine and preventive care and can help coordinate the member's total health care. Members never need a referral when visiting a participating specialist for covered services. Only services rendered by a participating provider are covered, except for emergency or urgently needed care.	Yes/ Optional	No	HMO (Aetna Open Access®)
Aetna POS	The Aetna POS plan is a two-tiered product that allows members to access care in one of two ways: PCP Referred, network, or; Self-Referred, network or non-network. Members have lower out-of-pocket costs when they use the HMO (referred) tier of the plan and follow the PCP referral process. Member cost sharing increases if members decide to self refer network or non-network.	Yes	Yes for PCP Referred Care; No for Self-Referred Care	QPOS®
Aetna POS No-Referral	The Aetna POS No-Referral plan is a two-tiered product that allows members to access care network or non-network. Members have lower out-of-pocket costs when they use the network tier of the plan. Member cost sharing increases if members decide to go non-network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care.	Yes/ Optional	No	Aetna Choice® POS (Open Access)
Aetna PPO	PPO plan members can access any recognized provider for covered services without a referral. Each time members seek health care, they have the freedom to choose either network providers at lower out-of-pocket costs, or non-network providers at higher out-of-pocket costs.	No	No	Open Choice® PPO
Aetna Indemnity	The Aetna indemnity plan option is available for employees who live outside the plan's network service area. Members coordinate their own health care and may access any recognized provider for covered services without a referral.	No	No	N/A

**Standard Health Benefit Plans and Consumer-directed PPO plans apply $0 copay for network preventive care as required by federal legislation.

AETNA HIGH DEDUCTIBLE HSA-COMPATIBLE PLANS

Aetna High Deductible HSA-compatible plans are compatible with a Health Savings Account (HSA). HSA-compatible plans provide integrated medical and pharmacy benefits. Preventive care services are waived from the deductible.

HSAs provide employers and their qualified employees with an affordable tax advantaged solution that allows them to better manage their qualified medical and dental expenses.

- Employees can build a savings fund to assist in covering their future medical and dental expenses. 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.

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

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 AND SECTION 132 TRANSIT REIMBURSEMENT ACCOUNTS

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

Premium Only Plans (POP)
Employees can pay for their portion of the group health insurance expenses on a pretax basis.

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

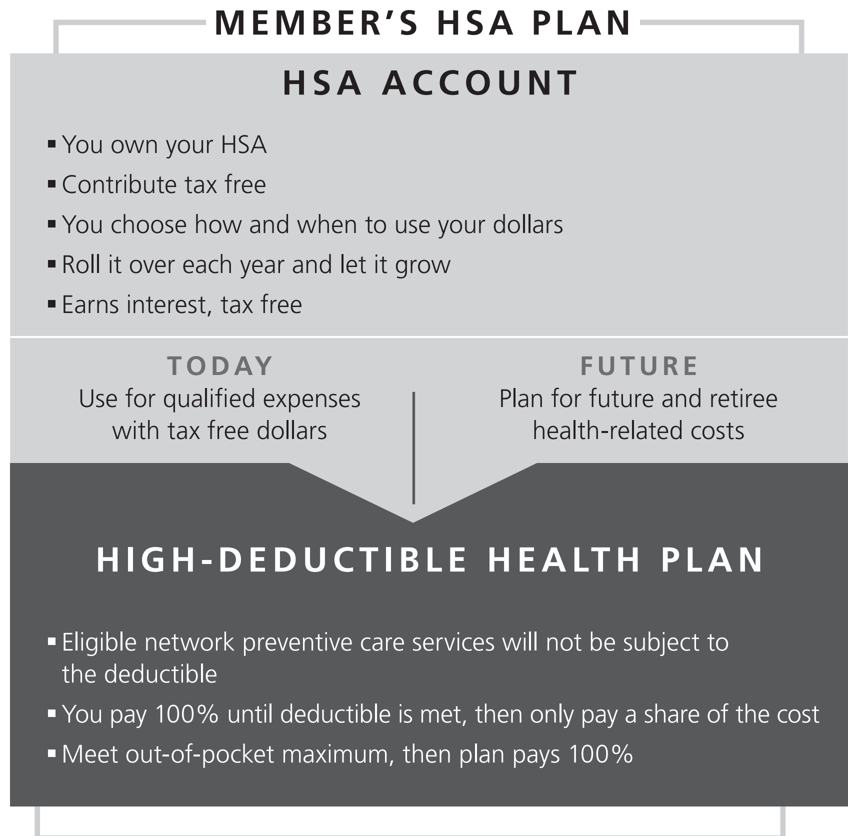
Transit Reimbursement Account (TRA)
TRAs allow participants to use pretax dollars to pay transportation and parking expenses for the purpose of commuting to and from work.

Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules, and are unfunded liabilities of your employer. Fund balances are not vested benefits. Health information programs provide general health information and are not a substitute for diagnosis and treatment by a physician or other health care professional. Information subject to change.

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.



CONSUMER-DIRECTED — HMO HSA COMPATIBLE PLAN OPTIONS

Plan Options	NJ HMO HSA COMPATIBLE NO-REFERRAL 1.1+*	NJ HMO HSA COMPATIBLE NO-REFERRAL 2.1+*	NJ HMO HSA COMPATIBLE NO-REFERRAL 3.1+*
Member Benefits	Network	Network	Network
	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100% after deductible	100% after deductible	100% after deductible
Benefit Year Deductible[1] (All covered prescription drug and medical expenses, except preventive services, apply to the deductible)	$1,650 single subscriber $3,300 family	$2,000 single subscriber $4,000 family	$2,500 single subscriber $5,000 family
Benefit Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$3,300 single subscriber $6,600 family	$4,000 single subscriber $8,000 family	$5,000 single subscriber $10,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Wellness On Us℠			
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one mammogram per benefit year for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period	$100/24 month period
Aetna Vision℠ Discount Program	Included	Included	Included
Primary Physician Office Visit	$20 copay after deductible	$30 copay after deductible	$30 copay after deductible
Specialist Office Visit	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Outpatient Services — Lab	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Outpatient Services — X-ray	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	70% after deductible	50% after deductible
Chiropractic Services (30 visits per benefit year)	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per benefit year)	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per benefit year)	$40 copay after deductible	$50 copay after deductible	$50 copay after deductible
Durable Medical Equipment ($2,500 Benefit Year Maximum)	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$300 copay per day, 5 day copay maximum per admission, after deductible	$400 copay per day, 5 day copay maximum per admission, after deductible	$500 copay per day, 5 day copay maximum per admission, after deductible
Outpatient Surgery: Hospital Outpatient Facility	$150 copay after deductible	$200 copay after deductible	$250 copay after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$150 copay after deductible	$200 copay after deductible	$250 copay after deductible
Emergency Room	80% after deductible	70% after deductible	50% after deductible
Prescription Drugs (Includes Self-Injectables)			
Prescription Drug Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%
Retail or Mail Order: 31-90-day supply	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Included	Included
***Optional Features:**	**Benefit Year:** Plans are available on a calendar or plan year basis. **Employer will elect one of two funding options:** (i) funding 50% or less or (ii) funding more than 50% of the single subscriber deductible per benefit year. Employer changes, requested during the year or upon renewal of the plan, to the elected funding option will be administered as a benefits plan change.		

See pages 22-23 for important plan provisions.

CONSUMER-DIRECTED — POS HSA COMPATIBLE PLAN OPTIONS

Plan Options	NJ POS HSA COMPATIBLE NO-REFERRAL 1.1+*		NJ POS HSA COMPATIBLE NO-REFERRAL 2.1+*	
Member Benefits	Network	Non-Network[3]	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100% after deductible	60% after deductible	100% after deductible	50% after deductible
Benefit Year Deductible[1] (All covered prescription drug and medical expenses, except preventive services, apply to the deductible)	$1,650 single subscriber $3,300 family	$3,300 single subscriber $6,600 family	$2,000 single subscriber $4,000 family	$4,000 single subscriber $8,000 family
Benefit Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$3,300 single subscriber $6,600 family	$6,600 single subscriber $13,200 family	$4,000 single subscriber $8,000 family	$8,000 single subscriber $16,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On Us℠				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per benefit year for all preventive care, except $750 combined maximum per benefit year for all preventive care for a dependent child from birth until the end of the benefit year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per benefit year for all preventive care, except $750 combined maximum per benefit year for all preventive care for a dependent child from birth until the end of the benefit year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one mammogram per benefit year for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	Not Covered	**$0** copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	$100/24 month period. Network and non-network combined.		$100/24 month period. Network and non-network combined.	
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	$20 copay after deductible	60% after deductible	$30 copay after deductible	50% after deductible
Specialist Office Visit	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Outpatient Services — Lab	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Outpatient Services — X-ray	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Chiropractic Services (30 visits per benefit year. Network and non-network combined)	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per benefit year. Network and non-network combined)	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per benefit year. Network and non-network combined)	$40 copay after deductible	60% after deductible	$50 copay after deductible	50% after deductible
Durable Medical Equipment ($2,500 Benefit Year Maximum. Network and non-network combined)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$300 copay per day, 5 day copay maximum per admission, after deductible	60% after deductible	$400 copay per day, 5 day copay maximum per admission, after deductible	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	$150 copay after deductible	60% after deductible;	$200 copay after deductible	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$150 copay after deductible	60% after deductible. Maximum benefit of $2,000 per member per benefit year.	$200 copay after deductible	50% after deductible. Maximum benefit of $2,000 per member per benefit year.
Emergency Room	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Options 1-4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	**Benefit Year:** Plans are available on a calendar or plan year basis. **Employer will elect one of two funding options:** (i) funding 50% or less or (ii) funding more than 50% of the network single subscriber deductible per benefit year. Employer changes, requested during the year or upon renewal of the plan, to the elected funding option will be administered as a benefits plan change.			

See pages 22-23 for important plan provisions.

CONSUMER-DIRECTED — POS HSA COMPATIBLE PLAN OPTIONS

Plan Options	NJ POS HSA COMPATIBLE NO-REFERRAL 3.1+*	
Member Benefits	Network	Non-Network[3]
	No Referral Needed	No Referral Needed
Plan Coinsurance	100% after deductible	50% after deductible
Benefit Year Deductible[1] (All covered prescription drug and medical expenses, except preventive services, apply to the deductible)	$2,500 single subscriber $5,000 family	$5,000 single subscriber $10,000 family
Benefit Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$5,000 single subscriber $10,000 family	$10,000 single subscriber $20,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited
Wellness On Us℠		
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per benefit year for all preventive care, except $750 combined maximum per benefit year for all preventive care for a dependent child from birth until the end of the benefit year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	**$0** copay, deductible waived	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one mammogram per benefit year for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	**$0** copay, deductible waived	
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	$100/24 month period. Network and non-network combined.	
Aetna Vision℠ Discount Program	Included	Not Covered
Primary Physician Office Visit	$30 copay after deductible	50% after deductible
Specialist Office Visit	$50 copay after deductible	50% after deductible
Outpatient Services — Lab	$50 copay after deductible	50% after deductible
Outpatient Services — X-ray	$50 copay after deductible	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	50% after deductible	50% after deductible
Chiropractic Services (30 visits per benefit year. Network and non-network combined)	$50 copay after deductible	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per benefit year. Network and non-network combined)	$50 copay after deductible	50% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per benefit year. Network and non-network combined)	$50 copay after deductible	50% after deductible
Durable Medical Equipment ($2,500 Benefit Year Maximum. Network and non-network combined)	50% after deductible	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$500 copay per day, 5 day copay maximum per admission, after deductible	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	$250 copay after deductible	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$250 copay after deductible	50% after deductible. Maximum benefit of $2,000 per member per benefit year.
Emergency Room	50% after deductible	50% after deductible
Prescription Drugs (Includes Self-Injectables)		
Prescription Drug Deductible	Options 1-4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Rx cost-shares will apply after deductible is met: Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Rx cost-shares will apply after deductible is met: Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Rx cost-shares will apply after deductible is met: Options 13: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	**Benefit Year:** Plans are available on a calendar or plan year basis. **Employer will elect one of two funding options**: (i) funding 50% or less or (ii) funding more than 50% of the network single subscriber deductible per benefit year. Employer changes, requested during the year or upon renewal of the plan, to the elected funding option will be administered as a benefits plan change.	

See pages 22-23 for important plan provisions.

CONSUMER-DIRECTED — PPO HSA COMPATIBLE PLAN OPTIONS

Plan Options	NJ PPO HSA COMPATIBLE 1+*		NJ PPO HSA COMPATIBLE 2+*	
Member Benefits	Network	Non-Network[3]	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Calendar Year Deductible[1] (All covered prescription drug and medical expenses, except preventive services, apply to the deductible)	$2,500 per member/ $5,000 family (Network and Non-Network combined)		$2,500 per member/ $5,000 family (Network and Non-Network combined)	
Calendar Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$5,000 per member/ $10,000 family (Network and Non-Network combined)		$2,500 per member/ $5,000 family (Network and Non-Network combined)	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	$0 copay, deductible waived	70%, deductible waived	100%, deductible waived	100%, deductible waived
Routine GYN Exams (Limited to one annual exam and Pap smear. Network and non-network combined)	$0 copay, deductible waived	70%, deductible waived	100%, deductible waived	100%, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	$0 copay, deductible waived	70%, deductible waived	100%, deductible waived	100%, deductible waived
Routine Eye Exam (One exam per 24 months. Network and non-network combined)	$0 copay, deductible waived	70% after deductible	100%, deductible waived	100% after deductible
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Specialist Office Visit	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Services — Lab	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Services — X-ray	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Durable Medical Equipment ($2,500 Calendar Year Maximum. Network and non-network combined)	50% after deductible	50% after deductible	100% after deductible	100% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Surgery: Hospital Outpatient Facility	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	90% after deductible	70% after deductible	100% after deductible	100% after deductible
Emergency Room (Copay waived if admitted)	90% after $100 copay and deductible	90% after $100 copay and deductible	100% after deductible	100% after deductible
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Integrated with Medical Deductible		Integrated with Medical Deductible	
Prescription Drugs: 30-day supply	$15/$25/$40 after deductible	50% after deductible	$0 after deductible	$0 after deductible
Retail or Mail Order: 31-90-day supply	$30/$50/$80 after deductible	50% after deductible	$0 after deductible	$0 after deductible
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Not Covered	Not Covered	Not Covered	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Included	Included	Included

See pages 22-23 for important plan provisions.

CONSUMER-DIRECTED — PPO FIRST DOLLAR PLAN OPTION

Plan Options	NJ PPO FIRST DOLLAR PLAN+*	
Member Benefits	Network	Non-Network[3]
	No Referral Needed	No Referral Needed
Health Fund	First $500 per member ($1,000 Family) in benefits (excluding member cost-sharing for prescription drug benefits) for Network and Non-Network benefits is paid at 100%, not subject to the deductible. After $500 per member ($1,000 Family) in benefits, the deductible applies for all covered services, except member cost-sharing for prescription drug benefits, preventive care (Network only), newborn hearing screenings, immunizations and blood lead services for lead poisoned children (which includes testing, medical evaluation and any necessary medical follow-up and treatment). After the deductible is met, coinsurance and/or copay apply. There is no rollover feature.	
Plan Coinsurance	80% after deductible	60% after deductible
Calendar Year Deductible[1]	$1,500 per member/$3,000 family (Network and Non-Network combined)	
Calendar Year Maximum Out-of-Pocket[2]	$4,000 per member/$8,000 family (Network and Non-Network combined)	
Lifetime Maximum Benefit	Unlimited	Unlimited
Preventive Care		
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	$0 copay, deductible waived	60% after deductible
Routine GYN Exams (Limited to one annual exam and Pap smear. Network and non-network combined)	$0 copay, deductible waived	60% after deductible
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	$0 copay, deductible waived	60% after deductible
Routine Eye Exam (One exam per 24 months. Network and non-network combined)	$0 copay, deductible waived	60% after deductible
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Not Covered
Primary Physician Office Visit	$20 copay after deductible	60% after deductible
Specialist Office Visit	$40 copay after deductible	60% after deductible
Outpatient Services — Lab	$40 copay after deductible	60% after deductible
Outpatient Services — X-ray	$40 copay after deductible	60% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80% after deductible	60% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	$40 copay after deductible	60% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	$40 copay after deductible	60% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	$40 copay after deductible	60% after deductible
Durable Medical Equipment ($2,500 Calendar Year Maximum. Network and non-network combined)	50% after deductible	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	80% after deductible	60% after deductible
Outpatient Surgery: Hospital Outpatient Facility	80% after deductible	60% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	80% after deductible	60% after deductible
Emergency Room (Copay waived if admitted)	80% after $100 copay and deductible	80% after $100 copay and deductible
Prescription Drugs (Includes Self-Injectables)		
Prescription Drug Deductible	Not Applicable	Not Applicable
Prescription Drugs: 30-day supply	$15/$25/$40	50%
Retail or Mail Order: 31-90-day supply	$30/$50/$80	50%
Contraceptives and Diabetic Supplies	Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Not Covered	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Included

See pages 22-23 for important plan provisions.

CONSUMER-DIRECTED — PPO BASIC HOSPITAL PLAN OPTION

Plan Options	NJ PPO BASIC HOSPITAL PLAN+*	
Member Benefits	Network	Non-Network[3]
	No Referral Needed	No Referral Needed
Plan Coinsurance	80% after deductible	60% after deductible
Calendar Year Deductible[1]	$2,500 per member/$5,000 family (Network and Non-Network combined)	
Calendar Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$5,000 per member/$10,000 family (Network and Non-Network combined)	
Lifetime Maximum Benefit	Unlimited	Unlimited
Preventive Care		
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined.)	$0 copay, deductible waived	60%, deductible waived
Routine GYN Exams (Limited to one annual exam and pap smear. Network and non-network combined.)	$0 copay, deductible waived	60%, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined.)	$0 copay, deductible waived	60%, deductible waived
Routine Eye Exam (One exam per 24 months. Network and non-network combined.)	$0 copay, deductible waived	60%, deductible waived
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Not Covered
Primary Physician Office Visit (Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and non-network combined)	$20 copay, deductible waived	60%, deductible waived
Specialist Office Visit (Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and non-network combined)	$20 copay, deductible waived	60%, deductible waived
Outpatient Services — Lab	80%, deductible waived	60%, deductible waived
Outpatient Services — X-ray	80%, deductible waived	60%, deductible waived
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80%, deductible waived	60%, deductible waived
Chiropractic Services (Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and non-network combined)	$20 copay, deductible waived	60%, deductible waived
Outpatient Physical/Occupational Therapy (Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and non-network combined)	$20 copay, deductible waived	60%, deductible waived
Outpatient Cognitive/Speech Therapy (Refer to Other Provisions. Three (3) office visits per member per calendar year. Network and non-network combined)	$20 copay, deductible waived	60%, deductible waived
Durable Medical Equipment	Not Covered	Not Covered
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	80% after deductible	60% after deductible
Outpatient Surgery: Hospital Outpatient Facility	80% after deductible	60% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	80% after deductible	60% after deductible
Emergency Room	80% after deductible	80% after deductible
Prescription Drugs (Includes Self-Injectables)		
Prescription Drug Deductible	Not Applicable	Not Applicable
Prescription Drugs	Rx Discount Network Card	Not Covered
Contraceptives and Diabetic Supplies	Included	Not Covered
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Included	Not Covered
90 Day Transition of Coverage (TOC) for Prior Authorization+	Not Applicable	Not Applicable
Other Provisions	Three (3) office visits per member per calendar year combined for primary physician office visits; specialist office visits; chiropractic care; outpatient physical, occupational, cognitive and speech therapy; outpatient mental illness; and outpatient detoxification and rehabilitation. Network and Non-Network combined.	

See pages 22-23 for important plan provisions.

COST-SHARING — HMO PLAN OPTIONS

Plan Options	NJ COST-SHARING HMO NO-REFERRAL 1.1+*	NJ COST-SHARING HMO NO-REFERRAL 2.1+*	NJ COST-SHARING HMO NO-REFERRAL 3.1+*	NJ COST-SHARING HMO NO-REFERRAL 4.1+*
Member Benefits	Network	Network	Network	Network
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	80% after deductible	70% after deductible	60% after deductible	50% after deductible
Calendar Year Deductible[1] (Deductible applies only to in-network inpatient hospital-type services/outpatient surgery)	$1,000 per member $2,000 family	$1,500 per member $3,000 family	$2,000 per member $4,000 family	$2,500 per member $5,000 family
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$1,500 per member $3,000 family	$3,000 per member $6,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On Us℠				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine GYN Exams (Limited to one exam and Pap smear per 365 days)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived	**$0** copay, deductible waived
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period	$100/24 month period	$100/24 month period
Aetna Vision℠ Discount Program	Included	Included	Included	Included
Primary Physician Office Visit	$20 copay, deductible waived	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
Specialist Office Visit	$40 copay, deductible waived	$40 copay, deductible waived	$50 copay, deductible waived	$50 copay, deductible waived
Outpatient Services — Lab	$0 copay, deductible waived	$0 copay, deductible waived	$0 copay, deductible waived	$0 copay, deductible waived
Outpatient Services — X-ray	$40 copay, deductible waived	$40 copay, deductible waived	$50 copay, deductible waived	$50 copay, deductible waived
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80%, deductible waived	70%, deductible waived	60%, deductible waived	50%, deductible waived
Chiropractic Services (30 visits per calendar year)	$40 copay, deductible waived	$40 copay, deductible waived	$50 copay, deductible waived	$50 copay, deductible waived
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year)	$40 copay, deductible waived	$40 copay, deductible waived	$50 copay, deductible waived	$50 copay, deductible waived
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year)	$40 copay, deductible waived	$40 copay, deductible waived	$50 copay, deductible waived	$50 copay, deductible waived
Durable Medical Equipment ($2,500 Calendar Year Maximum)	50%, deductible waived	50%, deductible waived	50%, deductible waived	50%, deductible waived
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	80% after deductible	70% after deductible	60% after deductible	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	80% after deductible	70% after deductible	60% after deductible	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	80% after deductible	70% after deductible	60% after deductible	50% after deductible
Emergency Room	80%, deductible waived	70%, deductible waived	60%, deductible waived	50%, deductible waived
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Included	Included	Included
***Optional Features:**	Referral Option: NJ COST-SHARING HMO 1.1	Referral Option: NJ COST-SHARING HMO 2.1	Referral Option: NJ COST-SHARING HMO 3.1	Referral Option: NJ COST-SHARING HMO 4.1

See pages 22-23 for important plan provisions.

COST-SHARING — POS PLAN OPTIONS

Plan Options	NJ COST-SHARING POS NO-REFERRAL 1.1+*		NJ COST-SHARING POS NO-REFERRAL 2.1+*	
Member Benefits	Network	Non-Network[3]	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Calendar Year Deductible[1] (Deductible applies only to in-network inpatient hospital-type services/outpatient surgery)	$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
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$5,000 per member $10,000 family	$10,000 individual $20,000 family	$5,000 per member $10,000 family	$10,000 individual $20,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On Us℠				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	Not Covered	**$0** copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	$100/24 month period. Network and non-network combined.		$100/24 month period. Network and non-network combined.	
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	$30 copay, deductible waived	60% after deductible	$30 copay, deductible waived	50% after deductible
Specialist Office Visit	$50 copay, deductible waived	60% after deductible	$50 copay, deductible waived	50% after deductible
Outpatient Services — Lab	$0 copay, deductible waived	60% after deductible	$0 copay, deductible waived	50% after deductible
Outpatient Services — X-ray	$50 copay, deductible waived	60% after deductible	$50 copay, deductible waived	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80%, deductible waived	60% after deductible	70%, deductible waived	50% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	$50 copay, deductible waived	60% after deductible	$50 copay, deductible waived	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay, deductible waived	60% after deductible	$50 copay, deductible waived	50% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay, deductible waived	60% after deductible	$50 copay, deductible waived	50% after deductible
Durable Medical Equipment ($2,500 Calendar Year Maximum. Network and non-network combined)	50%, deductible waived	50% after deductible	50%, deductible waived	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	80% after deductible	60% after deductible	70% after deductible	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	80% after deductible	60% after deductible. Maximum benefit of $2,000 per member per calendar year.	70% after deductible	50% after deductible. Maximum benefit of $2,000 per member per calendar year.
Emergency Room	80%, deductible waived	80%, deductible waived	70%, deductible waived	70%, deductible waived
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	Referral Option: NJ COST-SHARING POS 1.1		Referral Option: NJ COST-SHARING POS 2.1	

See pages 22-23 for important plan provisions.

TRADITIONAL — HMO PLAN OPTIONS

Plan Options	NJ HMO NO-REFERRAL 1.1+*	NJ HMO NO-REFERRAL 2.1+*	NJ HMO NO-REFERRAL 3.1+*	NJ HMO NO-REFERRAL 4.1+*
Member Benefits	Network	Network	Network	Network
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100%	100%	70%	50%
Calendar Year Deductible	N/A	N/A	N/A	N/A
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$1,500 per member $3,000 family	$2,500 per member $5,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On UsSM				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply)	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Routine GYN Exams (Limited to one exam and Pap smear per 365 days)	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary)	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Routine Eye Exam (One exam per 24 months)	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Glasses and Contact Lens Reimbursement	$100/24 month period	$100/24 month period	$100/24 month period	$100/24 month period
Aetna VisionSM **Discount Program**	Included	Included	Included	Included
Primary Physician Office Visit	$20 copay	$30 copay	$30 copay	$30 copay
Specialist Office Visit	$40 copay	$50 copay	$50 copay	$50 copay
Outpatient Services — Lab	$0 copay	$0 copay	$0 copay	$0 copay
Outpatient Services — X-ray	$40 copay	$50 copay	$50 copay	$50 copay
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80%	70%	70%	50%
Chiropractic Services (30 visits per calendar year)	$40 copay	$50 copay	$50 copay	$50 copay
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year)	$40 copay	$50 copay	$50 copay	$50 copay
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year)	$40 copay	$50 copay	$50 copay	$50 copay
Durable Medical Equipment ($2,500 Calendar Year Maximum)	50%	50%	50%	50%
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$250 copay per day, 5 day copay maximum per admission	$500 copay per day, 5 day copay maximum per admission	70%	50%
Outpatient Surgery: Hospital Outpatient Facility	$250 copay	$500 copay	70%	50%
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$250 copay	$500 copay	70%	50%
Emergency Room	80%	70%	70%	50%
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%
Contraceptives and Diabetic Supplies	Included	Included	Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Included	Included	Included
***Optional Features:**	Referral Option: NJ HMO 1.1	Referral Option: NJ HMO 2.1	Referral Option: NJ HMO 3.1	Referral Option: NJ HMO 4.1

See pages 22-23 for important plan provisions.

TRADITIONAL — POS PLAN OPTIONS

Plan Options	NJ POS NO-REFERRAL 1.1+*		NJ POS NO-REFERRAL 2.1+*	
Member Benefits	Network	Non-Network[3]	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100% after deductible	60% after deductible	100% after deductible	50% after deductible
Calendar Year Deductible[1]	N/A	$1,000 per member $2,000 family	N/A	$1,500 per member $3,000 family
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$1,500 per member $3,000 family	$4,500 per member $9,000 family	$2,500 per member $5,000 family	$7,500 per member $15,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On UsSM				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	Not Covered	**$0** copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	$100/24 month period. Network and non-network combined.		$100/24 month period. Network and non-network combined.	
Aetna VisionSM Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	$20 copay	60% after deductible	$30 copay	50% after deductible
Specialist Office Visit	$40 copay	60% after deductible	$50 copay	50% after deductible
Outpatient Services — Lab	$0 copay	60% after deductible	$0 copay	50% after deductible
Outpatient Services — X-ray	$40 copay	60% after deductible	$50 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	80%	60% after deductible	70%	50% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	$40 copay	60% after deductible	$50 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	$40 copay	60% after deductible	$50 copay	50% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	$40 copay	60% after deductible	$50 copay	50% after deductible
Durable Medical Equipment ($2,500 Calendar Year Maximum. Network and non-network combined)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$250 copay per day, 5 day copay maximum per admission	60% after deductible	$500 copay per day, 5 day copay maximum per admission	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	$250 copay	60% after deductible	$500 copay	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$250 copay	60% after deductible. Maximum benefit of $2,000 per member per calendar year.	$500 copay	50% after deductible. Maximum benefit of $2,000 per member per calendar year.
Emergency Room	80%	80%, deductible waived	70%	70%, deductible waived
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1 - 3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	Referral Option: NJ POS 1.1		Referral Option: NJ POS 2.1	

See pages 22-23 for important plan provisions.

TRADITIONAL — POS PLAN OPTIONS

Plan Options	NJ POS NO-REFERRAL 3.1+*		NJ POS NO-REFERRAL 4.1+*	
Member Benefits	Network No Referral Needed	Non-Network[3] No Referral Needed	Network No Referral Needed	Non-Network[3] No Referral Needed
Plan Coinsurance	70%	50% after deductible	50%	50% after deductible
Calendar Year Deductible[1]	N/A	$2,000 per member $4,000 family	N/A	$2,500 per member $5,000 family
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$5,000 per member $10,000 family	$10,000 per member $20,000 family	$5,000 per member $10,000 family	$10,000 per member $20,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Wellness On Us℠				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	**$0** copay, deductible waived	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	**$0** copay, deductible waived		**$0** copay, deductible waived	
Routine Eye Exam (One exam per 24 months)	**$0** copay, deductible waived	Not Covered	**$0** copay, deductible waived	Not Covered
Glasses and Contact Lens Reimbursement	$100/24 month period. Network and non-network combined.		$100/24 month period. Network and non-network combined.	
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	$30 copay	50% after deductible	$30 copay	50% after deductible
Specialist Office Visit	$50 copay	50% after deductible	$50 copay	50% after deductible
Outpatient Services — Lab	$0 copay	50% after deductible	$0 copay	50% after deductible
Outpatient Services — X-ray	$50 copay	50% after deductible	$50 copay	50% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	70%	50% after deductible	50%	50% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	$50 copay	50% after deductible	$50 copay	50% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay	50% after deductible	$50 copay	50% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay	50% after deductible	$50 copay	50% after deductible
Durable Medical Equipment ($2,500 Calendar Year Maximum. Network and non-network combined)	50%	50% after deductible	50%	50% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	70%	50% after deductible	50%	50% after deductible
Outpatient Surgery: Hospital Outpatient Facility	70%	50% after deductible	50%	50% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	70%	50% after deductible. Maximum benefit of $2,000 per member per calendar year.	50%	50% after deductible. Maximum benefit of $2,000 per member per calendar year.
Emergency Room	70%	70%, deductible waived	50%	50%, deductible waived
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1 - 3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	Referral Option: NJ POS 3.1		Referral Option: NJ POS 4.1	

See pages 22-23 for important plan provisions.

TRADITIONAL — HMO AND POS PLAN OPTIONS — STANDARD HEALTH BENEFIT OPTIONS

Plan Options	NJ SEH HMO NO-REFERRAL 1.1+*	NJ SEH POS NO-REFERRAL 1.1+*	
Member Benefits	Network	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100%	100%	70% after deductible
Calendar Year Deductible[1]	N/A	N/A	$2,500 per member $5,000 family
Calendar Year Maximum Out-of-Pocket[2] (Prescription drugs, including self-injectables, do not apply toward the Maximum Out-of-Pocket)	$5,000 per member $10,000 family	$5,000 per member $10,000 family	$5,000 per member $10,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Preventive Care			
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined)	$0 copay	$0 copay	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine GYN Exams (Limited to one exam and Pap smear per 365 days. Network and non-network combined)	$0 copay	$0 copay	
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined)	$0 copay	$0 copay	
Routine Eye Exam	Not Covered	Not Covered	Not Covered
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Included	Not Covered
Primary Physician Office Visit	$50 copay	$50 copay	70% after deductible
Specialist Office Visit	$50 copay	$50 copay	70% after deductible
Outpatient Services — Lab	$50 copay	$50 copay	70% after deductible
Outpatient Services — X-ray	$50 copay	$50 copay	70% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)	$50 copay	$50 copay	70% after deductible
Chiropractic Services (30 visits per calendar year. Network and non-network combined)	$50 copay	$50 copay	70% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay	$50 copay	70% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year. Network and non-network combined)	$50 copay	$50 copay	70% after deductible
Durable Medical Equipment (Unlimited Calendar Year Maximum. Network and non-network combined)	$0 copay	$0 copay	70% after deductible
Inpatient Hospital (Including Inpatient Mental Health and Substance Abuse)	$400 copay per day, 5 day copay maximum per admission; $4,000 calendar year copay maximum	$400 copay per day, 5 day copay maximum per admission; $4,000 calendar year copay maximum	70% after deductible
Outpatient Surgery: Hospital Outpatient Facility	$50 copay	$50 copay	70% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	$50 copay	$50 copay	70% after deductible
Emergency Room	$100 copay	$100 copay	$100 copay
Prescription Drugs (Includes Self-Injectables)			
Prescription Drug Deductible	Not Applicable	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible	Options 1-3: Not Applicable Option 4: Integrated with Medical Deductible
Prescription Drugs: 30-day supply	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: 50%	Option 1: $15/$35/$60 Option 2: $20/$40/$70 Option 3: $15/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Retail or Mail Order: 31-90-day supply	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: 50%	Option 1: $30/$70/$120 Option 2: $40/$80/$140 Option 3: $30/50% Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.	Options 1-3: Not Covered Option 4: Not Covered under Rx Plan. Subject to Non-Network Medical Deductible and Coinsurance.
Contraceptives and Diabetic Supplies	Options 1-4: Included	Options 1-4: Included	Options 1-3: Not Covered Option 4: Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included	Options 1-3: Not Covered Option 4: Included
90 Day Transition of Coverage (TOC) for Prior Authorization+	Included	Options 1-3: Included Option 4: Not Applicable	Options 1-4: Not Applicable
***Optional Features:**	Referral Option: NJ SEH HMO 1.1	Referral Option: NJ SEH POS 1.1	

See pages 22-23 for important plan provisions.

TRADITIONAL — PPO PLAN OPTIONS — STANDARD HEALTH BENEFIT OPTIONS

Plan Options	NJ SEH PPO PLAN A +		NJ SEH PPO PLAN C +	
Member Benefits	Network	Non-Network[3]	Network	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	100% after deductible for Inpatient Hospital Care; 70% after deductible for All Other Covered Charges	80% after deductible for Inpatient Hospital Care; 50% after deductible for All Other Covered Charges	90% after deductible	70% after deductible
Calendar Year Deductible[1]	$250 per member $750 family (Network and Non-Network combined)		$1,500 per member $3,000 family (Network and Non-Network combined)	
Calendar Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket.)	$5,000 per member (Network and Non-Network combined)		$4,000 per member $8,000 family (Network and Non-Network combined)	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply. Network and non-network combined.)	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited to $100 per member and $300 per family per calendar year for all preventive care. See Covered Charges with Special Limitations section of the plan documents.		Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per benefit year for all preventive care, except $750 combined maximum per benefit year for all preventive care for a dependent child from birth until the end of the benefit year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	
Routine GYN Exams (Includes pap smear and related expenses.)				
Routine Mammograms (Limited to one baseline mammogram for ages 35 through 39; one mammogram per benefit year for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary. Network and non-network combined.)				
Routine Eye Exam	Not Covered	Not Covered	Not Covered	Not Covered
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Not Covered	Included	Not Covered
Primary Physician Office Visit	Not Covered	Not Covered	$20 copay, deductible waived	70% after deductible
Specialist Office Visit	Not Covered	Not Covered	$20 copay, deductible waived	70% after deductible
Outpatient Services — Lab	Only covered if needed for a planned hospital admission or surgery and if the tests are done on an outpatient basis within seven days of the planned admission or surgery. Aetna will not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health. X-ray and laboratory tests which are not performed in connection with a planned hospital admission or surgery are not covered.		90% after deductible	70% after deductible
Outpatient Services — X-Ray			90% after deductible	70% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)			90% after deductible	70% after deductible
Chiropractic Services (30 visits per benefit year. Network and non-network combined.)	Not Covered	Not Covered	$20 copay, deductible waived	70% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per benefit year. Network and non-network combined.)	Only covered as part of an Inpatient Hospital confinement.		$20 copay, deductible waived	70% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per benefit year. Network and non-network combined.)	Only covered as part of an Inpatient Hospital confinement.		$20 copay, deductible waived	70% after deductible
Durable Medical Equipment	Not Covered	Not Covered	90% after deductible	70% after deductible
Inpatient Hospital (Plan A: Inpatient Mental Health and Substance Abuse are not covered. Plan C: Including Inpatient Mental Health and Substance Abuse.)	Facility Charges: 100% after $250 hospital confinement copay per day; $1,250 maximum copay per period of confinement; $2,500 maximum copay per Covered Person per Calendar Year; deductible waived. Physician and All Other Charges: 70% after deductible.	Facility Charges: 80% after $250 hospital confinement copay per day; $1,250 maximum copay per period of confinement; $2,500 maximum copay per Covered Person per Calendar Year; deductible waived. Physician and All Other Charges: 50% after deductible.	90% after deductible	70% after deductible
Outpatient Surgery: Hospital Outpatient Facility	Facility Charges: 100% after deductible; Physician and All Other Charges: 70% after deductible	Facility Charges: 80% after deductible; Physician and All Other Charges: 50% after deductible	90% after deductible	70% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	Facility Charges: 100% after deductible; Physician and All Other Charges: 70% after deductible	Facility Charges: 80% after deductible; Physician and All Other Charges: 50% after deductible	90% after deductible	70% after deductible
Emergency Room	Not Covered unless admitted	Not Covered unless admitted	90% after $100 copay and deductible	90% after $100 copay and deductible
Prescription Drugs (Includes Self-Injectables)				
Prescription Drug Deductible	Integrated with Medical Deductible		Integrated with Non-Network Medical Deductible	
Prescription Drugs: Up to 90 day supply	Prescription drugs are only covered while confined in a Hospital on an Inpatient basis only.		70% after Non-Network Deductible	
Contraceptives and Diabetic Supplies			Included	
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/ Inadequacy			Included	
90 Day Transition of Coverage (TOC) for Prior Authorization+	Not Applicable		Not Applicable	

See pages 22-23 for important plan provisions.

TRADITIONAL — INDEMNITY PLAN OPTIONS — STANDARD HEALTH BENEFIT OPTIONS

Plan Options	NJ INDEMNITY PLAN A2	NJ INDEMNITY PLAN C	NJ INDEMNITY PLAN D
Member Benefits	Non-Network[3]	Non-Network[3]	Non-Network[3]
	No Referral Needed	No Referral Needed	No Referral Needed
Plan Coinsurance	80% after deductible for Inpatient Hospital Care; 50% after deductible for All Other Covered Charges	70% after deductible	80% after deductible
Calendar Year Deductible[1]	$250 per member $750 family	$1,000 per member $2,000 family	$500 per member $1,000 family
Calendar Year Maximum Out-of-Pocket[2] (All amounts paid as deductible, copayment and coinsurance for covered services and supplies apply toward the Maximum Out-of-Pocket)	$7,750 per member	$4,000 per member $8,000 family	$2,500 per member $5,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Preventive Care			
Well-Baby/Child and Adult Physical Exams (Age and frequency schedules apply) **Routine GYN Exams** (Includes Pap smear and related expenses) **Routine Mammograms** (Limited to one baseline mammogram for ages 35 through 39; one annual mammogram for ages 40 and over; and members under age 40 with a family history of breast cancer or other breast cancer risk factors as medically necessary.)	Calendar Year Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited to $100 per Covered Person and $300 per Family. See Covered Charges with Special Limitations section of the plan documents.	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.	Preventive Care Benefit: No deductible or coinsurance applies. Benefits are limited. $500 combined maximum per calendar year for all preventive care, except $750 combined maximum per calendar year for all preventive care for a dependent child from birth until the end of the calendar year in which the dependent child attains age 1. See Covered Charges with Special Limitations section of the plan documents.
Routine Eye Exam	Not Covered	Not Covered	Not Covered
Glasses and Contact Lens Reimbursement	Not Covered	Not Covered	Not Covered
Aetna Vision℠ Discount Program	Included	Included	Included
Primary Physician Office Visit	Not Covered	70% after deductible	80% after deductible
Specialist Office Visit	Not Covered	70% after deductible	80% after deductible
Outpatient Services — Lab	Only covered if needed for a planned hospital admission or surgery and if the tests are done on an outpatient basis within seven days of the planned admission or surgery. Aetna will not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the member's health. X-ray and laboratory tests which are not performed in connection with a planned hospital admission or surgery are not covered.	70% after deductible	80% after deductible
Outpatient Services — X-ray		70% after deductible	80% after deductible
Outpatient Complex Imaging (MRA/MRS, MRI, PET and CAT Scans)		70% after deductible	80% after deductible
Chiropractic Services (30 visits per calendar year)	Not Covered	70% after deductible	80% after deductible
Outpatient Physical/Occupational Therapy (Physical and occupational therapy combined, 30 visits per calendar year)	Covered only as part of an Inpatient Hospital confinement	70% after deductible	80% after deductible
Outpatient Cognitive/Speech Therapy (Cognitive and speech therapy combined, 30 visits per calendar year)	Covered only as part of an Inpatient Hospital confinement	70% after deductible	80% after deductible
Durable Medical Equipment	Not Covered	70% after deductible	80% after deductible
Inpatient Hospital (Plan A2: Inpatient Mental Health and Substance Abuse are not covered. Plans C and D: Including Inpatient Mental Health and Substance Abuse)	Facility Charges: 80% after $250 hospital confinement copay per day; $1,250 maximum copay per period of confinement; $2,500 maximum copay per calendar year; deductible waived. Physician and All Other Charges: 50% after deductible.	70% after deductible	80% after deductible
Outpatient Surgery: Hospital Outpatient Facility	Facility Charges: 80% after deductible. Physician and All Other Charges: 50% after deductible	70% after deductible	80% after deductible
Outpatient Surgery: Ambulatory Surgical Center or Facility other than a Hospital Outpatient Facility	Facility Charges: 80% after deductible. Physician and All Other Charges: 50% after deductible	70% after deductible	80% after deductible
Emergency Room (Copay waived if admitted)	Not Covered unless admitted.	70% after $100 copay and deductible	80% after $100 copay and deductible
Prescription Drugs (Includes Self-Injectables)			
Prescription Drug Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible	Integrated with Medical Deductible
Prescription Drugs	80% after deductible. Prescription drugs are only covered while confined in a Hospital on an Inpatient basis only.	70% after deductible	80% after deductible
Contraceptives and Diabetic Supplies		Included	Included
Performance Drugs or Supplies for the Treatment of Erectile Dysfunction, Impotence or Sexual Dysfunction/Inadequacy		Included	Included
90 Day Transition of Coverage (TOC) for Prior Authorization[+]	Not Applicable	Not Applicable	Not Applicable

See pages 22-23 for important plan provisions.

IMPORTANT PLAN PROVISIONS

All Plan Options

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

[+]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.

"No Referral" Provision for HSA Compatible, Cost-Sharing and Traditional HMO and POS No-Referral Plans: A member will pay the Primary Physician Office Visit cost-share when the member obtains covered benefits from any participating primary care physician. Members will pay the Specialist Office Visit cost-share when the member obtains covered benefits from any participating specialist.

"Transition of Coverage (TOC) for Prior Authorizations" helps members of new groups to transition to Aetna by providing a 90-calendar-day opportunity, beginning on the group's initial effective date, during which time prior authorization requirements will not apply to certain drugs. Once the 90 calendar days have expired, prior authorization edits will apply to all drugs requiring prior authorization as listed in the 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.

Note: For a summary list of Limitations and Exclusions, refer to pages 44-45. Please refer to Aetna's Producer World® website at www.aetna.com for more detailed small business benefits descriptions. Or for more information, please contact your licensed agent or Aetna Sales Representative.

HMO and POS HSA Compatible No-Referral Plans (Pages 8-10)

[1]The Single Subscriber Deductible can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the benefit year.

[2]The Single Subscriber Maximum Out-of-Pocket can only be met when a member is enrolled for self-only coverage with no dependent coverage. The Family Maximum Out-of-Pocket can be met by a combination of family members or by any single individual within the family. Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the benefit year.

[3]POS HSA Compatible No-Referral Plans: You may choose providers in our network (physicians and facilities) or may visit a non-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use a non-network provider. The non-network provider* will be paid based on either the "allowed charges" or the provider's actual billed charges for covered services and supplies. The "allowed charge" means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or other state when services or supplies are provided in such state. The maximum allowed charge shall be based on the 80th percentile of the PHCS profile.

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

This applies when you choose to get care outside of the network. When you have no choice in the providers you see (for example, when you are taken to an emergency room after a car accident), your applicable copayment or coinsurance and deductible for the network level of benefits will be applied, and you should contact Aetna if your providers ask you to pay more. Generally, you are not responsible for any outstanding balance billed by your providers in an emergency situation.

*Aetna will pay benefits for prosthetic and orthotic appliances at the greater of Aetna's contracted rate with the network provider or the same reimbursement rate for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or non-network basis.

PPO HSA Compatible, PPO First Dollar, PPO Basic Hospital, Cost-Sharing HMO/HMO No-Referral, Cost-Sharing POS/POS No-Referral, Traditional HMO/HMO No-Referral and Traditional POS/POS No-Referral Plans (Pages 11-19)

[1]Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

[2]Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket amount to the Family Maximum Out-of-Pocket.

[3]PPO HSA Compatible, PPO First Dollar and PPO Basic Hospital Plans: You may choose providers in our network (physicians and facilities) or may visit a non-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use a non-network provider. The non-network provider* will be paid based on either the "allowed charges" or the provider's actual billed charges for covered services and supplies. The "allowed charge" means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or other state when services or supplies are provided in such state. The maximum allowed charge shall be based on the 80th percentile of the PHCS profile.

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

This applies when you choose to get care outside of the network. When you have no choice in the providers you see (for example, when you are taken to an emergency room after a car accident), your applicable copayment, coinsurance and deductible for the network level of benefits will be applied, and you should contact Aetna if your providers ask you to pay more. Generally, you are not responsible for any outstanding balance billed by your providers in an emergency situation.

*Aetna will pay benefits for prosthetic and orthotic appliances at the greater of Aetna's contracted rate with the network provider or the same reimbursement rate for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or non-network basis.

[3]Cost-Sharing POS/POS No-Referral and Traditional POS/POS No-Referral Plans: You may choose providers in our network (physicians and facilities) or may visit a non-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use a non-network provider. The non-network provider* will be paid based on either the "allowed charges" or the provider's actual billed charges for covered services and supplies. The "allowed charge" means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or other state when services or supplies are provided in such state. The maximum allowed charge shall be based on the 80th percentile of the PHCS profile.

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

This applies when you choose to get care outside of the network. When you have no choice in the providers you see (for example, when you are taken to an emergency room after a car accident), your applicable copayment or coinsurance and deductible for the network level of benefits will be applied, and you should contact Aetna if your providers ask you to pay more. Generally, you are not responsible for any outstanding balance billed by your providers in an emergency situation.

*Aetna will pay benefits for prosthetic and orthotic appliances at the greater of Aetna's contracted rate with the network provider or the same reimbursement rate for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or non-network basis.

Traditional PPO Plans (Page 20)

NJ SEH PPO Plan A

[1]Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

NJ SEH PPO Plan C

[1]Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

[2]Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket amount to the Family Maximum Out-of-Pocket.

All SEH PPO Plans

You may choose providers in our network (physicians and facilities) or may visit a non-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use a non-network provider. The non-network provider* will be paid based on either the “allowed charges” or the provider’s actual billed charges for covered services and supplies. The “allowed charge” means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or other state when services or supplies are provided in such state. The maximum allowed charge shall be based on the 80th percentile of the PHCS profile.

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

This applies when you choose to get care outside of the network. When you have no choice in the providers you see (for example, when you are taken to an emergency room after a car accident), your applicable copayment, coinsurance and deductible for the network level of benefits will be applied, and you should contact Aetna if your providers ask you to pay more. Generally, you are not responsible for any outstanding balance billed by your providers in an emergency situation.

*Aetna will pay benefits for prosthetic and orthotic appliances at the greater of Aetna’s contracted rate with the network provider or the same reimbursement rate for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or non-network basis.

Traditional Indemnity Plans (Page 21)

NJ Indemnity Plan A2

[1]Once three or more members in a family have incurred a combined total of Covered Charges toward their Per Member Deductible equal to the Per Covered Family Deductible, each member in that family will be considered to have met his or her per member Deductible for the rest of that Calendar Year. The Covered Charges that each member in a family may use toward the Per Covered Family Deductible may not exceed the amount of the Per Member Deductible.

NJ Indemnity Plans C and D

[1]Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible.

[2]Once the Family Maximum Out-of-Pocket is met, all family members will be considered as having met their Maximum Out-of-Pocket for the remainder of the calendar year. No one family member may contribute more than the Individual Maximum Out-of-Pocket amount to the Family Maximum Out-of-Pocket.

All Indemnity Plans:

[3]Providers* will be paid based on either the “allowed charges” or the provider’s actual billed charges for covered services and supplies. The “allowed charge” means a standard amount based on the Prevailing Healthcare Charges System (PHCS) profile, published and available from the Ingenix, Inc., for New Jersey or other state when services or supplies are provided in such state. The maximum allowed charge shall be based on the 80th percentile of the PHCS profile.

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

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

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 Matters℠

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

Aetna Dental/Medical Integration℠ (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.[2] 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.

[2] "Dental/medical integration, Improved oral health can lead to a better overall health" *Smart Business Chicago* (1/07).

*DMI may not be available in all states.

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

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 usual 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.

Aetna Dental Preventive Care℠ Plan

The Preventive Care plan is a low-cost dental plan that covers preventive and diagnostic procedures. Members pay nothing for these services and may 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.**

Freedom-of-Choice plan design option

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

Dual Option plan*

In the Dual Option plan design the DMO 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.

*Dual Option does not apply to Voluntary Dental plans for groups with less than 25 eligible employees.

†Discounts are not insurance.

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

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	Option 2	Option 3 Freedom-of-Choice — Monthly selection between the DMO and PPO Max		Option 4
	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/40	PPO Max Plan 100/80/50
Office Visit Copay	$5	$5	None	None
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual Maximum Benefit	None	None	$1,000	$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%	90%	70%	80%
Resin filling — 2 surfaces, anterior	80%	90%	70%	80%
Oral Surgery				
Extraction — exposed root or erupted tooth	80%	90%	70%	80%
Extraction of impacted tooth — soft tissue	80%	90%	70%	80%
***MAJOR SERVICES**				
Complete upper denture	50%	60%	40%	50%
Crown — Porcelain with noble metal[1]	50%	60%	40%	50%
Pontic — Porcelain with noble metal[1]	50%	60%	40%	50%
Pontic — Porcelain with noble metal	50%	60%	40%	50%
Inlay — Metallic (3 or more surfaces)	50%	60%	40%	50%
Oral Surgery				
Removal of impacted tooth — partially bony	50%	60%	40%	50%
Endodontic Services				
Bicuspid root canal therapy	80%	90%	40%	50%
Molar root canal therapy	50%	60%	40%	50%
Periodontic Services				
Scaling & root planing — per quadrant	80%	90%	40%	50%
Osseous surgery — per quadrant	50%	60%	40%	50%
***ORTHODONTIC SERVICES**	$2,300 copay	$2,300 copay	Not covered	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply	Does not apply

Note: For New Jersey groups with 25 or more eligible employees, the DMO in Plan Options 2 & 10 cannot be sold on a standalone basis to a customer with primary business location in New Jersey. It must be part of a Dual Option sale packaged with either one of the PPO plans in Plan Options 4-6 or 9.

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

Fixed dollar copay amounts on the DMO in Options 2, 3, 8 & 10 are the member's responsibility.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 2, 3, 8 & 10 or the PPO in Plan Option 7.1.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10 and the PPO in Plan Option 5. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on PPO in Plan Option 9.

Plan Options 3, 4 & 7.1; PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	**Option 5 Active PPO High-Option Plan**		**Option 6**	**Option 7.1 Preventive Dental**
	Preferred Plan 100/80/50	Non-Preferred Plan 80/60/40	PPO 1500 Plan 100/80/50	Preventive/PPO Max 100/0/0
Office Visit Copay	None	None	None	None
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	None
Annual Maximum Benefit	$1,500	$1,000	$1,500	None
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	80%	100%	100%
Comprehensive oral exam	100%	80%	100%	100%
Problem-focused oral exam	100%	80%	100%	100%
X-rays				
Bitewing — single film	100%	80%	100%	100%
Complete series	100%	80%	100%	100%
PREVENTIVE SERVICES				
Adult Cleaning	100%	80%	100%	100%
Child Cleaning	100%	80%	100%	100%
Sealants — per tooth	100%	80%	100%	100%
Fluoride application — with cleaning	100%	80%	100%	100%
Space maintainers	100%	80%	100%	100%
BASIC SERVICES				
Amalgam filling — 2 surfaces	80%	60%	80%	Not Covered
Resin filling — 2 surfaces, anterior	80%	60%	80%	Not Covered
Oral Surgery				
Extraction — exposed root or erupted tooth	80%	60%	80%	Not Covered
Extraction of impacted tooth — soft tissue	80%	60%	80%	Not Covered
***MAJOR SERVICES**				
Complete upper denture	50%	40%	50%	Not Covered
Crown — Porcelain with noble metal[1]	50%	40%	50%	Not Covered
Pontic — Porcelain with noble metal[1]	50%	40%	50%	Not Covered
Pontic — Porcelain with noble metal	50%	40%	50%	Not Covered
Inlay — Metallic (3 or more surfaces)	50%	40%	50%	Not Covered
Oral Surgery				
Removal of impacted tooth — partially bony	50%	40%	50%	Not Covered
Endodontic Services				
Bicuspid root canal therapy	80%	60%	50%	Not Covered
Molar root canal therapy	50%	40%	50%	Not Covered
Periodontic Services				
Scaling & root planing — per quadrant	80%	60%	50%	Not Covered
Osseous surgery — per quadrant	50%	40%	50%	Not Covered
***ORTHODONTIC SERVICES**	50%	40%	50%	Not Covered
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	Does not apply

Note: For New Jersey groups with 25 or more eligible employees, the DMO in Plan Options 2 & 10 cannot be sold on a standalone basis to a customer with primary business location in New Jersey. It must be part of a Dual Option sale packaged with either one of the PPO plans in Plan Options 4-6 or 9.

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

Fixed dollar copay amounts on the DMO in Options 2, 3, 8 & 10 are the member's responsibility.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 2, 3, 8 & 10 or the PPO in Plan Option 7.1.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10 and the PPO in Plan Option 5. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on PPO in Plan Option 9.

Plan Options 3, 4 & 7.1; PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP DENTAL PLANS

Available With an Aetna Medical Plan to Groups with 2-50 Eligible Employees Available Without Medical Plan to Groups with 3-50 Eligible Employees	Option 8 Freedom-of-Choice — Monthly selection between the DMO and PPO		Option 9	Option 10
	DMO Plan 100/90/60	PPO $1500 Plan 100/80/50	PPO 2000 Plan 100/80/50	DMO plan 41
Office Visit Copay	$5	None	None	$5
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	$50; 3X Family Maximum	$50; 3X Family Maximum	None
Annual Maximum Benefit	None	$1,500	$2,000	None
DIAGNOSTIC SERVICES				
Oral Exams				
Periodic oral exam	100%	100%	100%	No Charge
Comprehensive oral exam	100%	100%	100%	No Charge
Problem-focused oral exam	100%	100%	100%	No Charge
X-rays				
Bitewing — single film	100%	100%	100%	No Charge
Complete series	100%	100%	100%	No Charge
PREVENTIVE SERVICES				
Adult Cleaning	100%	100%	100%	No Charge
Child Cleaning	100%	100%	100%	No Charge
Sealants — per tooth	100%	100%	100%	$10
Fluoride application — with cleaning	100%	100%	100%	No Charge
Space maintainers	100%	100%	100%	$100
BASIC SERVICES				
Amalgam filling — 2 surfaces	90%	80%	80%	$32
Resin filling — 2 surfaces, anterior	90%	80%	80%	$55
Oral Surgery				
Extraction — exposed root or erupted tooth	90%	80%	80%	$30
Extraction of impacted tooth — soft tissue	90%	80%	80%	$80
***MAJOR SERVICES**				
Complete upper denture	60%	50%	50%	$500
Crown — Porcelain with noble metal[1]	60%	50%	50%	$513
Pontic — Porcelain with noble metal[1]	60%	50%	50%	$488
Pontic — Porcelain with noble metal	60%	50%	50%	$488
Inlay — Metallic (3 or more surfaces)	60%	50%	50%	$463
Oral Surgery				
Removal of impacted tooth — partially bony	60%	50%	80%	$175
Endodontic Services				
Bicuspid root canal therapy	90%	50%	80%	$195
Molar root canal therapy	60%	50%	80%	$435
Periodontic Services				
Scaling & root planing — per quadrant	90%	50%	80%	$65
Osseous surgery — per quadrant	60%	50%	80%	$445
***ORTHODONTIC SERVICES**	$2,300 copay	Not covered	50%	$2,300 copay
Orthodontic Lifetime Maximum	Does not apply	Does not apply	$1,000	Does not apply

Note: For New Jersey groups with 25 or more eligible employees, the DMO in Plan Options 2 & 10 cannot be sold on a standalone basis to a customer with primary business location in New Jersey. It must be part of a Dual Option sale packaged with either one of the PPO plans in Plan Options 4-6 or 9.

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

Fixed dollar copay amounts on the DMO in Options 2, 3, 8 & 10 are the member's responsibility.

*Coverage Waiting Period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 2, 3, 8 & 10 or the PPO in Plan Option 7.1.

Access to negotiated discounts: On the PPO plans in Plan Options 3-9, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Plan Options 2, 3, 8 & 10 and the PPO in Plan Option 5. All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on PPO in Plan Option 9.

Plan Options 3, 4 & 7.1; PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Out-of-network plan payments are limited by geographic area on Plan Options 5, 6 and 8 to the prevailing fees at the 80th percentile and the 90th percentile on Plan Option 9.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

Available With and Without an Aetna Medical Plan to Groups with 3-50 Eligible Employees	Voluntary Option 2	Option 3 Freedom-of-Choice — Monthly selection between the DMO and PPO Max	
	DMO Plan 100/80/50	DMO Plan 100/90/60	PPO Max Plan 100/70/40
Office Visit Copay	$10	$10	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	None	None	$75; 3X Family Maximum
Annual Maximum Benefit	None	None	$1,000
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 fillings	80%	90%	70%
Resin fillings, anterior	80%	90%	70%
Oral Surgery			
Extraction — exposed root or erupted tooth	80%	90%	70%
Extraction of impacted tooth — soft tissue	80%	90%	70%
***MAJOR SERVICES**			
Complete upper denture	50%	60%	40%
Partial upper denture (resin base)	50%	60%	40%
Crown — Porcelain with noble metal[1]	50%	60%	40%
Pontic — Porcelain with noble metal[1]	50%	60%	40%
Inlay — Metallic (3 or more surfaces)	50%	60%	40%
Oral Surgery			
Removal of impacted tooth — partially bony	50%	60%	40%
Endodontic Services			
Bicuspid root canal therapy	80%	90%	40%
Molar root canal therapy	50%	60%	40%
Periodontic Services			
Scaling & root planing — per quadrant	80%	90%	40%
Osseous surgery — per quadrant	50%	60%	40%
***ORTHODONTIC SERVICES**	$2,400 copay	$2,400 copay	Not covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

New Jersey Note: For groups with primary business location in New Jersey, 25 or more eligible employees and who contribute to the cost of the dental plan; the DMO in Voluntary Options 2 & 5 cannot be sold on a standalone basis.

*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 2, 3 & 5 or the PPO in Plan Option V7.1.

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

Fixed dollar copay amounts on the DMO in Voluntary Options 2, 3 & 5 are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Voluntary Plan Options 3, 4 & V7.1, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Plan Options 2, 3 & 5.

Voluntary Plan Options 3, 4 & V7.1; PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA SMALL GROUP VOLUNTARY DENTAL PLANS

Available With and Without an Aetna Medical Plan to Groups with 3-50 Eligible Employees	Voluntary Option 4	Voluntary Option 5	Voluntary Option V7.1 Preventive Dental
	PPO Max Plan 100/80/50	DMO Plan 41	Preventive/PPO Max 100/0/0
Office Visit Copay	N/A	$10	N/A
Annual Deductible per Member (does not apply to Diagnostic & Preventive Services)	$75; 3X Family Maximum	None	N/A
Annual Maximum Benefit	$1,500	None	Unlimited
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	100%	No Charge	100%
Comprehensive oral exam	100%	No Charge	100%
Problem-focused oral exam	100%	No Charge	100%
X-rays			
Bitewing — single film	100%	No Charge	100%
Complete series	100%	No Charge	100%
PREVENTIVE SERVICES			
Adult Cleaning	100%	No Charge	100%
Child Cleaning	100%	No Charge	100%
Sealants — per tooth	100%	$10	100%
Fluoride application — with cleaning	100%	No Charge	100%
Space maintainers	100%	$100	100%
BASIC SERVICES			
Amalgam fillings	80%	$32	Not Covered
Resin fillings, anterior	80%	$55	Not Covered
Oral Surgery			
Extraction — exposed root or erupted tooth	80%	$30	Not Covered
Extraction of impacted tooth — soft tissue	80%	$80	Not Covered
***MAJOR SERVICES**			
Complete upper denture	50%	$500	Not Covered
Partial upper denture (resin base)	50%	$513	Not Covered
Crown — Porcelain with noble metal[1]	50%	$488	Not Covered
Pontic — Porcelain with noble metal[1]	50%	$488	Not Covered
Inlay — Metallic (3 or more surfaces)	50%	$463	Not Covered
Oral Surgery			
Removal of impacted tooth — partially bony	50%	$175	Not Covered
Endodontic Services			
Bicuspid root canal therapy	50%	$195	Not Covered
Molar root canal therapy	50%	$435	Not Covered
Periodontic Services			
Scaling & root planing — per quadrant	50%	$65	Not Covered
Osseous surgery — per quadrant	50%	$445	Not Covered
***ORTHODONTIC SERVICES**	Not covered	$2,400 copay	Not Covered
Orthodontic Lifetime Maximum	Does not apply	Does not apply	Does not apply

New Jersey Note: For groups with primary business location in New Jersey, 25 or more eligible employees and who contribute to the cost of the dental plan; the DMO in Voluntary Options 2 & 5 cannot be sold on a standalone basis.

*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 2, 3 & 5 or the PPO in Plan Option V7.1.

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

Fixed dollar copay amounts on the DMO in Voluntary Options 2, 3 & 5 are the member's responsibility.

Access to negotiated discounts: On the PPO plans in Voluntary Plan Options 3, 4 & V7.1, members may be eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Voluntary Plan Options 2, 3 & 5.

Voluntary Plan Options 3, 4 & V7.1; PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

AETNA OUT-OF-STATE PPO SMALL GROUP DENTAL PLANS

	Low Option No Ortho	Low Option Ortho	Medium Option No Ortho
Dental Plan	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
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	$1,000	$1,500
DIAGNOSTIC SERVICES			
Oral Exams			
Periodic oral exam	100%	100%	100%
Comprehensive oral exam	100%	100%	100%
Problem-focused oral exam	100%	100%	100%
X-rays			
Bitewing — single film	100%	100%	100%
Complete series	100%	100%	100%
PREVENTIVE SERVICES			
Adult Cleaning	100%	100%	100%
Child Cleaning	100%	100%	100%
Sealants — per tooth	100%	100%	100%
Fluoride application — 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**	Not covered	50%	Not covered
Orthodontic Lifetime Maximum	Does not apply	$1,000	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.

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

PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

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 OUT-OF-STATE PPO SMALL GROUP DENTAL PLANS

	Medium Option Ortho	High Option No Ortho	High Option Ortho
Dental Plan	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
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	$2,000	$2,000
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**	50%	Not covered	50%
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.

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

PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

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 OUT-OF-STATE PPO VOLUNTARY SMALL GROUP DENTAL PLANS

	Option 1 No Ortho	Option 1 Ortho
Dental Plan	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**	Not covered	50%
Orthodontic Lifetime Maximum	Does not apply	$1,000

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

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

PPO Max Non-Preferred (out-of-network) Coverage is limited to a maximum of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 46.

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

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

Aetna Avenue

LIFE AND DISABILITY OVERVIEW

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

LIFE INSURANCE

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

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

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

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

Giving you (and your employees) what you want

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

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

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

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

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

Our fresh approach to life

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

AD&D ULTRA®

AD&D Ultra is standardly included with our small group life and disability insurance or benefits plans and provides employees and their families with the same coverage as a typical accidental death and dismemberment plan — and then some. This includes extra features at no additional cost to you, 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

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

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

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

INTEGRATED HEALTH AND DISABILITY

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

- Predictive modeling identifies medical members most likely to experience a disability, potentially preventing a disability from occurring or minimizing the impact for better outcomes.
- Health Insurance Portability and Accountability Act (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 page 47.

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

TERM LIFE PLAN OPTIONS

	2-9 Employees	10-50 Employees
Basic Life Schedule	Flat $10,000, $15,000, $20,000, $50,000	Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000
Guaranteed Issue	$20,000	10-25 employees $75,000 26-50 employees $100,000
Disability 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
Conversion	Included	Included
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 period	Passenger restraint and airbag, education benefit for your child and/or spouse, child care, repatriation of remains, coma, Total Disability, 365-day covered loss period
OPTIONAL DEPENDENT TERM LIFE		
Spouse Amount	Not Available	$5,000
Child Amount	Not Available	$2,000

PACKAGED LIFE AND DISABILITY PLAN OPTIONS

	Low Option	Medium Option	High Option
TERM LIFE PLAN OPTIONS			
Basic Life Schedule	Flat $10,000	Flat $20,000	Flat $50,000
Guaranteed Issue **2-9 Lives** **10-50 Lives**	 $10,000 $10,000	 $20,000 $20,000	 $20,000 $50,000
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	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
Accelerated Death Benefit	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness	Up to 75% of Life Amount for terminal illness
Conversion	Included	Included	Included
Dependent Life	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000	Spouse $5,000; Child $2,000
AD&D ULTRA®			
AD&D Ultra®	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 OPTIONS			
Monthly Benefit	Flat $500; No offsets	Flat $1,000; Offsets are Workers' Compensation, any State Disability Plan and Primary and Family Social Security benefits	
Elimination Period	30 days	30 days	30 days
Definition of Disability	Own Occupation: Earnings loss of 20% or more	Own Occupation: Earnings loss of 20% or more	First 24 months of benefits: Own occupation: Earnings Loss of 20% or more; Any reasonable occupation thereafter: 40% earnings loss
Benefit Duration	24 months	24 months	60 months
Pre-Existing Condition Limitation	3/12	3/12	3/12
Types of Disability	Occupational & Non-Occupational	Occupational & Non-Occupational	Occupational & Non-Occupational
Separate Periods of Disability	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter	15 days during elimination period 6 months thereafter
Mental Health/Substance Abuse	24 months	24 months	24 months
Waiver of Premium	Included	Included	Included
OTHER PLAN PROVISIONS			
Eligibility	Active Full Time Employees	Active Full Time Employees	Active Full Time Employees
Rate Guarantee	1 year	1 year	1 year
Rates PEPM	$8.00	$15.00	$27.00

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

Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

ALL PRODUCTS

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.

Census Data	■ Census data must be provided on all eligible (and COBRA/State Continuation eligible) employees and includes name, age/date of birth, date of hire, gender, dependent status, and work and home zip code. ■ Retirees are not eligible. ■ New Business rating will be based on final enrollment.
Case Submissions	■ Groups with 2 to 50 eligible employees must have all completed paperwork into Aetna Underwriting 5 business days prior to the requested effective date for all groups. If not received by this date, the effective date will be moved to the next available effective date.
Dependent Eligibility	■ Eligible dependents include an employee's spouse, domestic partners and same-sex civil union partners. ■ If both husband and wife/partner work for the same company, they may enroll together or separately. ■ If an employee and dependent work for the same company, refer to Employee Eligibility section. ■ Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26. ■ At the election of the employer, dependents beyond age 26 may remain on their parent's New Jersey fully insured medical plan through age 30, until their 31st birthday. To be eligible, the parents of the overage dependent must be actively covered under a New Jersey-issued group health contract. This does NOT apply to Small Groups sitused in another state, regardless of where the employee resides. Eligible dependents must be the insured's child (by blood or by law) and must meet the following criteria: – Is younger than 31 years of age; – Is unmarried; – Has no dependents; – Is a resident of New Jersey OR is enrolled as a full-time student; – Is not provided coverage as a named subscriber, enrollee or covered person under any other health plan (cannot be entitled to Medicare); – Elects coverage before their 30th birthday; – The employee completes the New Jersey mandated form to enroll dependents up to the age of 31. ■ For dependent life, dependents are eligible from 14 days up to their 19th birthday or to their 23rd birthday, if in school. ■ Dependents are not eligible for AD&D or Disability coverage. ■ For Medical and Dental, dependents must enroll in the same benefits as the employee (participation not required). ■ Employees may select coverage for eligible dependents under the Dental plan, even if they selected Single coverage under the Medical plan. See Product-specific Life/AD&D and Disability guidelines under Product Specifications. ■ Individuals cannot be covered as an employee and a dependent under the same plan. ■ Children eligible for coverage through both parents cannot be covered by both parents under the same plan.
Effective Date	■ The group effective date will be the 1st or the 15th of the month. ■ The effective date requested by the employer may be up to 60 days in advance.

Employee Eligibility

- Eligible employees are defined as those employees who are permanent and work on a full-time basis with a normal work week of at least 25 hours, receive compensation, and who have met any authorized waiting period requirements. This includes the owner(s) of a business and their spouses/dependent(s) and corporate officers. This includes a sole proprietor with one or more eligible employees, 1099 contractors or a partner of a partnership, if included as an employee under the health benefits plan of a small employer.
- Employees in the waiting period are considered when determining the group size.
- If an employee and dependent work for the same company and elect to enroll as employee and dependent, applicable documentation to determine dependent's actual employee eligibility status must be provided as any other employee of the group. (i.e., WR-30, Partnership document, W-2 and payroll stub).
- Union employees who have collectively bargained for their health plan are excluded as eligible employees for the purpose of health coverage.
- Employees who do not meet the definition of a permanent full-time employee will not be eligible. (e.g., leased, part-time, temporary, seasonal or substitute employees).
- 1099 contractors, stockholders, partners or other outside consultants, who are not active, permanent full-time employees are not eligible.
- For Life and Disability Only: Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day.
- An employee can waive Medical coverage and still enroll for Dental, Life/AD&D and Disability.

Retirees

- Aetna offers coverage for Medicare-eligible retirees in accordance with the Eligibility Guidelines for the Aetna Golden Medicare Plan® and the Aetna Golden Choice Plan®.
- Retirees and members of Aetna's Medicare group plans are not eligible for Life, Disability or Dental coverage.

Continuation — COBRA or NJ State Continuation

- Eligible enrollees are required to be included on the census. (COBRA employees not eligible for Life or Disability.) (State continuation employees not eligible for Life, Dental or Disability.)
- Continuation qualifying event, length, start and end date must be provided.
- Employers with 20 or more employees full & part time are required to offer COBRA Coverage.
- Employers with less than 20 full-time employees are required to offer State Continuation.

Employer Eligibility

- Medical Plans can be offered to groups of 2-50 eligible employees.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Medical plans can be offered to sole proprietorships with one or more eligible employees, partnerships or corporations.
- A group conducting business under a d.b.a. must submit a copy of the DBA certificate or fictitious name certificate.
- Associations, Taft-Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage.
- Dental and Disability have ineligible industries which are listed separately below. The Dental ineligible list does not apply when dental is sold in combination with medical.
- Submission of the most recent WR30/Quarterly Wage and Tax Statement must contain the names, salaries, etc. of all employees of the employer group.
  - Employees who have terminated or work part-time should be noted accordingly on the WR-30.
  - Employees not listed on the WR-30 should have a payroll stub indicating Federal & State Tax with-holding.

If employee is sole proprietor, partner or corporate officer, the Proof of Eligibility form must be completed and submitted with the following:

Sole Proprietor	Partner	Corporate Officers
Must submit one of the following: ■ IRS Form 1040C or 1040F ■ IRS Form 1040SE ■ IRS Form ES	Must submit one of the following: ■ IRS Form 1065 (Schedule K-1) ■ IRS Form 1040 SE ■ IRS Form ES	Must submit one of the following: ■ IRS Form 1120, 1120 A or 1120 W (C-Corp & Personal Service C) ■ IRS Form 1120 S, K-1 or 1040 ES (S-Corp)
Submit all applicable: ■ Assumed Name Certificate (Fictitious Business Name or DBA) AND ■ Filed Certificate of Organization (Only required for LLC)	Submit all applicable: ■ State-Filed Partnership Agreement ■ Filed Assumed Name Certificate (Fictitious Business Name or DBA) AND ■ Filed Certificate of Organization (Only required for LLC or LLP) AND ■ State Business License reflecting SIC	Submit all applicable: ■ Assumed Name Certificate (Fictitious Business Name or DBA) AND ■ Articles of Incorporation (Complete, including name of officers) AND ■ Filed Certificate of Qualification (if incorporated in a different state) ■ State Business License reflecting SIC

Prior Aetna Coverage	■ Groups that have been terminated for non-payment by Aetna may require six (6) months of premium with application and must pay all premiums still owed on the prior Aetna plan before the new plan will be issued.
Final Rates	Rating will be based on final enrollment based on information provided on enrollment forms.
Initial Premium Check	■ The initial premium payment may be in the form of a check or electronic funds transfer. ■ The initial premium submission is not a binder check and does not bind Aetna to provide coverage. ■ The initial premium submission equal to one month's premium must accompany application. ■ If the request for coverage is denied due to business ineligibility, participation and/or contribution not met or other permissible reasons, the initial premium submission will be returned to the employer. ■ If the initial premium submission is returned or declined for non-sufficient funds, coverage will be retroactively termed to the effective date.
Newly Formed Business	Must provide the following documentation for consideration: ■ Payroll records or letter from attorney or Certified Public Accountant attesting to the names of all employees, number of hours worked on a regular basis, indication of salary draw, ■ Estimated average number of full-time employees expected for the current calendar year, ■ Tax I.D. number, and ■ Copy of Business License.
Plan Change Ancillary Additions	■ Requests to add or change ancillary benefits must be requested by the desired effective date. ■ The future renewal date of the ancillary products will be the same as the medical plan renewal date.
Producers	■ Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna Products. ■ All quotes are subject to change based upon additional information that becomes available in the quoting process and during the case submission/installation, including any change in census.
Replacing Other Group Coverage	■ A copy of the current billing statement that includes the account summary showing the plan is paid to the current premium due date. ■ The employer should be told not to cancel any existing medical coverage until they have been notified of approval.
Waiting Period	■ The employer decides whether or not to impose a waiting period. ■ The available waiting periods are 0, 30, 60, 90, 120, 150 or 180 days. ■ We strongly recommend an effective date of the 1st or 15th of the policy month following the waiting period of 0, 30, 60, 90,120 or 150 (excludes 180 days) for new or rehired employees. If electing this option, please indicate on the employer application. ■ Changes to waiting period allowed on anniversary only.

SPECIFIC TO PRODUCTS

	Medical	Dental	Basic Term Life and Packaged Life & Disability
Product Availability	■ 2 to 50 eligible employees. ■ May be written standalone or with ancillary coverage as noted in the following columns.	■ 2 eligible employees — Standard Dental Plans available with Medical. Voluntary Dental Plans not available. ■ 3 to 50 eligible employees — Standard and Voluntary Dental plans available with or without Medical. Voluntary DMO (V2) cannot be offered standalone. ■ Orthodontia coverage is available to dependent children only for groups with 10 or more eligible employees.	■ 2 to 9 eligible employees if sold with Medical. ■ 10 to 50 eligible employees on a standalone basis. ■ Must meet the qualifications of a small business. The same employer eligibility guidelines that apply to Medical will apply to Basic Term Life and Packaged Life/Disability coverage. ■ Employees may elect Basic Term Life or the Packaged Life/Disability coverage even if they do not elect medical coverage. Basic Term Life and Packaged Life/Disability cannot be offered as a dual option.
Carve Out/ Excluded Class	■ Employees covered under a union sponsored plan cannot be included as eligible employees. ■ Carve Outs are permitted provided minimum participation and eligibility requirements are met.	Not allowed.	Not applicable.
Option Sales	It is strongly recommended that Aetna be the sole carrier for groups with 2-19 eligible employees.	■ All dental plans must be offered on a full-replacement basis. ■ No other employer-sponsored dental plan can be offered.	Not applicable.
Employer Contribution	Coverage can be denied if the employer contributes less than 10% of the annual cost of the health benefits plan.	■ Standard dental plans, employers must contribute at least 25% of the total cost of the plan or 50% of the cost of employee-only coverage. ■ Coverage can be denied based on inadequate contributions. ■ For Voluntary dental plans, employer contribution of less than 50% of the cost of employee-only coverage. Employee Pay All plans are permitted.	■ 2 to 9 eligible employees — 100% of the total cost of the Basic Term Life plan (excluding Optional Dependent Term). ■ 10 to 50 eligible employees — at least 50% of the total cost of the plans (excluding Optional Dependent Term). ■ Coverage can be denied based on inadequate contributions.
Out-of-State/ Situs Employees	■ Any employee located in CT, DE, MD, NJ, NY, PA, VA or DC (situs area) but not residing in an Aetna HMO, POS and/or PPO network will be enrolled in a New Jersey Indemnity benefit plan. ■ Any active employee, who lives and works in a state other than within the group situs area (CT, DE, MD, NJ, NY, PA, VA and DC), is considered an out-of-state employee. ■ For groups requesting coverage, no more than 50% of the employees may work outside the situs area. Aetna will quote an out-of-state PPO or Indemnity plan for those employees. ■ For groups requesting benefits with more than 50% of the group's employees residing outside the region, Aetna may decline to offer coverage to those out-of-state employees.	■ Employees who reside outside of CT, DE, MD, NJ, NY, PA, VA and DC are considered outside the situs region. ■ Out-of-State/Situs employees will be offered one of the specific out-of-state/situs dental PPO plans. Employees who fall outside a dental PPO network area will default to a comparable/ Indemnity plan. ■ Maximum Out-of-State/Situs employee percentage (and/or number of employees) will agree with the Medical guideline.	Not applicable.
Participation	■ Groups with 2 to 50 eligible employees — 75% of eligibles must enroll including those covered under a spouse's group health benefits plan, Medicare, NJ Family Care, or Medicaid. In calculating participation, individuals with these types of other coverages must be counted as participating. Example: 22 lives, 2 covered under spouse (22 x 75% = 16.5, rounded up = 17 (to meet participation); 17-2 (covered under spouse) = 15 must enroll) ■ Dependent participation is not required. ■ Employees waiving must complete the waiver section and provide proof of other coverage by providing a copy of their spouse's current I.D. card. ■ Coverage can be denied based on inadequate participation.	■ For non-contributory plans, 100% participation is required, excluding those with other qualifying dental coverage. ■ 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. Standard Dental Plans ■ 2 to 3 eligible employees — 100% participation is required, excluding those with other qualifying existing dental coverage. ■ 4 to 50 eligible employees — 75% participation is required, excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental Plan. Voluntary Dental Plans ■ 3 to 50 eligible employees — 25% participation, excluding those with other qualifying existing dental coverage or a minimum of 3 enrollees (5 enrollees for orthodontia coverage) whichever is greater is required.	■ Employees may elect Basic Term Life or Packaged Life/Disability insurance even if they do not elect Medical coverage. However, the group must meet the required participation percentage. If not, then Basic Term Life/ Disability will be declined for the group. ■ 2 to 9 eligible employees — – 100% participation is required Example: 9 employees, 3 waiving Medical. All 9 must enroll for Life. ■ 10 to 50 eligible employees — – 75% must participate when the plan is at least partially contributory. – 100% participation is required for all non-contributory plans.

SPECIFIC TO PRODUCTS

Late Applicants

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 follows:

	Medical	Dental	Basic Term Life and Packaged Life & Disability
Late Applicants	■ Late applicants will be enrolled as of the date the individual requests coverage unless the effective date requested is more than 31 days prior to Aetna's receipt of the application. In that case, the effective date will be 31 days prior to Aetna's receipt of the application.	■ 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.	■ 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).
Industries	■ All industries eligible. ■ The employer should provide the SIC code (four-digit number or six-digit code) filed with the state on the business tax return and/or Workers' Compensation form (optional for Medical).	■ Ineligible industry list applies only when Dental is sold standalone or packaged only with Group Insurance. ■ This list does not apply when Dental is sold in combination with Medical.	■ Basic Term Life Only — all industries are eligible ■ Disability — the following industries are not eligible for the Packaged Life/Disability plan:

Dental — Ineligible Industries

SIC Description	SIC Range
Bowling Centers	7933
Business Associations	8611
Dance Studios, Schools	7911
Employment Agencies	7361-7363
Misc. Amusement and Recreation	7999
Misc. Membership Organizations	8699
Misc. Services	8999
Physical Fitness Facilities	7991
Private Households	8811
Professional Sports Clubs & Producers, Race Tracks	7941-7948
Professional Membership Organizations, Labor Unions, Civic Social & Fraternal Organizations, Political Organizations	8621-8651
Public Golf Courses, Amusements, Membership Sports & Recreation Clubs	7992-7997
Religious Organizations	8661
Theatrical Producers, Bands, Orchestras, Actors	7922-7929

Basic Term Life and Packaged Life & Disability — Ineligible Industries (Disability)

SIC Description	SIC Range
Mining	1000-1499
Service — Detective Services	7381
Explosives, Bombs & Pyrotechnics	2892-2899
Automotive Repairs/ Services	7500-7599
Asbestos Products	3291-3292
Motion Picture/ Amusement	7800-7999
Primary Metal Industries & Recreation	3310-3329
Fire Arms & Ammunition	3480-3489
Doctors Offices/Clinics	8010-8043
Liquor Stores	5921
Membership Associations	8600-8699
Security Brokers	6211
Service-Private Households	8800-8899
Real Estate — Agents	6531
Non-classified Establishments	9999

MEDICAL ONLY

Dual and Triple Product Options

- Allow dual option offerings to groups of 2-50 eligible employees.
- Allow triple option offerings to groups for 3-50 eligible employees, as long as at least 1 plan is an HSA plan.
- Only set up multiple plans if at least 1 employee enrolls in each plan.
- Not allow the same medical plan to be offered with different Pharmacy options. To offer dual or triple option, the medical plans must be different.
- Not allow calendar year and plan year deductible plans to be offered at the same time to the same group. If multiple HSA plans are offered within a group, they must all be calendar year or plan year plans.

Rate Tier Structure

- 4 tiers required.
- Class Rated based on demographics.

DENTAL ONLY

Coverage Waiting Period

- 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 group's immediately preceding 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.
- Example: Prior Major coverage but no Orthodontics coverage. Aetna plan has coverage for both Major and Orthodontics. The waiting period is waived for Major Services but not for Orthodontics Services.
- There is no Coverage Waiting Period on DMO.

Product Packaging

- For groups with 25+ employees, DMO options cannot be sold as the only dental plan. It must be sold as a Dual Option sale with a dental PPO (or Voluntary PPO) plan.
- For groups with <25 employees, DMO options can be either sold standalone or packaged with any PPO option as a Dual Option.
- PPO plans can be sold standalone or packaged with DMO as a Dual Option.
- Freedom-of-Choice cannot be sold with any other option. It must be the only plan sold.
- Voluntary DMO must be offered with Voluntary PPO.

Open Enrollment

- Open enrollments are prohibited for Voluntary plans.
- An employee or dependent can enroll at any time but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible, unless a qualifying life event has occurred or the enrollee is less than age 5.

Reinstatement

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

BASIC TERM LIFE AND PACKAGED LIFE & DISABILITY

Job Classification (Position) **Schedules**

- 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 waiting 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. For example, a schedule may be structured as follows:

Position/Job Class	Basic Term Life Amount	Packaged Life/Disability
Executives	$50,000	High Option
Managers/Supervisors	$20,000	Medium Option
All Other Employees	$10,000	Low Option

Guaranteed Issue Coverage

- Aetna provides certain amounts of Life insurance to all timely entrants without requiring an employee to answer any Medical questions. These insurance amounts are called "Guaranteed Issue."
- Employees wishing to obtain increased insurance amounts will be required to submit Evidence of Insurability which means they must complete a Medical questionnaire and may be required to submit to a Medical exam.

Evidence of Insurability (EOI)

Evidence of Insurability (evidence of good health) is required when one or more of the following conditions exist:

- Life amounts are above the maximum Guaranteed Issue amount.
- Late Entrant — coverage is not requested within 31 days of eligibility for contributory coverage.
- Reinstatement or restoration of coverage is requested.
- New coverage is requested during the anniversary period.
- Coverage is requested outside of the employer's anniversary period due to qualifying life event (marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.)
- Dependent coverage option was initially refused by employee but requested later. The dependent would be considered a late entrant and subject to EOI, and may be declined for medical reasons.

Continuity of Coverage (no loss/no gain)

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

Contractual Underwriting

- Open enrollments are prohibited.
- Life is bundled with medical at the employer level not the employee level. Therefore, a subscriber within a given group can waive medical Underwriting coverage and still enroll for Life/AD&D.
- Life coverage can be offered to sole proprietorships, partnerships or corporations.
- Associations, Taft-Hartley groups, employee leasing firms and closed groups are not eligible for coverage and must be written individually.
- Must meet the qualification of a small business. The same employer eligibility guidelines that apply to medical will apply to the life coverage.

Medical Underwriting

New Business Medical Evaluation

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

Guarantee Issue Amounts

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

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

  Example:
  Applying for $50,000
  54-year-old male
  Heart attack 6 months ago, no surgery
  Reduced to $20,000 life
  All other employees will be issued $50,000.
- In those states that have a case size differential for completing different sections of the health questions, the determining factor is based on the number of enrolled employees and not the number of eligible employees.

New Hire

- New hires wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit Evidence of Insurability (EOI), which means they must complete a medical questionnaire.
- If the employee has an unacceptable medical conditions; the employee will be reduced to the Guaranteed Issue amount.

LIMITATIONS AND EXCLUSIONS

MEDICAL

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

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Custodial care
- Dental care or treatment, including appliances and dental implants, except as otherwise stated in the contract
- Donor egg retrieval
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in the contract
- Eye surgery, such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring)
- Immunizations for travel or work
- Non-medically necessary services or supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Services or supplies furnished in connection with any procedures to enhance fertility which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following:
  - a) Procedures: in vitro fertilization; embryo transfer; embryo freezing; and Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), donor sperm, surrogate motherhood; and
  - b) Prescription drugs not eligible under the prescription drugs section of the contract.
- For PPO Basic Hospital Plans: Services or supplies furnished in connection with any procedures to enhance fertility
- Services or supplies related to Cosmetic Surgery except as otherwise stated in the Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes
- For the PPO HSA-Compatible, PPO First Dollar Plans and PPO Basic Hospital Plans: Weight control services, including surgical procedures, medical treatment, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, except as provided for in the Food Products for Inherited Metabolic Disease provision, exercise programs, exercise or other equipment and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

PRE-EXISTING CONDITIONS EXCLUSION PROVISION

The following provisions only apply to small employers of at least two but not more than five eligible employees. These provisions also apply to "late enrollees" for any small employer. However, this provision does not apply to late enrollees if 10 or more late enrollees request enrollment during any 30-day enrollment period. The "Pre-Existing Conditions" provision does not apply to a dependent who is an adopted child or who is a child placed for adoption or to a newborn child if the employee enrolls the dependent and agrees to make the required payments within 30 days after the dependent's eligibility date. Pre-existing condition exclusion provisions are waived for any individual under the age of 19.

A Pre-Existing Condition is an illness or injury which manifests itself in the six months before a member's enrollment date, and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the enrollment date. This 180-day period may be reduced by the length of time the member was covered under any creditable coverage if, without application of any waiting period, the creditable coverage was continuous to a date not more than 90 days prior to becoming a member.

This limitation does not affect benefits for other unrelated conditions or pregnancy, or birth defects in a covered dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Aetna waives this limitation for a member's Pre-Existing Condition if the condition was payable under creditable coverage which covered the member right before the member's coverage under the Aetna plan started.

If a new member was covered under creditable coverage prior to enrollment under the Aetna plan and the creditable coverage was continuous to a date not more than 90 days prior to the enrollment date under the Aetna plan, we will provide credit as follows. We give credit for the time the member was covered under the creditable coverage without regard to the specific benefits included in the creditable coverage. We count the days the member was covered under creditable coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation. The person must sign and complete his or her enrollment form within 30 days of the date the employee's active full-time service begins. We do not cover any charges actually incurred before the person's coverage starts. If the small employer has included an eligibility waiting period, an employee must still meet it, before becoming covered.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, please provide Aetna with a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at **1-888-70-AETNA** (**1-888-702-3862**) **for HMO/POS products or 1-888-80-AETNA (1-888-802-3862) for Traditional/PPO products** if assistance is needed in obtaining a Certificate of Creditable Coverage from prior carriers or with any questions on the information noted above.

LIMITATIONS AND EXCLUSIONS

DENTAL

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

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

SPECIFIC SERVICE LIMITATIONS:

- 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 felony provided that the covered person is convicted of the felony.
- A covered person's intoxication or being under the influence of any narcotics unless administered or consumed on the advice of a physician.
- 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

- Is due to intentionally self-inflicted injury (while sane or insane).
- Results from your committing or attempting to commit a felony or taking part in a riot or civil commotion.
- Is due to war or any act of war (declared or not declared).
- Results from an automobile accident caused by you while you are 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.

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This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/Dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Discount programs provide access to discounted prices and are NOT insured benefits. **The member is responsible for the full cost of the discounted services**. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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