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# Pennsylvania plan guide

Creating the right health benefits package starts with you and your employees

Plans effective January 1, 2015  
For businesses with 1 – 50 employees

[www.aetna.com](http://www.aetna.com)

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# Choosing the right health plan

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

We believe creating the right health benefits and insurance plan means combining these four options to meet a company's specific needs: **benefits, network, cost sharing, funding.**

## Experience matters

We take the time to listen and learn about your needs. Our experience allows us to share knowledge and provide tools to help achieve the right balance of cost and coverage.

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

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

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

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# Information about your plan due to health care reform

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

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

## Essential health benefits package

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

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

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

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

All cost sharing must apply toward the OOP maximum\*, including in-network medical, behavioral health and pharmacy cost sharing. This does not include premiums, bills for the amounts over what the plan “recognizes” or spending for non-covered services.

The out-of-pocket maximum must include:

- Copays
- Deductibles
- Coinsurance

## Fees

These fees are included in your premium:

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

## Guaranteed issue

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

- Group health plans/insurance coverage (insured only)
- Individual health insurance coverage (including medical conversion)
- Pharmacy (insured only)
- Behavioral health (insured only)\*\*

Please note that guaranteed issue is not available for:

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

## Rating rule changes

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

\*Prescription drugs may have a separate out-of-pocket maximum.

\*\*No standalone insured behavioral health.

## Pediatric dental/vision

Pediatric dental and vision mandates are a separate essential health benefit category and are included with your medical benefits. We will cover those services in 2015 according to the benchmark plan coverage.

## Pediatric dental

Plan name	Traditional HMO/HNOnly plans with no deductible	Traditional HMO/HNOnly/ Indemnity plans with deductible	Consumer-directed – HMO HSA-compatible plans	Consumer-directed – HMO HSA-compatible 5700 100% plan	Traditional QPOS/HNOption/ PPO plans with no in-network deductible	
	In network	In network	In network	In network	In network	Out of network
<b>Dental checkup</b> (a/k/a preventive/diagnostic)	0%	0%, deductible waived	0% after deductible	0% after deductible	0%	30% after deductible
<b>Dental basic</b>	30%	30% after deductible	30% after deductible	0% after deductible	30%	50% after deductible
<b>Dental major</b>	50%	50% after deductible	50% after deductible	0% after deductible	50%	50% after deductible
<b>Dental ortho</b>	50%	50% after deductible	50% after deductible	0% after deductible	50%	50% after deductible

Plan name	Traditional QPOS/HNOption/ PPO plans with in-network deductible		Consumer-directed – HNOption and PPO HSA-compatible plans		Consumer-directed – HNOption and PPO HSA-compatible 5700 100% plans	
	In network	Out of network	In network	Out of network	In network	Out of network
<b>Dental checkup</b> (a/k/a preventive/diagnostic)	0%, deductible waived	30% after deductible	0% after deductible	30% after deductible	0% after deductible	30% after deductible
<b>Dental basic</b>	30% after deductible	50% after deductible	30% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Dental major</b>	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible
<b>Dental ortho</b>	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible	50% after deductible

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

# Pediatric vision

Plan name	Traditional HMO/HNOnly plans with no deductible	Traditional HMO/HNOnly/ Indemnity plans with deductible	Consumer-directed – HMO HSA-compatible plans	Consumer-directed – HMO HSA-compatible 5700 100% plan	Traditional QPOS/HNOption/ PPO plans with no in-network deductible	
	In network	In network	In network	In network	In network	Out of network
<b>Vision exam</b> (one exam per 12 months)	0%	0%, deductible waived	0%, deductible waived	0%, deductible waived	0%	50% after deductible
<b>Eyeglass frames, prescription lenses or prescription contact lenses*</b>	0%	0%, deductible waived	0% after deductible	0% after deductible	0%	50% after deductible

Plan name	Traditional QPOS/HNOption/ PPO plans with in-network deductible		Consumer-directed – HNOption and PPO HSA-compatible plans		Consumer-directed – HNOption and PPO HSA-compatible 5700 100% plans	
	In network	Out of network	In network	Out of network	In network	Out of network
<b>Vision exam</b> (one exam per 12 months)	0%, deductible waived	50% after deductible	0%, deductible waived	50% after deductible	0%, deductible waived	50% after deductible
<b>Eyeglass frames, prescription lenses or prescription contact lenses*</b>	0%, deductible waived	50% after deductible	0% after deductible	50% after deductible	0% after deductible	50% after deductible

\*The pediatric vision plan will cover the following:

- One set of eyeglass frames per 12 months.
- One pair of prescription lenses per 12 months
- Prescription contact lenses maximum per 12 months: daily disposables (up to three-month supply), extended wear disposable (up to six-month supply) and nondisposable lenses (one set).
- Important Notes: This plan will cover either one pair of prescription lenses for eyeglass frames or prescription contact lenses, but not both, per 12 months. Coverage does not include the office visit for the fitting of prescription contact lenses.

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

# Choosing the right plan for your business

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

Take a look at what's available.

## Medical plans

- Traditional plans
- Consumer-directed plans

## Plan levels

You can choose up to four levels of health plans. These levels are named using metals—bronze, silver, gold and platinum. Each level includes the same essential health benefits. But the levels differ in how much the health plan pays.

Health plan levels	Average amount the plan pays for covered services	Premium cost for employees
<b>Bronze</b>	60%	Lowest
<b>Silver</b>	70%	Lower
<b>Gold</b>	80%	Higher
<b>Platinum</b>	90%	Highest

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

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

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

- **Secure member website.** Your employees get self-service tools, plus health plan and health information through their Aetna Navigator® website. Think of it as the key that unlocks the full value of their health benefits package. Encourage them to sign up at [www.aetna.com](http://www.aetna.com).
- **Member Payment Estimator.** With an Aetna health plan, your employees can compare and estimate costs\* for office visits, tests, surgeries and more. This means they can save money\*\*—and avoid surprises. This online tool factors in their deductible, coinsurance and copays, plus contracted rates. They can see how much they have to pay and how much the plan will pay. They can log in to their Aetna Navigator member website to use the tool.
- **Online provider directory.** Finding doctors, specialists, hospitals and more in the Aetna network is easy with our DocFind® search tool. It's available at [www.aetna.com](http://www.aetna.com) and the Aetna Navigator member website.
- **My Life Values.** Your employees get 24/7 online services and support for managing their everyday personal and work matters.
- **iTriage.** This is a free mobile app that lets members research symptoms and diseases, find a medical provider and even book an appointment—all from the convenience of their mobile device. iTriage will guide them to network doctors, hospitals and facilities based on your company health plan. It can help direct your employees to the most appropriate, cost-effective care.

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

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

## Dental plans

- Dental Maintenance Organization or DMO® plan
- PPO
- PPO Max
- Freedom-of-Choice plan design

## Dental plan extras

There's extra value built into our dental portfolio:

- **Dental-medical integration.** Our program encourages preventive dental care among employees who have diabetes or heart disease, or who are pregnant. This can lead to more of your employees taking steps to stay healthy.

## Vision plans

- Aetna Vision<sup>SM</sup> Preferred plans

## Vision plan extras

- **Choice and convenience and flexibility.** Members have the choice to go to any vision provider. Plus, for added convenience, members can easily schedule an eye exam online with some participating providers. Our plans help members fit vision care in to their lifestyle and our bundled plan options provide the administrative ease of having one bill, one renewal and one trusted company to work for you.
- **The value of a balanced network.** We offer a balanced network of independent eye care providers as well as in-network retail providers that include most preferred national optical retail chains offering flexible evening and weekend hours.
- **Discounts.** Aetna Vision Preferred plan offers additional savings on contact lenses, eyeglasses, prescription sunglasses, LASIK vision correction and more at most in-network locations. Availability varies by state.

## Life and disability plans

- Basic life
- Supplemental life
- AD&D Ultra®
- Supplemental AD&D Ultra®
- Dependent life
- Short-term disability
- Long-term disability

## Life and disability plan extras

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

\*These services are discount programs, not insurance.



# Choose from a wide range of health benefits and insurance options to fit your needs

## About our benefits

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

## About our network

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

## About our cost sharing

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

## About our funding options

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

## Cost sharing and premiums for every budget

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

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

## Health and wellness programs

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

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

- Women's health and preventive health reminders
- Simple Steps To A Healthier Life program
- Informed Health® 24-hour nurse line\*
- Aetna discount programs
- Personal health record

### Women's preventive health benefits

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

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

## We make things easy for you

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

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

\*While only a doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on thousands of health topics. Members should contact their doctor first with any questions or concerns about their health care needs.

# **Aetna medical overview**

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



# Medical overview

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

## Pennsylvania provider network\*

### HMO, Health Network Only, QPOS, Health Network Option & PPO Plans

Adams	Clarion	Lackawanna	Pike
Allegheny	Clinton	Lancaster	Schuylkill
Armstrong	Columbia	Lawrence	Snyder
Beaver	Cumberland	Lebanon	Somerset
Bedford	Dauphin	Lehigh	Sullivan
Berks	Delaware	Luzerne	Susquehanna
Blair	Erie	Lycoming	Venango
Bradford	Fayette	Mercer	Washington
Bucks	Franklin	Monroe	Wayne
Butler	Fulton	Montgomery	Westmoreland
Cambria	Greene	Northampton	Wyoming
Carbon	Indiana	Perry	York
Chester	Jefferson	Philadelphia	

### PPO Plans Only

Cameron	McKean
Centre	Mifflin
Clearfield	Montour
Crawford	Potter
Elk	Tioga
Forest	Union
Huntingdon	Warren
Juniata	

\*Network subject to change.

# Product information

Product name	Product description	PCP required	Referrals required	DocFind network name
<b>HMO</b>	A health maintenance organization (HMO) uses a network of participating providers. Each family member selects a primary care physician (PCP) participating in the Aetna 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
<b>QPOS®</b>	QPOS (Quality Point-of-Service®) is a two-tiered product that allows members to access care in one of two ways: 1. PCP referred in network, 2. Self-referred, in or out of 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 in or out of network.	Yes	Yes for PCP-referred care.  No for self-referred care.	QPOS®
<b>Health Network Option (HNOption)</b>	Health Network Option (HNOption) is a two-tiered product that allows members to access care in or out of network. Members have lower out-of-pocket costs when they use the in-network tier of the plan. Member cost sharing increases if members decide to go out of network. Members may go to their PCP or directly to a participating specialist without a referral. It is their choice, each time they seek care.	Optional	No	Aetna Health Network Option <sup>SM</sup> (Open Access)
<b>PPO</b>	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 participating providers at lower out-of-pocket costs, or nonparticipating providers at higher out-of-pocket costs.	No	No	Open Choice® PPO
<b>Indemnity</b>	This 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

## **Aetna high-deductible HSA-compatible HMO/Health Network Option (Open Access)/PPO plans**

Aetna high-deductible HMO, health network option (open access) and PPO health plans are compatible with a health savings account (HSA). HSA-compatible plans provide integrated medical and pharmacy benefits.

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 help cover their future medical and dental expenses. HSAs 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 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.

#### **HSA Account**

- Member owns the HSA
- Contributions are tax free
- Member chooses how and when to use HSA dollars
- Roll it over each year and let it grow
- Earns interest, tax free

#### **Today or in the future**

- Use now for qualified expenses with tax-free dollars
- Plan for future and retiree health-related costs

#### **High-deductible health plan**

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

## **Health reimbursement arrangement (HRA)**

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

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

### **COBRA administration**

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

### **Section 125 Cafeteria Plans and Section 132 Transit Reimbursement Accounts**

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

#### **Premium-only plans (POP)**

Employees can pay for their portion of the group health insurance expenses on a pretax basis. First-year POP fees are waived with the purchase of medical with five or more enrolled employees.

#### **Flexible 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.

### **Group situs**

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

## Multi-state solution

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

Employers based in Pennsylvania can offer PA PPO plans to their employees who live and work outside of the “situs” region. The situs region comprises the following eight states — PA, NJ, DE, MD, DC, VA, NY and CT.

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

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

## Administrative fees

Fee description	Fee	
<b>Premium-only plan (POP)</b>		
<b>Initial set-up*</b>	\$190	
<b>Renewal</b>	\$125	
<b>Health reimbursement arrangement (HRA) and flexible spending account (FSA)**</b>		
	<b>Initial set-up</b>	<b>Renewal fee</b>
2–25 employees	\$360	\$235
26–50 employees	\$460	\$285
<b>Monthly fees***</b>	\$5.45 per participant	
<b>Additional set-up fee</b> for “stacked” plans (those electing an Aetna HRA and FSA simultaneously)	\$150	
<b>Participation fee</b> for “stacked” participants	\$10.45 per participant	
<b>Minimum fees</b>		
0–25 employees	\$25 per month minimum	
26–50 employees	\$50 per month minimum	
<b>COBRA services</b>		
<b>Annual fee</b>		
20–50 employees	\$165	
<b>Per employee per month</b>		
20–50 employees	\$0.95	
<b>Initial notice fee</b>	\$3.00 per notice (includes notices at time of implementation and during ongoing administration)	
<b>Minimum fees</b>		
20–50 employees	\$25 per month minimum	
<b>Transit Reimbursement Account (TRA)</b>		
<b>Annual fee</b>	\$350	
<b>Transit monthly fees</b>	\$4.25 per participant	
<b>Parking monthly fees</b>	\$3.15 per participant	

\*Nondiscrimination testing provided annually after open enrollment for POP and FSA only. Additional off-cycle testing available at employer request for \$100 fee. Nondiscrimination testing only available for FSA and POP products.

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

\*\*\*For HRA, if the employer opts out of Streamline, the fee is increased \$1.50 per participant. For FSA, the debit card is available for an additional \$1 per participant per month. Mailing reimbursement checks direct to employee homes is an additional \$1 per participant per month.

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

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

## Traditional – HMO plans

Plan name	PA Platinum HMO 150D \$20	PA Gold HMO 500D \$25	PA Gold HMO 600D \$35	PA Gold HMO 750D \$45
<b>Member benefits</b>	Network care	Network care	Network care	Network care
<b>Plan year deductible</b>	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
<b>Plan out-of-pocket limit</b>	Medical: \$2,000/\$4,000 Rx: \$4,600/\$9,200	\$5,000/\$10,000	\$5,000/\$10,000	\$6,000/\$12,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded	Embedded	Embedded	Embedded
<b>Primary care physician office visit</b>	\$20 copay	\$25 copay	\$35 copay	\$45 copay
<b>Specialist office visit</b>	\$40 copay	\$50 copay	\$60 copay	\$65 copay
<b>Walk-in clinics</b>	\$20 copay	\$25 copay	\$35 copay	\$45 copay
<b>Diagnostic testing: Lab</b>	Covered in full	\$15 copay	\$15 copay	\$10 copay
<b>Diagnostic testing: X-ray</b>	Covered in full	\$50 copay	\$60 copay	\$65 copay
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$150 copay	\$250 copay	\$300 copay	\$300 copay
<b>Inpatient hospital</b>	\$150 copayment per day, 5 day copay max per admission	\$500 copayment per day, 5 day copay max per admission	\$600 copayment per day, 5 day copay max per admission	\$750 copayment per day, 5 day copay max per admission
<b>Outpatient surgery</b>	\$125 copay	\$500 copay	\$600 copay	\$750 copay
<b>Emergency room<sup>3</sup></b>	\$125 copay	\$250 copay	\$300 copay	\$300 copay
<b>Urgent care</b>	\$75 copay	\$75 copay	\$75 copay	\$75 copay
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	\$40 copay	\$50 copay	\$60 copay	\$65 copay
<b>Chiropractic services</b> (20 visits per plan year)	25%	25%	25%	25%
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay
<b>Preferred brand drugs</b>	\$40 copay	\$50 copay	\$50 copay	\$50 copay
<b>Nonpreferred generic and brand drugs</b>	\$70 copay	\$125 copay	\$125 copay	\$125 copay
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000

Refer to page 31 for important plan provisions.



# Traditional – HMO plans

Plan name	PA Gold HMO 1000 100%	PA Gold HMO 1000 80%	PA Silver HMO 1500 100%	PA Silver HMO 1500 50%
<b>Member benefits</b>	Network care	Network care	Network care	Network care
<b>Plan year deductible</b>	\$1,000/\$2,000	\$1,000/\$2,000	\$1,500/\$3,000	\$1,500/\$3,000
<b>Plan out-of-pocket limit</b>	\$5,000/\$10,000	\$5,000/\$10,000	\$6,350/\$12,700	\$5,000/\$10,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded	Embedded	Embedded	Embedded
<b>Primary care physician office visit</b>	\$25 copay, deductible waived	\$25 copay, deductible waived	\$35 copay after deductible	50% after deductible
<b>Specialist office visit</b>	\$50 copay, deductible waived	\$50 copay, deductible waived	\$60 copay after deductible	50% after deductible
<b>Walk-in clinics</b>	\$25 copay, deductible waived	\$25 copay, deductible waived	\$35 copay after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	\$10 copay, deductible waived	10% after deductible	\$20 copay after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$50 copay, deductible waived	10% after deductible	\$60 copay after deductible	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$300 copay, deductible waived	20% after deductible	\$350 copay after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	20% after deductible	Covered in full after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	20% after deductible	Covered in full after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$300 copay, deductible waived	\$250 copay, deductible waived	\$350 copay after deductible	50% after deductible
<b>Urgent care</b>	\$75 copay, deductible waived	\$75 copay, deductible waived	\$75 copay after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	\$50 copay, deductible waived	10% after deductible	\$60 copay after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year)	25%, deductible waived	10% after deductible	25% after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay
<b>Preferred brand drugs</b>	\$50 copay	\$50 copay	\$50 copay	\$50 copay
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	\$125 copay	\$125 copay	\$125 copay
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000

## Traditional – HMO plans

Plan name	PA Silver HMO 2000 100%	PA Silver HMO 2000 50%	PA Silver HMO 2250 100% \$500	PA Silver HMO 5000 100%
<b>Member benefits</b>	Network care	Network care	Network care	Network care
<b>Plan year deductible</b>	\$2,000/\$4,000	\$2,000/\$4,000	\$2,250/\$4,500	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$6,350/\$12,700	\$5,000/\$10,000	\$6,350/\$12,700	\$6,600/\$13,200
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded	Embedded	Embedded	Embedded
<b>Primary care physician office visit</b>	\$45 copay, deductible waived	50% after deductible	\$30 copay, deductible waived	\$20 copay, deductible waived
<b>Specialist office visit</b>	\$75 copay, deductible waived	50% after deductible	\$60 copay after deductible	\$40 copay, deductible waived
<b>Walk-in clinics</b>	\$45 copay, deductible waived	50% after deductible	\$30 copay, deductible waived	\$20 copay, deductible waived
<b>Diagnostic testing: Lab</b>	\$25 copay, deductible waived	50% after deductible	20% after deductible	\$20 copay, deductible waived
<b>Diagnostic testing: X-ray</b>	\$75 copay, deductible waived	50% after deductible	20% after deductible	\$40 copay, deductible waived
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$350 copay, deductible waived	50% after deductible	\$300 copay after deductible	\$350 copay, deductible waived
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	\$500 copay per admission after deductible	Covered in full after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	\$300 copay after deductible	Covered in full after deductible
<b>Emergency room<sup>3</sup></b>	\$350 copay, deductible waived	50% after deductible	\$300 copay after deductible	\$350 copay, deductible waived
<b>Urgent care</b>	\$75 copay, deductible waived	50% after deductible	\$75 copay after deductible	\$75 copay, deductible waived
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	\$75 copay, deductible waived	50% after deductible	\$60 copay after deductible	\$40 copay, deductible waived
<b>Chiropractic services</b> (20 visits per plan year)	25%, deductible waived	25% after deductible	25% after deductible	25%, deductible waived
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay/ T1: \$10 copay	T1A: \$3 copay, deductible waived/ T1: \$10 copay, deductible waived	T1A: \$3 copay/ T1: \$10 copay
<b>Preferred brand drugs</b>	\$50 copay	\$50 copay	\$50 copay after deductible	\$50 copay
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	\$125 copay	\$125 copay after deductible	\$125 copay
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000

Refer to page 31 for important plan provisions.

# Consumer-directed – HMO HSA-compatible plans

Plan name	PA Silver HMO 2250 100% HSA	PA Silver HMO 2000 90% HSA	PA Silver HMO 2700 100% HSA
<b>Member benefits</b>	Network care	Network care	Network care
<b>Plan year deductible</b>	\$2,250/\$4,500	\$2,000/\$4,000	\$2,700/\$5,400
<b>Plan out-of-pocket limit</b>	\$6,450/\$12,900	\$6,450/\$12,900	\$6,450/\$12,900
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Non-embedded	Non-embedded	Non-embedded
<b>Primary care physician office visit</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Specialist office visit</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Walk-in clinics</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Diagnostic testing: Lab</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Diagnostic testing: X-ray</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Emergency room<sup>3</sup></b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Urgent care</b>	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Chiropractic services</b> (20 visits per plan year)	Covered in full after deductible	10% after deductible	Covered in full after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)			
<b>Prescription drug deductible</b>	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
<b>Preferred generic drugs</b>	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible
<b>Preferred brand drugs</b>	\$50 copay after deductible	\$50 copay after deductible	\$50 copay after deductible
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	\$125 copay after deductible	\$125 copay after deductible
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible

Refer to page 31 for important plan provisions.

# Consumer-directed – HMO HSA-compatible plans

Plan name	PA Bronze HMO 4500 100% HSA	PA Bronze HMO 3000 HSA	PA Bronze HMO 5700 100% HSA
<b>Member benefits</b>	Network care	Network Care	Network Care
<b>Plan year deductible</b>	\$4,500/\$9,000	\$3,000/\$6,000	\$5,700/\$11,400
<b>Plan out-of-pocket limit</b>	\$6,450/\$12,900	\$6,450/\$12,900	\$5,700/\$11,400
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Non-embedded	Non-embedded	Non-embedded
<b>Primary care physician office visit</b>	Covered in full after deductible	\$40 copay after deductible	Covered in full after deductible
<b>Specialist office visit</b>	Covered in full after deductible	\$60 copay after deductible	Covered in full after deductible
<b>Walk-in clinics</b>	Covered in full after deductible	\$40 copay after deductible	Covered in full after deductible
<b>Diagnostic testing: Lab</b>	Covered in full after deductible	\$20 copay after deductible	Covered in full after deductible
<b>Diagnostic testing: X-ray</b>	Covered in full after deductible	\$60 copay after deductible	Covered in full after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	Covered in full after deductible	\$300 copay after deductible	Covered in full after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	\$500 copayment per day, 5 day copay max per admission, after deductible	Covered in full after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	\$500 copay after deductible	Covered in full after deductible
<b>Emergency room<sup>3</sup></b>	Covered in full after deductible	\$300 copay after deductible	Covered in full after deductible
<b>Urgent care</b>	Covered in full after deductible	\$75 copay after deductible	Covered in full after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	Covered in full after deductible	\$60 copay after deductible	Covered in full after deductible
<b>Chiropractic services</b> (20 visits per plan year)	Covered in full after deductible	25% after deductible	Covered in full after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)			
<b>Prescription drug deductible</b>	Integrated with medical deductible	Integrated with medical deductible	Integrated with medical deductible
<b>Preferred generic drugs</b>	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	T1A and T1: Covered in full after deductible
<b>Preferred brand drugs</b>	\$50 copay after deductible	\$50 copay after deductible	Covered in full after deductible
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	\$125 copay after deductible	Covered in full after deductible
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Preferred and nonpreferred: covered in full after deductible

Refer to page 31 for important plan provisions.

# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Platinum QPOS 150D \$20 PA Platinum HNOption 150D \$20 PA Platinum PPO 150D \$20		PA Gold QPOS 500D \$25 PA Gold HNOption 500D \$25 PA Gold PPO 500D \$25	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$0/\$0	\$5,000/\$10,000	\$0/\$0	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	Medical: \$2,000/\$4,000 Rx: \$4,600/\$9,200	Medical: \$10,000/\$20,000 QPOS/HNOption Rx: not covered PPO Rx: Unlimited/unlimited	\$5,000/\$10,000	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>		Embedded		Embedded
<b>Primary care physician office visit</b>	\$20 copay	50% after deductible	\$25 copay	50% after deductible
<b>Specialist office visit</b>	\$40 copay	50% after deductible	\$50 copay	50% after deductible
<b>Walk-in clinics</b>	\$20 copay	50% after deductible	\$25 copay	50% after deductible
<b>Diagnostic testing: Lab</b>	Covered in full	50% after deductible	\$15 copay	50% after deductible
<b>Diagnostic testing: X-ray</b>	Covered in full	50% after deductible	\$50 copay	50% after deductible
<b>Imaging (MRA/MRS, MRI, PET and CAT scans)</b>	\$150 copay	50% after deductible	\$250 copay	50% after deductible
<b>Inpatient hospital</b>	\$150 copayment per day, 5 day copay max per admission	50% after deductible	\$500 copayment per day, 5 day copay max per admission	50% after deductible
<b>Outpatient surgery</b>	\$125 copay	50% after deductible	\$500 copay	50% after deductible
<b>Emergency room<sup>3</sup></b>		\$125 copay		\$250 copay
<b>Urgent care</b>	\$75 copay	50% after deductible	\$75 copay	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$40 copay	50% after deductible	\$50 copay	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25%	25% after deductible	25%	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$40 copay	QPOS/HNOption: not covered PPO: 50%	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$70 copay	QPOS/HNOption: not covered PPO: 50%	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Gold QPOS 600D \$35 PA Gold HNOption 600D \$35 PA Gold PPO 600D \$35		PA Gold QPOS 750D \$45 PA Gold HNOption 750D \$45 PA Gold PPO 750D \$45	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$0/\$0	\$5,000/\$10,000	\$0/\$0	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$5,000/\$10,000	\$10,000/\$20,000	\$6,000/\$12,000	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>		Embedded		Embedded
<b>Primary care physician office visit</b>	\$35 copay	50% after deductible	\$45 copay	50% after deductible
<b>Specialist office visit</b>	\$60 copay	50% after deductible	\$65 copay	50% after deductible
<b>Walk-in clinics</b>	\$35 copay	50% after deductible	\$45 copay	50% after deductible
<b>Diagnostic testing: Lab</b>	\$15 copay	50% after deductible	\$10 copay	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$60 copay	50% after deductible	\$65 copay	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$300 copay	50% after deductible	\$300 copay	50% after deductible
<b>Inpatient hospital</b>	\$600 copayment per day, 5 day copay max per admission	50% after deductible	\$750 copayment per day, 5 day copay max per admission	50% after deductible
<b>Outpatient surgery</b>	\$600 copay	50% after deductible	\$750 copay	50% after deductible
<b>Emergency room<sup>3</sup></b>		\$300 copay		\$300 copay
<b>Urgent care</b>	\$75 copay	50% after deductible	\$75 copay	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$60 copay	50% after deductible	\$65 copay	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25%	25% after deductible	25%	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$50 copay	QPOS/HNOption: not covered PPO: 50%	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	QPOS/HNOption: not covered PPO: 50%	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

Refer to page 31 for important plan provisions.

# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Gold QPOS 1000 100/50 PA Gold HNOption 1000 100/50 PA Gold PPO 1000 100/50		PA Gold QPOS 1000 80/50 PA Gold HNOption 1000 80/50 PA Gold PPO 1000 80/50	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$1,000/\$2,000	\$5,000/\$10,000	\$1,000/\$2,000	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$5,000/\$10,000	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded		Embedded	
<b>Primary care physician office visit</b>	\$25 copay, deductible waived	50% after deductible	\$25 copay, deductible waived	50% after deductible
<b>Specialist office visit</b>	\$50 copay, deductible waived	50% after deductible	\$50 copay, deductible waived	50% after deductible
<b>Walk-in clinics</b>	\$25 copay, deductible waived	50% after deductible	\$25 copay, deductible waived	50% after deductible
<b>Diagnostic testing: Lab</b>	\$10 copay, deductible waived	50% after deductible	10% after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$50 copay, deductible waived	50% after deductible	10% after deductible	50% after deductible
<b>Imaging (MRA/MRS, MRI, PET and CAT scans)</b>	\$300 copay, deductible waived	50% after deductible	20% after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	20% after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$300 copay, deductible waived		\$250 copay, deductible waived	
<b>Urgent care</b>	\$75 copay, deductible waived	50% after deductible	\$75 copay, deductible waived	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$50 copay, deductible waived	50% after deductible	10% after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25%, deductible waived	25% after deductible	10% after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$50 copay	QPOS/HNOption: not covered PPO: 50%	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	QPOS/HNOption: not covered PPO: 50%	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Silver QPOS 1500 100/50 PA Silver HNOption 1500 100/50 PA Silver PPO 1500 100/50		PA Silver QPOS 1500 50/50 PA Silver HNOption 1500 50/50 PA Silver PPO 1500 50/50	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$1,500/\$3,000	\$5,000/\$10,000	\$1,500/\$3,000	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$6,350/\$12,700	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded		Embedded	
<b>Primary care physician office visit</b>	\$35 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Specialist office visit</b>	\$60 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Walk-in clinics</b>	\$35 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	\$20 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$60 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$350 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$350 copay after deductible		50% after deductible	
<b>Urgent care</b>	\$75 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$60 copay after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25% after deductible	25% after deductible	25% after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$50 copay	QPOS/HNOption: not covered PPO: 50%	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	QPOS/HNOption: not covered PPO: 50%	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

Refer to page 31 for important plan provisions.



# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Silver QPOS 2000 100/50 PA Silver HNOption 2000 100/50 PA Silver PPO 2000 100/50		PA Silver QPOS 2000 50/50 PA Silver HNOption 2000 50/50 PA Silver PPO 2000 50/50	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$2,000/\$4,000	\$5,000/\$10,000	\$2,000/\$4,000	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$6,350/\$12,700	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded		Embedded	
<b>Primary care physician office visit</b>	\$45 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Specialist office visit</b>	\$75 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Walk-in clinics</b>	\$45 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	\$25 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$75 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Imaging (MRA/MRS, MRI, PET and CAT scans)</b>	\$350 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$350 copay, deductible waived		50% after deductible	
<b>Urgent care</b>	\$75 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$75 copay, deductible waived	50% after deductible	50% after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25%, deductible waived	25% after deductible	25% after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	N/A	N/A	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$50 copay	QPOS/HNOption: not covered PPO: 50%	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$125 copay	QPOS/HNOption: not covered PPO: 50%	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

# Traditional – QPOS, HNOption and PPO plans

Plan name	PA Silver QPOS 2250 100/50 \$500 PA Silver HNOption 2250 100/50 \$500 PA Silver PPO 2250 100/50 \$500		PA Silver QPOS 5000 100/50 PA Silver HNOption 5000 100/50 PA Silver PPO 5000 100/50	
	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$2,250/\$4,500	\$5,000/\$10,000	\$5,000/\$10,000	\$10,000/\$20,000
<b>Plan out-of-pocket limit</b>	\$6,350/\$12,700	\$10,000/\$20,000	\$6,600/\$13,200	\$20,000/\$40,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded		Embedded	
<b>Primary care physician office visit</b>	\$30 copay, deductible waived	50% after deductible	\$20 copay, deductible waived	50% after deductible
<b>Specialist office visit</b>	\$60 copay after deductible	50% after deductible	\$40 copay, deductible waived	50% after deductible
<b>Walk-in clinics</b>	\$30 copay, deductible waived	50% after deductible	\$20 copay, deductible waived	50% after deductible
<b>Diagnostic testing: Lab</b>	20% after deductible	50% after deductible	\$20 copay, deductible waived	50% after deductible
<b>Diagnostic testing: X-ray</b>	20% after deductible	50% after deductible	\$40 copay, deductible waived	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	\$300 copay after deductible	50% after deductible	\$350 copay; deductible waived	50% after deductible
<b>Inpatient hospital</b>	\$500 copay per admission after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Outpatient surgery</b>	\$300 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$300 copay after deductible		\$350 copay, deductible waived	
<b>Urgent care</b>	\$75 copay after deductible	50% after deductible	\$75 copay, deductible waived	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$60 copay after deductible	50% after deductible	\$40 copay, deductible waived	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25% after deductible	25% after deductible	25%, deductible waived	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	Integrated with medical deductible	QPOS/HNOption: N/A PPO: integrated with medical deductible	N/A	N/A
<b>Preferred generic drugs</b>	T1A: \$3 copay, deductible waived/ T1: \$10 copay, deductible waived	QPOS/HNOption: not covered PPO: 50%, deductible waived	T1A: \$3 copay/ T1: \$10 copay	QPOS/HNOption: not covered PPO: 50%
<b>Preferred brand drugs</b>	\$50 copay after deductible	QPOS/HNOption: not covered PPO: 50% after deductible	\$50 copay	QPOS/HNOption: not covered PPO: 50%
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	QPOS/HNOption: not covered PPO: 50% after deductible	\$125 copay	QPOS/HNOption: not covered PPO: 50%
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered	Preferred: 50% up to \$500; nonpreferred: 50% up to \$1,000	Not covered

Refer to page 31 for important plan provisions.

# Consumer-directed – HNOption/PPO HSA – compatible plans

Plan name	PA Silver HNOption 2250 100/50 HSA PA Silver PPO 2250 100/50 HSA		PA Silver HNOption 2000 90/50 HSA PA Silver PPO 2000 90/50 HSA	
<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$2,250/\$4,500	\$5,000/\$10,000	\$2,000/\$4,000	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$6,450/\$12,900	\$10,000/\$20,000	\$6,450/\$12,900	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>		Non-embedded		Non-embedded
<b>Primary care physician office visit</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Specialist office visit</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Walk-in clinics</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>		Covered in full after deductible		10% after deductible
<b>Urgent care</b>	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	Covered in full after deductible	50% after deductible	10% after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	Covered in full after deductible	25% after deductible	10% after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible
<b>Preferred generic drugs</b>	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	HNOption: not covered PPO: 50% after deductible	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Preferred brand drugs</b>	\$50 copay after deductible	HNOption: not covered PPO: 50% after deductible	\$50 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	HNOption: not covered PPO: 50% after deductible	\$125 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered

# Consumer-directed – HNOption/PPO HSA – compatible plans

Plan name	PA Silver HNOption 2700 100/50 HSA PA Silver PPO 2700 100/50 HSA		PA Bronze HNOption 4500 100/50 HSA PA Bronze PPO 4500 100/50 HSA	
	<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care
<b>Plan year deductible</b>	\$2,700/\$5,400	\$5,000/\$10,000	\$4,500/\$9,000	\$5,000/\$10,000
<b>Plan out-of-pocket limit</b>	\$6,450/\$12,900	\$10,000/\$20,000	\$6,450/\$12,900	\$10,000/\$20,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Non-embedded		Non-embedded	
<b>Primary care physician office visit</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Specialist office visit</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Walk-in clinics</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Inpatient hospital</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Outpatient surgery</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	Covered in full after deductible		Covered in full after deductible	
<b>Urgent care</b>	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	Covered in full after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	Covered in full after deductible	25% after deductible	Covered in full after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible
<b>Preferred generic drugs</b>	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	HNOption: not covered PPO: 50% after deductible	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Preferred brand drugs</b>	\$50 copay after deductible	HNOption: not covered PPO: 50% after deductible	\$50 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	HNOption: not covered PPO: 50% after deductible	\$125 copay after deductible	HNOption: not covered PPO: 50% after deductible
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered

Refer to page 31 for important plan provisions.

# Consumer-directed – HNOption/PPO HSA – compatible plans

Plan name	PA Bronze HNOption 3000 HSA PA Bronze PPO 3000 HSA		PA Bronze HNOption 5700 100/50 HSA PA Bronze PPO 5700 100/50 HSA	
	<b>Member benefits</b>	Network care	Out-of-network care <sup>1</sup>	Network care
<b>Plan year deductible</b>	\$3,000/\$6,000	\$5,000/\$10,000	\$5,700/\$11,400	\$10,000/\$20,000
<b>Plan out-of-pocket limit</b>	\$6,450/\$12,900	\$10,000/\$20,000	\$5,700/\$11,400	\$20,000/\$40,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Non-embedded		Non-embedded	
<b>Primary care physician office visit</b>	\$40 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Specialist office visit</b>	\$60 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Walk-in clinics</b>	\$40 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Diagnostic testing: Lab</b>	\$20 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Diagnostic testing: X-ray</b>	\$60 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Imaging (MRA/MRS, MRI, PET and CAT scans)</b>	\$300 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Inpatient hospital</b>	\$500 copayment per day, 5 day copay max per admission after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Outpatient surgery</b>	\$500 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Emergency room<sup>3</sup></b>	\$300 copay after deductible		Covered in full after deductible	
<b>Urgent care</b>	\$75 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST. Network and out-of-network care combined.)	\$60 copay after deductible	50% after deductible	Covered in full after deductible	50% after deductible
<b>Chiropractic services</b> (20 visits per plan year. Network and out-of-network care combined.)	25% after deductible	25% after deductible	Covered in full after deductible	25% after deductible
<b>Prescription drugs<sup>4</sup></b> (up to 30-day supply)				
<b>Prescription drug deductible</b>	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible	Integrated with medical deductible	HNOption: N/A PPO: integrated with medical deductible
<b>Preferred generic drugs</b>	T1A: \$3 copay after deductible/ T1: \$10 copay after deductible	HNOption: Not covered PPO: 50% after deductible	T1A and T1: covered in full after deductible	HNOption: not covered PPO: 50% after deductible
<b>Preferred brand drugs</b>	\$50 copay after deductible	HNOption: not covered PPO: 50% after deductible	Covered in full after deductible	HNOption: not covered PPO: 50% after deductible
<b>Nonpreferred generic and brand drugs</b>	\$125 copay after deductible	HNOption: not covered PPO: 50% after deductible	Covered in full after deductible	HNOption: not covered PPO: 50% after deductible
<b>Specialty drugs</b> (self-injectable, infused and oral specialty drugs, excludes insulin)	Preferred: 50% up to \$500 after deductible; nonpreferred: 50% up to \$1,000 after deductible	Not covered	Preferred and nonpreferred: covered in full after deductible	Not covered

## Traditional – Indemnity plan

<b>Plan name</b>	<b>PA Silver Indemnity 2000 80%</b>
<b>Member benefits</b>	Out-of-network care <sup>1</sup>
<b>Plan year deductible</b>	\$2,000/\$4,000
<b>Plan out-of-pocket limit</b>	\$6,000/\$12,000
<b>Deductible &amp; out-of-pocket limit accumulation<sup>2</sup></b>	Embedded
<b>Primary care physician office visit</b>	20% after deductible
<b>Specialist office visit</b>	20% after deductible
<b>Walk-in clinics</b>	20% after deductible
<b>Diagnostic testing: Lab</b>	20% after deductible
<b>Diagnostic testing: X-ray</b>	20% after deductible
<b>Imaging</b> (MRA/MRS, MRI, PET and CAT scans)	20% after deductible
<b>Inpatient hospital</b>	20% after deductible
<b>Outpatient surgery</b>	20% after deductible
<b>Emergency room<sup>3</sup></b>	20% after deductible
<b>Urgent care</b>	20% after deductible
<b>Rehabilitation services (PT/OT/ST)</b> (30 visits per plan year, PT/OT combined, and 30 visits per plan year, ST)	20% after deductible
<b>Chiropractic services</b> (20 visits per plan year)	20% after deductible
<b>Prescription drugs</b>	
<b>Prescription drug deductible</b>	Integrated with medical deductible
<b>Prescription drugs</b>	20% after deductible
<b>Specialty drugs</b>	20% after deductible

Refer to page 31 for important plan provisions.

# Important plan provisions

## <sup>1</sup>**QPOS, HNOption and PPO Plans—How we pay for out-of-network care:**

We cover the cost of services based on whether doctors are “in network” or “out of network.”

Members may choose a provider (doctor or hospital) in our network. They may choose to visit an out-of-network provider. When members choose a doctor who is out of network, the Aetna health plan may pay some of that doctor’s bill. Most of the time, members will pay a lot more money out of pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, the plan limits the amount it will pay. This limit is called the “recognized” or “allowed” amount. Those amounts are:

Professional Services: 90% of Medicare

Facility Services: 90% of Medicare

Out-of-network doctors set their own rates. It may be higher — sometimes much higher — than what the Aetna plan “recognizes.” Out-of-network doctors may bill for the dollar amount that the plan doesn’t “recognize.”

Members must also pay any copayments, coinsurance and deductibles under the plan. No dollar amount above the “recognized charge” counts toward the deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit [www.aetna.com](http://www.aetna.com). Type “how Aetna pays” in the search box.

Members can avoid these extra costs by getting care from our broad network of health care providers. Go to [www.aetna.com](http://www.aetna.com) and click on “Find a Doctor” on the left side of the page. Existing members may sign on to their Aetna Navigator member site.

This applies when members choose to get care out of network. When they have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if they received care in network. Members pay cost sharing and deductibles for the in-network level of benefits. Contact us if a provider asks for more. Members are not responsible for any bill above the “recognized” amount for emergency services beyond the plan’s cost sharing and deductibles.

## <sup>1</sup>**Indemnity plan:**

Payment for care is determined based on the lowest of: the provider’s usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as “reasonable” or “recognized” charges.

Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify or obtain prior approval for certain services.

For a summary list of limitations and exclusions, refer to page 61. Please refer to [www.aetna.com](http://www.aetna.com) for specific Summary of Benefits and Coverage documents. Or for more information, please contact your licensed agent or Aetna sales representative.

<sup>2</sup>**Embedded** – No one family member may contribute more than the individual deductible/out-of-pocket limit amount to the family deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the plan year.

**Non-embedded** – The individual deductible/out-of-pocket limit can only be met when a member is enrolled for self-only coverage with no dependent coverage. The family deductible/out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the family deductible/out-of-pocket limit is met, all family members will be considered as having met their deductible/out-of-pocket limit for the remainder of the plan year.

Deductible credit and deductible carryover do not apply.

<sup>3</sup>**Emergency room:** Copay is waived if admitted. Coinsurance is not waived if admitted.

## <sup>4</sup>**Rx plan provisions:**

- T1A = Value drugs. T1 = Preferred generic drugs.
- Contraceptives and diabetic supplies included.
- If the physician prescribes or the member requests a covered brand-name prescription drug when a generic prescription drug equivalent is available, the member will pay the difference in cost between the brand-name prescription drug and the generic prescription drug equivalent plus the applicable cost sharing. The cost difference between the generic and brand does not count toward the out-of-pocket limit.
- Precertification and step therapy apply.
- Not all drugs are covered. It is important to look at the Preferred Drug List (Aetna Value Plus Formulary) to understand which drugs are covered.

# **Aetna dental plans**

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



# Dental overview

## The Mouth Matters<sup>SM</sup>

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

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

## The Dental Maintenance Organization (DMO)<sup>®</sup>

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 on Aetna Navigator or with a call to Member Services. If specialty care is needed, the primary care dentist can refer the member to a participating specialist. However, members may visit orthodontists without a referral. There are virtually no claim forms to file, and benefits are not subject to deductibles or annual maximums.

## Preferred Provider Organization (PPO) plan

Members can choose a dentist who participates in the network or choose a licensed dentist who does not. Participating dentists have agreed to offer our members covered services at a negotiated rate and will not bill members for amounts over the plan's "recognized" charge.

## PPO Max plan

While the PPO Max dental insurance plan uses the PPO network, when members use out-of-network dentists the service will be covered based on the PPO fee schedule, rather than the usual and prevailing charge. The member will share in more of the costs and out-of-network doctors may bill for amounts over the plan's "recognized" charge. This plan offers members a quality dental insurance plan with a significantly lower premium that encourages in-network usage.

## Freedom-of-Choice plan design option

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

## Dual option\*\* plan

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

## Voluntary dental option

The voluntary dental option provides a solution to meet the individual needs of members in the face of rising health care costs. Administration is easy, and members benefit from low group rates and the convenience of payroll deductions.

## Aetna Dental Preventive Care<sup>SM</sup> plan

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

<sup>1</sup>MayoClinic.com. "Oral health: A window to your overall health." [www.mayoclinic.com/health/dental/DE00001](http://www.mayoclinic.com/health/dental/DE00001). February 5, 2011. Accessed July 2014.

\*DMI may not be available in all states.

\*\*Dual option does not apply to preventive plans or voluntary dental 3–9 size plans.

# Aetna 2 – 9 small group dental plans

	<b>Option 1 Aetna Dental Preventive Care</b>	<b>Option 2</b>	<b>Option 3 Freedom-of-Choice</b> — Monthly selection between the DMO and PPO Max	
	PPO Max plan – Aetna Dental Preventive Care	DMO plan 100/80/50	DMO plan 100/90/60	PPO Max plan 100/70/40
<b>Office visit copay</b>	N/A	\$5	\$5	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	None	None	\$50; 3X family maximum
<b>Annual maximum benefit</b>	None	None	None	\$1,000
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
<b>X-rays</b>				
Bitewing – single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
<b>Preventive services</b>				
Adult cleaning	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%
Sealants – per tooth	100%	100%	100%	100%
Fluoride application	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
<b>Basic services</b>				
Amalgam filling – 2 surfaces	Not covered	80%	90%	70%
Resin filling – 2 surfaces, anterior	Not covered	80%	90%	70%
<b>Oral surgery</b>				
Extraction – exposed root or erupted tooth	Not covered	80%	90%	70%
Extraction of impacted tooth – soft tissue	Not covered	80%	90%	70%
<b>Major services*</b>				
Complete upper denture	Not covered	50%	60%	40%
Partial upper denture (resin base)	Not covered	50%	60%	40%
Crown – porcelain with noble metal**	Not covered	50%	60%	40%
Pontic – porcelain with noble metal**	Not covered	50%	60%	40%
Inlay – metallic (3 or more surfaces)	Not covered	50%	60%	40%
<b>Oral surgery</b>				
Removal of impacted tooth – partially bony	Not covered	50%	60%	40%
<b>Endodontic services</b>				
Bicuspid root canal therapy	Not covered	80%	90%	40%
Molar root canal therapy	Not covered	50%	60%	40%
<b>Periodontic services</b>				
Scaling & root planing – per quadrant	Not covered	80%	90%	40%
Osseous surgery – per quadrant	Not covered	50%	60%	40%
<b>Orthodontic services</b>				
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna 2–9 small group dental plans

	Option 4	Option 5 Active PPO High-Option Plan		Option 6
	PPO Max plan 100/80/50	Preferred plan 100/80/50	Nonpreferred plan 80/60/40	PPO 1500 plan 100/80/50
<b>Office visit copay</b>	N/A	N/A	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	\$1,500	\$1,500	\$1,000	\$1,500
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	100%	100%	80%	100%
Comprehensive oral exam	100%	100%	80%	100%
Problem-focused oral exam	100%	100%	80%	100%
<b>X-rays</b>				
Bitewing—single film	100%	100%	80%	100%
Complete series	100%	100%	80%	100%
<b>Preventive services</b>				
Adult cleaning	100%	100%	80%	100%
Child cleaning	100%	100%	80%	100%
Sealants—per tooth	100%	100%	80%	100%
Fluoride application	100%	100%	80%	100%
Space maintainers	100%	100%	80%	100%
<b>Basic services</b>				
Amalgam filling—2 surfaces	80%	80%	60%	80%
Resin filling—2 surfaces, anterior	80%	80%	60%	80%
<b>Oral surgery</b>				
Extraction—exposed root or erupted tooth	80%	80%	60%	80%
Extraction of impacted tooth—soft tissue	80%	80%	60%	80%
<b>Major services*</b>				
Complete upper denture	50%	50%	40%	50%
Partial upper denture (resin base)	50%	50%	40%	50%
Crown—porcelain with noble metal**	50%	50%	40%	50%
Pontic—porcelain with noble metal**	50%	50%	40%	50%
Inlay—metallic (3 or more surfaces)	50%	50%	40%	50%
<b>Oral surgery</b>				
Removal of impacted tooth—partially bony	50%	50%	40%	50%
<b>Endodontic services</b>				
Bicuspid root canal therapy	50%	80%	60%	50%
Molar root canal therapy	50%	50%	40%	50%
<b>Periodontic services</b>				
Scaling & root planing—per quadrant	50%	80%	60%	50%
Osseous surgery—per quadrant	50%	50%	40%	50%
<b>Orthodontic services</b>				
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

# Aetna 2 – 9 small group dental plans

	<b>Option 7 Freedom-of-Choice</b> — Monthly selection between the DMO and PPO Max		<b>Option 8 Active PPO Max</b>	
	DMO plan 100/90/60	PPO Max plan 100/80/0	Preferred plan 100/80/50	Nonpreferred plan 80/60/50
<b>Office visit copay</b>	\$0	N/A	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	None	\$1,000	\$1,500	\$1,000
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	100%	100%	100%	80%
Comprehensive oral exam	100%	100%	100%	80%
Problem-focused oral exam	100%	100%	100%	80%
<b>X-rays</b>				
Bitewing—single film	100%	100%	100%	80%
Complete series	100%	100%	100%	80%
<b>Preventive services</b>				
Adult cleaning	100%	100%	100%	80%
Child cleaning	100%	100%	100%	80%
Sealants—per tooth	100%	100%	100%	80%
Fluoride application	100%	100%	100%	80%
Space maintainers	100%	100%	100%	80%
<b>Basic services</b>				
Amalgam filling—2 surfaces	90%	80%	80%	60%
Resin filling—2 surfaces, anterior	90%	80%	80%	60%
<b>Oral surgery</b>				
Extraction—exposed root or erupted tooth	90%	80%	80%	60%
Extraction of impacted tooth—soft tissue	90%	80%	80%	60%
<b>Major services*</b>				
Complete upper denture	60%	Not covered	50%	50%
Partial upper denture (resin base)	60%	Not covered	50%	50%
Crown—porcelain with noble metal**	60%	Not covered	50%	50%
Pontic—porcelain with noble metal**	60%	Not covered	50%	50%
Inlay—metallic (3 or more surfaces)	60%	Not covered	50%	50%
<b>Oral surgery</b>				
Removal of impacted tooth—partially bony	60%	Not covered	50%	50%
<b>Endodontic services</b>				
Bicuspid root canal therapy	90%	Not covered	50%	50%
Molar root canal therapy	60%	Not covered	50%	50%
<b>Periodontic services</b>				
Scaling & root planing—per quadrant	90%	Not covered	50%	50%
Osseous surgery—per quadrant	60%	Not covered	50%	50%
<b>Orthodontic services</b>				
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna 2–9 small group dental plans

	<b>Option 9 PPO Max 100/80</b>	<b>Option 10 PPO 1000</b>
	PPO Max plan 100/80/0	PPO plan 100/80/50
<b>Office visit copay</b>	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	\$1,000	\$1,000
<b>Diagnostic services</b>		
<b>Oral exams</b>		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
<b>X-rays</b>		
Bitewing—single film	100%	100%
Complete series	100%	100%
<b>Preventive services</b>		
Adult cleaning	100%	100%
Child cleaning	100%	100%
Sealants—per tooth	100%	100%
Fluoride application	100%	100%
Space maintainers	100%	100%
<b>Basic services</b>		
Amalgam filling—2 surfaces	80%	80%
Resin filling—2 surfaces, anterior	80%	80%
<b>Oral surgery</b>		
Extraction—exposed root or erupted tooth	80%	80%
Extraction of impacted tooth—soft tissue	80%	80%
<b>Major services*</b>		
Complete upper denture	Not covered	50%
Partial upper denture (resin base)	Not covered	50%
Crown—porcelain with noble metal**	Not covered	50%
Pontic—porcelain with noble metal**	Not covered	50%
Inlay—metallic (3 or more surfaces)	Not covered	50%
<b>Oral surgery</b>		
Removal of impacted tooth—partially bony	Not covered	50%
<b>Endodontic services</b>		
Bicuspid root canal therapy	Not covered	50%
Molar root canal therapy	Not covered	50%
<b>Periodontic services</b>		
Scaling & root planing—per quadrant	Not covered	50%
Osseous surgery—per quadrant	Not covered	50%
<b>Orthodontic services</b>		
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna small group voluntary dental plans 3–9

	<b>Voluntary Option 1 Aetna Dental Preventive Care</b>	<b>Voluntary Option 2</b>	<b>Voluntary Option 3 Freedom-of-Choice — Monthly selection between the DMO and PPO Max</b>	
	PPO Max plan – Aetna Dental Preventive Care	DMO plan 100/80/50	DMO plan 100/90/60	PPO Max plan 100/70/40
<b>Office visit copay</b>	N/A	\$10	\$10	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	None	None	\$75; 3X family maximum
<b>Annual maximum benefit</b>	None	None	None	\$1,000
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
<b>X-rays</b>				
Bitewing—single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
<b>Preventive services</b>				
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%
<b>Basic services</b>				
Amalgam fillings	Not covered	80%	90%	70%
Resin fillings, anterior	Not covered	80%	90%	70%
<b>Oral surgery</b>				
Extraction—exposed root or erupted tooth	Not covered	80%	90%	70%
Extraction of impacted tooth—soft tissue	Not covered	80%	90%	70%
<b>Major services*</b>				
Complete upper denture	Not covered	50%	60%	40%
Partial upper denture (resin base)	Not covered	50%	60%	40%
Crown—porcelain with noble metal**	Not covered	50%	60%	40%
Pontic—porcelain with noble metal**	Not covered	50%	60%	40%
Inlay—metallic (3 or more surfaces)	Not covered	50%	60%	40%
<b>Oral surgery</b>				
Removal of impacted tooth—partially bony	Not covered	50%	60%	40%
<b>Endodontic services</b>				
Bicuspid root canal therapy	Not covered	80%	90%	40%
Molar root canal therapy	Not covered	50%	60%	40%
<b>Periodontic services</b>				
Scaling & root planing—per quadrant	Not covered	80%	90%	40%
Osseous surgery—per quadrant	Not covered	50%	60%	40%
<b>Orthodontic services</b>				
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna small group voluntary dental plans 3–9

	<b>Voluntary Option 4</b>	<b>Voluntary Option 5 Freedom-of-Choice — Monthly selection between the DMO and PPO Max</b>		<b>Voluntary Option 6 Active PPO Max</b>	
	PPO Max plan 100/80/50	DMO plan 100/90/60	PPO Max plan 100/80/0	Preferred plan 100/80/50	Nonpreferred plan 80/60/50
<b>Office visit copay</b>	N/A	\$0	N/A	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$75; 3X family maximum	None	\$50; 3X family maximum	\$75; 3X family maximum	\$75; 3X family maximum
<b>Annual maximum benefit</b>	\$1,500	None	\$1,000	\$1,500	\$1,000
<b>Diagnostic services</b>					
<b>Oral exams</b>					
Periodic oral exam	100%	100%	100%	100%	80%
Comprehensive oral exam	100%	100%	100%	100%	80%
Problem-focused oral exam	100%	100%	100%	100%	80%
<b>X-rays</b>					
Bitewing—single film	100%	100%	100%	100%	80%
Complete series	100%	100%	100%	100%	80%
<b>Preventive services</b>					
Adult cleaning	100%	100%	100%	100%	80%
Child cleaning	100%	100%	100%	100%	80%
Sealants—per tooth	100%	100%	100%	100%	80%
Fluoride application—with cleaning	100%	100%	100%	100%	80%
Space maintainers	100%	100%	100%	100%	80%
<b>Basic services</b>					
Amalgam fillings	80%	90%	80%	80%	60%
Resin fillings, anterior	80%	90%	80%	80%	60%
<b>Oral surgery</b>					
Extraction—exposed root or erupted tooth	80%	90%	80%	80%	60%
Extraction of impacted tooth—soft tissue	80%	90%	80%	80%	60%
<b>Major services*</b>					
Complete upper denture	50%	60%	Not covered	50%	50%
Partial upper denture (resin base)	50%	60%	Not covered	50%	50%
Crown—porcelain with noble metal**	50%	60%	Not covered	50%	50%
Pontic—porcelain with noble metal**	50%	60%	Not covered	50%	50%
Inlay—metallic (3 or more surfaces)	50%	60%	Not covered	50%	50%
<b>Oral surgery</b>					
Removal of impacted tooth—partially bony	50%	60%	Not covered	50%	50%
<b>Endodontic services</b>					
Bicuspid root canal therapy	50%	90%	Not covered	50%	50%
Molar root canal therapy	50%	60%	Not covered	50%	50%
<b>Periodontic services</b>					
Scaling & root planing—per quadrant	50%	90%	Not covered	50%	50%
Osseous surgery—per quadrant	50%	60%	Not covered	50%	50%
<b>Orthodontic services</b>					
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna small group voluntary dental plans 3 – 9

	<b>Vol Option 7 PPO Max 100/80</b>	<b>Vol Option 8 PPO 1000</b>
	PPO Max plan 100/80/0	PPO 1000 plan 100/80/50
<b>Office visit copay</b>	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	\$1,000	\$1,000
<b>Diagnostic services</b>		
<b>Oral exams</b>		
Periodic oral exam	100%	100%
Comprehensive oral exam	100%	100%
Problem-focused oral exam	100%	100%
<b>X-rays</b>		
Bitewing—single film	100%	100%
Complete series	100%	100%
<b>Preventive services</b>		
Adult cleaning	100%	100%
Child cleaning	100%	100%
Sealants—per tooth	100%	100%
Fluoride application—with cleaning	100%	100%
Space maintainers	100%	100%
<b>Basic services</b>		
Amalgam fillings	80%	80%
Resin fillings, anterior	80%	80%
<b>Oral surgery</b>		
Extraction—exposed root or erupted tooth	80%	80%
Extraction of impacted tooth—soft tissue	80%	80%
<b>Major services*</b>		
Complete upper denture	Not covered	50%
Partial upper denture (resin base)	Not covered	50%
Crown—porcelain with noble metal**	Not covered	50%
Pontic—porcelain with noble metal**	Not covered	50%
Inlay—metallic (3 or more surfaces)	Not covered	50%
<b>Oral surgery</b>		
Removal of impacted tooth—partially bony	Not covered	50%
<b>Endodontic services</b>		
Bicuspid root canal therapy	Not covered	50%
Molar root canal therapy	Not covered	50%
<b>Periodontic services</b>		
Scaling & root planing—per quadrant	Not covered	50%
Osseous surgery—per quadrant	Not covered	50%
<b>Orthodontic services</b>		
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply

Refer to page 47 for footnotes.



# Aetna standard and voluntary dental plan selections 10–50

	<b>Option 1A DMO Fixed Copay 42</b>	<b>Option 2A DMO 100/80/50</b>	<b>Option 3A DMO 100/100/60</b>	<b>Option 4A DMO Fixed Copay 56</b>
	Plan code 42	DMO plan 100/80/50	DMO plan 100/100/60	Plan code 56
<b>Office visit copay</b>	\$5	\$5	\$5	\$5
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	None	None	None
<b>Annual maximum benefit</b>	None	None	None	None
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	No charge	100%	100%	No charge
Comprehensive oral exam	No charge	100%	100%	No charge
Problem-focused oral exam	No charge	100%	100%	No charge
<b>X-rays</b>				
Bitewing—single film	No charge	100%	100%	No charge
Complete series	No charge	100%	100%	No charge
<b>Preventive services</b>				
Adult cleaning	No charge	100%	100%	No charge
Child cleaning	No charge	100%	100%	No charge
Sealants—per tooth	\$10	100%	100%	No charge
Fluoride application—with cleaning	No charge	100%	100%	No charge
Space maintainers	\$100	100%	100%	No charge
<b>Basic services</b>				
Amalgam filling—2 surfaces	\$32	80%	100%	No charge
Resin filling—2 surfaces, anterior	\$55	80%	100%	No charge
<b>Endodontic services</b>				
Bicuspid root canal therapy	\$195	80%	100%	No charge
<b>Periodontic services</b>				
Scaling & root planing—per quadrant	\$65	80%	100%	\$25
<b>Oral surgery</b>				
Extraction—exposed root or erupted tooth	\$30	80%	100%	No charge
Extraction of impacted tooth—soft tissue	\$80	80%	100%	No charge
<b>Major services*</b>				
Complete upper denture	\$500	50%	60%	\$185
Partial upper denture (resin base)	\$513	50%	60%	\$185
Crown—porcelain with noble metal <sup>1</sup>	\$488	50%	60%	\$150
Pontic—porcelain with noble metal <sup>1</sup>	\$488	50%	60%	\$150
Inlay—metallic (3 or more surfaces)	\$463	50%	60%	\$150
<b>Oral surgery</b>				
Removal of impacted tooth—partially bony	175**	50%	60%	\$45
<b>Endodontic services</b>				
Molar root canal therapy	435**	50%	60%	\$125
<b>Periodontic services</b>				
Osseous surgery—per quadrant	\$445**	50%	60%	\$140
<b>Orthodontic services*</b>	\$2,300 copay	\$2,300 copay	\$2,300 copay	\$2,300 copay
<b>Orthodontic lifetime maximum</b>	Does not apply	Does not apply	Does not apply	Does not apply

Refer to page 47 for footnotes.

# Aetna standard and voluntary dental plan selections 10–50

	<b>Option 5A Freedom-of-Choice–PPO Max —</b> Monthly selection between the DMO and PPO Max		<b>Option 6A Freedom-of-Choice–PPO Max High —</b> Monthly selection between the DMO and PPO Max	
	DMO plan 100/90/60	PPO Max plan 100/70/40	DMO plan 100/100/60	PPO Max plan 100/80/50
<b>Office visit copay</b>	\$5	None	\$5	None
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	None	\$50; 3X family maximum
<b>Annual maximum benefit</b>	None	\$1,000	None	\$1,000
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
<b>X-rays</b>				
Bitewing—single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
<b>Preventive services</b>				
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%
<b>Basic services</b>				
Amalgam filling—2 surfaces	90%	70%	100%	80%
Resin filling—2 surfaces, anterior	90%	70%	100%	80%
<b>Endodontic services</b>				
Bicuspid root canal therapy	90%	70%	100%	80%
<b>Periodontic services</b>				
Scaling & root planing—per quadrant	90%	70%	100%	80%
<b>Oral surgery</b>				
Extraction—exposed root or erupted tooth	90%	70%	100%	80%
Extraction of impacted tooth—soft tissue	90%	70%	100%	80%
<b>Major services*</b>				
Complete upper denture	60%	40%	60%	50%
Partial upper denture (resin base)	60%	40%	60%	50%
Crown—porcelain with noble metal <sup>1</sup>	60%	40%	60%	50%
Pontic—porcelain with noble metal <sup>1</sup>	60%	40%	60%	50%
Inlay—metallic (3 or more surfaces)	60%	40%	60%	
<b>Oral surgery</b>				
Removal of impacted tooth—partially bony	60%	40%	60%	50%
<b>Endodontic services</b>				
Molar root canal therapy	60%	40%	60%	50%
<b>Periodontic services</b>				
Osseous surgery—per quadrant	60%	40%	60%	50%
<b>Orthodontic services*</b>	\$2,300 copay	40%	\$2,300 copay	50%
<b>Orthodontic lifetime maximum</b>	Does not apply	\$1,000	Does not apply	\$1,000

Refer to page 47 for footnotes.

# Aetna standard and voluntary dental plan selections 10–50

	<b>Option 7A Freedom-of-Choice – PPO 1000 80th —</b> Monthly selection between the DMO and PPO		<b>Option 8A Freedom-of-Choice – PPO 1500 90th —</b> Monthly selection between the DMO and PPO	
	Plan code 56	PPO plan 100/80/50	DMO plan 100/100/60	PPO plan 100/80/50
<b>Office visit copay</b>	\$5	None	\$5	None
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	None	\$50; 3X family maximum
<b>Annual maximum benefit</b>	None	\$1,000	None	\$1,500
<b>Diagnostic services</b>				
<b>Oral exams</b>				
Periodic oral exam	No charge	100%	100%	100%
Comprehensive oral exam	No charge	100%	100%	100%
Problem-focused oral exam	No charge	100%	100%	100%
<b>X-rays</b>				
Bitewing – single film	No charge	100%	100%	100%
Complete series	No charge	100%	100%	100%
<b>Preventive services</b>				
Adult cleaning	No charge	100%	100%	100%
Child cleaning	No charge	100%	100%	100%
Sealants – per tooth	No charge	100%	100%	100%
Fluoride application – with cleaning	No charge	100%	100%	100%
Space maintainers	No charge	100%	100%	100%
<b>Basic services</b>				
Amalgam filling – 2 surfaces	No charge	80%	100%	80%
Resin filling – 2 surfaces, anterior	No charge	80%	100%	80%
<b>Endodontic services</b>				
Bicuspid root canal therapy	No charge	80%	100%	80%
<b>Periodontic services</b>				
Scaling & root planing – per quadrant	\$25	80%	100%	80%
<b>Oral surgery</b>				
Extraction – exposed root or erupted tooth	No charge	80%	100%	80%
Extraction of impacted tooth – soft tissue	No charge	80%	100%	80%
<b>Major services*</b>				
Complete upper denture	\$185	50%	60%	50%
Partial upper denture (resin base)	\$185	50%	60%	50%
Crown – porcelain with noble metal <sup>1</sup>	\$150	50%	60%	50%
Pontic – porcelain with noble metal <sup>1</sup>	\$150	50%	60%	50%
Inlay – metallic (3 or more surfaces)	\$150	50%	60%	50%
<b>Oral surgery</b>				
Removal of impacted tooth – partially bony	\$45	50%	60%	80%
<b>Endodontic services</b>				
Molar root canal therapy	\$125	50%	60%	80%
<b>Periodontic services</b>				
Osseous surgery – per quadrant	\$140	50%	60%	80%
<b>Orthodontic services*</b>				
<b>Orthodontic lifetime maximum</b>	Does not apply	\$1,000	Does not apply	\$1,000

Refer to page 47 for footnotes.

# Aetna standard and voluntary dental plan selections 10–50

	<b>Option 8B Freedom-of-Choice – PPO 1500 80th — Monthly selection between the DMO and PPO</b>		<b>Option 9A Freedom-of-Choice – PPO 2000 80th — Monthly selection between the DMO and PPO</b>		<b>Option 10A PPO Max 1000</b>
	DMO plan 100/100/60	PPO plan 100/80/50	DMO plan 100/100/60	PPO plan 100/80/50	PPO Max plan 100/80/50
<b>Office visit copay</b>	\$5	None	\$5	None	None
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	None	\$50; 3X family maximum	None	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	None	\$1,500	None	\$2,000	\$1,000
<b>Diagnostic services</b>					
<b>Oral exams</b>					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
<b>X-rays</b>					
Bitewing—single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
<b>Preventive services</b>					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants—per tooth	100%	100%	100%	100%	100%
Fluoride application—with cleaning	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
<b>Basic services</b>					
Amalgam filling—2 surfaces	100%	80%	100%	80%	80%
Resin filling—2 surfaces, anterior	100%	80%	100%	80%	80%
<b>Endodontic services</b>					
Bicuspid root canal therapy	100%	80%	100%	80%	80%
<b>Periodontic services</b>					
Scaling & root planing—per quadrant	100%	80%	100%	80%	80%
<b>Oral surgery</b>					
Extraction—exposed root or erupted tooth	100%	80%	100%	80%	80%
Extraction of impacted tooth—soft tissue	100%	80%	100%	80%	80%
<b>Major services*</b>					
Complete upper denture	60%	50%	60%	50%	50%
Partial upper denture (resin base)	60%	50%	60%	50%	50%
Crown—porcelain with noble metal <sup>1</sup>	60%	50%	60%	50%	50%
Pontic—porcelain with noble metal <sup>1</sup>	60%	50%	60%	50%	50%
Inlay—metallic (3 or more surfaces)	60%	50%	60%	50%	50%
<b>Oral surgery</b>					
Removal of impacted tooth—partially bony	60%	80%	60%	80%	80%
<b>Endodontic services</b>					
Molar root canal therapy	60%	80%	60%	80%	80%
<b>Periodontic services</b>					
Osseous surgery—per quadrant	60%	80%	60%	80%	80%
<b>Orthodontic services*</b>					
<b>Orthodontic lifetime maximum</b>	Does not apply	\$1,000	Does not apply	\$1,000	\$1,000

Refer to page 47 for footnotes.

# Aetna standard and voluntary dental plan selections 10–50

	Option 10B PPO Max 1000 Plus	Option 11A PPO Max 1500	Option 12A PPO 1000 90th	Option 12B PPO 1000 90th Plus	Option 13A PPO 2000 80th
	PPO Max plan 100/80/50	PPO Max plan 100/80/50	PPO 1000 plan 100/80/50	PPO 1000 plan 100/80/50	PPO 2000 plan 100/80/50
<b>Office visit copay</b>	None	None	None	None	None
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$50; 3X Family maximum	\$50; 3X Family maximum	\$50; 3X Family maximum	\$50; 3X Family maximum	\$50; 3X Family maximum
<b>Annual maximum benefit</b>	\$1,000	\$1,500	\$1,000	\$1,000	\$2,000
<b>Diagnostic services</b>					
<b>Oral exams</b>					
Periodic oral exam	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%
<b>X-rays</b>					
Bitewing—single film	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%
<b>Preventive services</b>					
Adult cleaning	100%	100%	100%	100%	100%
Child cleaning	100%	100%	100%	100%	100%
Sealants—per tooth	100%	100%	100%	100%	100%
Fluoride application—with cleaning	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%
<b>Basic services</b>					
Amalgam filling—2 surfaces	80%	80%	80%	80%	80%
Resin filling—2 surfaces, anterior	80%	80%	80%	80%	80%
<b>Endodontic services</b>					
Bicuspid root canal therapy	80%	80%	80%	80%	80%
<b>Periodontic services</b>					
Scaling & root planing—per quadrant	80%	80%	80%	80%	80%
<b>Oral surgery</b>					
Extraction—exposed root or erupted tooth	80%	80%	80%	80%	80%
Extraction of impacted tooth—soft tissue	80%	80%	80%	80%	80%
<b>Major services*</b>					
Complete upper denture	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%
Crown—porcelain with noble metal <sup>1</sup>	50%	50%	50%	50%	50%
Pontic—porcelain with noble metal <sup>1</sup>	50%	50%	50%	50%	50%
Inlay—metallic (3 or more surfaces)	50%	50%	50%	50%	50%
<b>Oral surgery</b>					
Removal of impacted tooth—partially bony	80%	80%	80%	80%	80%
<b>Endodontic services</b>					
Molar root canal therapy	80%	80%	80%	80%	80%
<b>Periodontic services</b>					
Osseous surgery—per quadrant	80%	80%	80%	80%	80%
<b>Orthodontic services*</b>					
<b>Orthodontic lifetime maximum</b>	\$1,000	\$1,000	\$1,000	\$1,000	\$1,500

Refer to page 47 for footnotes.

# Aetna standard and voluntary dental plan selections 10–50

	<b>Option 14A PPO 1500 90th</b>	<b>Option 15A Active PPO 80th</b>		<b>Option 16A Active PPO 90th</b>	
	PPO plan 100/80/50	Preferred plan 100/80/50	Nonpreferred plan 80/60/40	Preferred plan 100/90/60	Nonpreferred plan 100/80/50
<b>Office visit copay</b>	None	N/A	N/A	N/A	N/A
<b>Annual deductible per member</b> (does not apply to diagnostic & preventive services)	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum	\$50; 3X family maximum
<b>Annual maximum benefit</b>	\$1,500	\$1,500	\$1,000	\$1,500	\$1,000
<b>Diagnostic services</b>					
<b>Oral exams</b>					
Periodic oral exam	100%	100%	80%	100%	100%
Comprehensive oral exam	100%	100%	80%	100%	100%
Problem-focused oral exam	100%	100%	80%	100%	100%
<b>X-rays</b>					
Bitewing—single film	100%	100%	80%	100%	100%
Complete series	100%	100%	80%	100%	100%
<b>Preventive services</b>					
Adult cleaning	100%	100%	80%	100%	100%
Child cleaning	100%	100%	80%	100%	100%
Sealants—per tooth	100%	100%	80%	100%	100%
Fluoride application—with cleaning	100%	100%	80%	100%	100%
Space maintainers	100%	100%	80%	100%	100%
<b>Basic services</b>					
Amalgam filling—2 surfaces	80%	80%	60%	90%	80%
Resin filling—2 surfaces, anterior	80%	80%	60%	90%	80%
<b>Endodontic services</b>					
Bicuspid root canal therapy	80%	80%	60%	90%	80%
<b>Periodontic services</b>					
Scaling & root planing—per quadrant	80%	80%	60%	90%	80%
<b>Oral surgery</b>					
Extraction—exposed root or erupted tooth	80%	80%	60%	90%	80%
Extraction of impacted tooth—soft tissue	80%	80%	60%	90%	80%
<b>Major services*</b>					
Complete upper denture	50%	50%	40%	60%	50%
Partial upper denture (resin base)	50%	50%	40%	60%	50%
Crown—porcelain with noble metal <sup>1</sup>	50%	50%	40%	60%	50%
Pontic—porcelain with noble metal <sup>1</sup>	50%	50%	40%	60%	50%
Inlay—metallic (3 or more surfaces)	50%	50%	40%	60%	50%
<b>Oral surgery</b>					
Removal of impacted tooth—partially bony	80%	80%	60%	90%	80%
<b>Endodontic services</b>					
Molar root canal therapy	80%	80%	60%	90%	80%
<b>Periodontic services</b>					
Osseous surgery—per quadrant	80%	80%	60%	90%	80%
<b>Orthodontic services*</b>					
<b>Orthodontic lifetime maximum</b>	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000

Refer to page 47 for footnotes.

# Footnotes

## Aetna 2–9 small group dental plans

\*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in plan options 2, 3 & 7 and the PPO in plan options 1 & 9.

The DMO in plan option 2 can be offered with any of the PPO plans in plan options 4–6 & 8–10 in a dual option package. Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 2, 3 & 7 and the PPO in plan option 5.

Plan options 1, 3, 4 & 7–9; PPO Max nonpreferred (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.

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

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 61.

## Aetna small group voluntary dental plans 3–9

\*Coverage waiting period: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service. Does not apply to the DMO in voluntary plan options 2, 3 & 5, and on the PPO in voluntary plan options 1, 5 & 7.

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 1 & 3–7; PPO Max nonpreferred (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.

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.

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

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 61.

## Aetna standard and voluntary dental plan selections 10–50

\*Coverage waiting period applies to voluntary PPO plans in plan options 5A–8A, 8B, 9A–10A, 10B, 11A–12A, 12B and 13A–16A: Must be an enrolled member of the plan for 12 months before becoming eligible for coverage of any major service including orthodontic services. Does not apply to DMO in plan options 1A–8A, 8B and 9A and standard plans.

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

<sup>1</sup>There will be an additional patient charge for the actual cost for gold/high noble metal for these procedures in DMO options 1A, 4A and 7A.

Fixed dollar amounts on the DMO in plan options 1A–8A, 8B and 9A including office visit and ortho copays, are the member's responsibility.

The DMO in plan options 1A–4A can be offered with any of the PPO plans in plan options 10A–B, 11A–12A, 12B and 13A–16A in a dual option package.

Plan options 5A, 6A, 10A–B and 11A: PPO Max nonpreferred (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 the PPO in plan options 7A, 8B, 9A, 13A and 15A to the prevailing fees at the 80<sup>th</sup> percentile and the 90<sup>th</sup> percentile in plan options 8A, 12A–B, 14A and 16A.

Most oral surgery, endodontic and periodontic services are covered as basic services on the DMO in plan options 1A–8A, 8B and 9A and on the PPO in plan options 5A, 6A, and 7A. All oral surgery, endodontic and periodontic services are covered as basic services on the PPO in plan options 8A–B, 9A–10A, 10B, 11A–12A, 12B, 13A–16A. General anesthesia is covered as a basic service on the PPO in plan options 5A–8A, 8B, 9A–10A, 10B, 11A–12A, 12B and 13A–16A.

PPO and PPO Max plans: Resin fillings are allowed on posterior teeth in plan options 5A–16A, 8B, 10B and 12B.

Coverage for implants is included as a major service on the PPO in plan option 8B, 9A and 13A.

Plan options 10B and 12B: The calendar-year maximum does not apply to preventive services

All plan options are available without and with orthodontic coverage for dependent children only.

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

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

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

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

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of limitations and exclusions, refer to page 61.



# Aetna vision plans

Value you can see — our Premier, Plus and Basic Aetna Vision<sup>SM</sup> Preferred plans were designed to provide affordable premiums, network choice and low member out-of-pocket expense.



# Vision overview

## See why Aetna Vision Preferred is the right choice for you and your employees

- Members can go where they want and buy what they want — in- and out-of-network benefits included for most services.
- Offer as a voluntary benefit with affordable premiums and no extra cost to your bottom line.
- Pretax advantages for both you and your employees.
- Four-year rate guarantee included.
- Administrative ease when you have multiple benefits with Aetna — one bill, one renewal, one trusted company to work with.
- Award-winning live customer service and self-service tools available seven days a week.
- Low member out-of-pocket expense.
- Value, choice, and convenience. Members can choose any frame available includes value-priced frames to high-quality designer frames with no confusing frame towers or formularies.
- Discounts on additional eyeglass purchases and non-covered items including LASIK surgery.\*
- Informational welcome packet is sent to each enrolled subscriber and includes member ID card, benefit summary and nearest provider locations to the member's home ZIP code.

## Keep an eye on your employee's health

We are committed to vision wellness, patient education and the associated preventive care.

Encouraging employees to get vision care can help lower unnecessary costs and improve overall health. During a routine eye exam, all aspects of vision are checked, including the eye's structure and how well the eyes work together. Annual eye exams allow eye care providers to monitor the health of the eyes and track changes that can occur from year to year. Besides measuring vision, eye exams help find early signs of certain chronic health conditions including diabetes, high blood pressure, heart disease, high cholesterol and eye disease.<sup>1</sup>

\*Discounts may not be available in all states.

\*\*Results will vary for different plan designs. Example does not include premiums.

<sup>1</sup>[Allaboutvision.com/eye-exam/importance.htm](http://Allaboutvision.com/eye-exam/importance.htm), April 2012. Accessed July 2014.

<sup>2</sup>Jobson Vision Watch, Vision Council Member Benefits Report, June 2011.

<sup>3</sup>Jobson Consumer Perceptions of Managed Vision Care Report 2011.

## Discover the freedom to see any licensed vision office or retailer

Nearly 60 percent of eyewear dollars in the United States are spent at optical retailers.<sup>2</sup> With Aetna Vision Preferred, you and your employees will have access to thousands of independent providers and the most desired retail locations nationwide. We have one of the largest national networks with over 65,000 vision office and retailers, featuring most national retailers,<sup>3</sup> including LensCrafters®, Pearle Vision®, Sears® Optical, Target Optical® and JCPenney Optical. Most have evening and weekend hours, including Sundays and are located in or near shopping centers for added convenience. Can't find your provider in our network? No problem. We reimburse for most services from out-of-network vision care providers, so members are covered no matter who they see for routine eye care.

## Low member out-of-pocket costs

Aetna Vision Preferred offers savings in or out of network for routine eye exams, contact lenses and eyeglasses, including prescription sunglasses and designer frames.

## Sample out-of-pocket costs for a member\*\*\*

	Retail price	Out-of-pocket costs with Aetna Vision Preferred	Savings with Aetna Vision Preferred
<b>Exam</b>	\$114.00	\$10.00	\$104.00
<b>Frames</b>	\$124.41	\$0	\$124.41
<b>Lenses</b>	\$ 83.00	\$10.00	\$ 73.00
<b>Total</b>	\$321.41	\$20.00	\$301.41

# Aetna Vision Preferred – Premier plan

	In network	Out of network
In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.		
<b>Exam – coverage allowed for one eye exam every rolling 12 months</b>		
<b>Routine eye exam</b>	\$10 copay	\$25 reimbursement
<b>Standard contact lens fit/follow</b>	\$40 discounted fee	Not covered
<b>Premium contact lens fit/follow</b>	10% off retail	Not covered
<b>Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)</b>		
<b>Any frame available at location</b>	\$130 plan allowance	\$65 reimbursement
<b>Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)</b>		
<b>Single vision lenses</b>	\$10 copay	\$20 reimbursement
<b>Bifocal vision lenses</b>	\$10 copay	\$40 reimbursement
<b>Trifocal vision lenses</b>	\$10 copay	\$65 reimbursement
<b>Lenticular vision lenses</b>	\$10 copay	\$65 reimbursement
<b>Standard progressive lenses</b>	\$75 copay	\$40 reimbursement
<b>Premium progressive lenses</b>	20% discount off retail minus \$120 allowance plus \$75 copay = member out of pocket	\$40 reimbursement
<b>UV treatment</b>	\$15 discounted fee	Not covered
<b>Tint (solid and gradient)</b>	\$15 discounted fee	Not covered
<b>Standard plastic scratch coating</b>	\$15 discounted fee	Not covered
<b>Standard polycarbonate lenses – child to age 19</b>	\$40 discounted fee	Not covered
<b>Standard polycarbonate lenses – adult</b>	\$40 discounted fee	Not covered
<b>Standard anti-reflective coating</b>	\$45 discounted fee	Not covered
<b>Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)</b>		
<b>Conventional contact lenses</b>	\$115 plan allowance	\$80 reimbursement
<b>Disposable contact lenses</b>	\$115 plan allowance	\$80 reimbursement
<b>Medically necessary contact lenses</b>	\$0 copay	\$200 reimbursement

## Discounts

### Available at in network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**



# Aetna Vision Preferred – Plus plan

	In network	Out of network
In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.		
<b>Exam – coverage allowed for one eye exam every rolling 12 months</b>		
<b>Routine eye exam</b>	\$10 copay	\$25 reimbursement
<b>Standard contact lens fit/follow</b>	\$40 discounted fee	Not covered
<b>Premium contact lens fit/follow</b>	10% off retail	Not covered
<b>Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)</b>		
<b>Any frame available at location</b>	\$130 plan allowance	\$65 reimbursement
<b>Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)</b>		
<b>Single vision lenses</b>	\$25 copay	\$10 reimbursement
<b>Bifocal vision lenses</b>	\$25 copay	\$25 reimbursement
<b>Trifocal vision lenses</b>	\$25 copay	\$55 reimbursement
<b>Lenticular vision lenses</b>	\$25 copay	\$55 reimbursement
<b>Standard progressive lenses</b>	\$90 copay	\$25 reimbursement
<b>Premium progressive lenses</b>	20% discount off retail minus \$120 allowance plus \$90 copay = member out of pocket	\$25 reimbursement
<b>UV treatment</b>	\$15 discounted fee	Not covered
<b>Tint (solid and gradient)</b>	\$15 discounted fee	Not covered
<b>Standard plastic scratch coating</b>	\$0 copay	\$15 reimbursement
<b>Standard polycarbonate lenses – child to age 19</b>	\$0 copay	\$35 reimbursement
<b>Standard polycarbonate lenses – adult</b>	\$40 discounted fee	Not covered
<b>Standard anti-reflective coating</b>	\$45 discounted fee	Not covered
<b>Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)</b>		
<b>Conventional contact lenses</b>	\$130 plan allowance	\$90 reimbursement
<b>Disposable contact lenses</b>	\$130 plan allowance	\$90 reimbursement
<b>Medically necessary contact lenses</b>	\$0 Copay	\$200 reimbursement

## Discounts

### Available at in network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at [www.aetnavision.com](http://www.aetnavision.com)

Discounts may not be available in all states.

# Aetna Vision Preferred – Basic plan

	In network	Out of network
In-network amount represents member copay, plan allowance or fixed discounted fee. Out-of-network amount represents the maximum reimbursement amount.		
<b>Exam – coverage allowed for one eye exam every rolling 12 months</b>		
<b>Routine eye exam</b>	\$20 copay	\$20 reimbursement
<b>Standard contact lens fit/follow</b>	\$40 discounted fee	Not covered
<b>Premium contact lens fit/follow</b>	10% off retail	Not covered
<b>Frames – coverage allowed for one eyeglass frame every rolling 12 or 24 months (rates vary by frame frequency)</b>		
<b>Any frame available at location</b>	\$100 plan allowance	\$50
<b>Lens – coverage allowed for one pair of prescription eyeglass lenses every rolling 12 months (in lieu of contact lenses per benefit period)</b>		
<b>Single vision lenses</b>	\$20 copay	\$15 reimbursement
<b>Bifocal vision lenses</b>	\$20 copay	\$30 reimbursement
<b>Trifocal vision lenses</b>	\$20 copay	\$60 reimbursement
<b>Lenticular vision lenses</b>	\$20 copay	\$60 reimbursement
<b>Standard progressive lenses</b>	\$85 copay	\$30 reimbursement
<b>Premium progressive lenses</b>	20% discount off retail minus \$120 allowance plus \$85 copay = member out of pocket	\$30 reimbursement
<b>UV treatment</b>	\$15 discounted fee	Not covered
<b>Tint (solid and gradient)</b>	\$15 discounted fee	Not covered
<b>Standard plastic scratch coating</b>	\$15 discounted fee	Not covered
<b>Standard polycarbonate lenses – child to age 19</b>	\$40 discounted fee	Not covered
<b>Standard polycarbonate lenses – adult</b>	\$40 discounted fee	Not covered
<b>Standard anti-reflective coating</b>	\$45 discounted fee	Not covered
<b>Contacts – coverage for one order of contact lenses every rolling 12 months (in lieu of eyeglass lenses per benefit period)</b>		
<b>Conventional contact lenses</b>	\$105 plan allowance	\$75 reimbursement
<b>Disposable contact lenses</b>	\$105 plan allowance	\$75 reimbursement
<b>Medically necessary contact lenses</b>	\$0 copay	\$200 reimbursement

## Discounts

### Available at in network locations

- 15 percent off balance over the plan allowance on conventional contact lenses
- 20 percent off balance over the plan allowance on frames
- Up to 40 percent off additional pairs of eyeglasses or prescription sunglasses
- 15 percent discount off retail or 5 percent discount off the promotional price for LASIK vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**
- 20 percent off noncovered items, including photochromic/transition and polarized lenses
- Receive significant savings after lens benefit has been exhausted by ordering replacement contact lenses online at **www.aetnavision.com**

Discounts may not be available in all states.

# **Aetna life & disability**

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

# Life & disability

## overview

**For groups of 2 to 50**, Aetna Life Insurance Company (Aetna) offers several options for Small Group life and disability insurance plans. All 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.

- Life
- Short-term disability
- Long-term disability (10–50 only)
- Life and Disability Packaged 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<sup>SM</sup>** 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 the amended normal Social Security retirement age without premium payments (unless they retire sooner), if an employee becomes permanently and totally disabled while insured due to an illness or injury before 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 term life plans and in our packaged life and disability plans, and provides employees and their families with the same coverage as a typical accidental death and personal loss plan — and then some. This includes extra benefits at no additional cost to you, such as coverage for education or child-care expenses that make this protection even more valuable.

Covered losses include:

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

Extra benefits for the following:

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

\*Only available if insured loses life.

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

## Disability insurance

Did you know the ability to earn an income is the most important financial resource for an individual? Yet, few take steps to help protect this important resource from the threat of a disability.

No one wants to think about it, but injury or illness can happen at any time. It can impact both your business and your employees' financial well-being. Your business can lose the productivity of valued employees. Your employees can lose their paycheck.

That is why disability insurance is so important. It provides protection for your business and your employees.

## We understand disability

We have experienced and caring professionals who understand the challenges of disability. We realize how important it is for your employees to be able to work. That is why we are dedicated to providing solutions.

Here's a few ways our disability plans protect you and your employees:

- Consultative support from your account team is based on the unique needs of your business
- Our embedded **Behavioral Health Unit (BHU)** has compassionate licensed therapists and psychiatric nurses who recognize the complexities of behavioral health conditions. They work with your employees and their health care providers to overcome barriers blocking successful return to work
- Master's level **Vocational Rehabilitation Consultants** offer a coordinated productivity approach centered on the employee's abilities to aid your employee's transition back to the workforce

## More choices for interaction

Our best-in-class technology offers more choices for you and your employees to interact with us. Whether you choose mail, phone, e-mail, mobile application or our convenient WorkAbility® Absence Management System online portal, information is available on your schedule, not ours.

For a summary list of Limitations and Exclusions, refer to pages 62–63.



# Life: 2 – 9 Standard QRS and 10 – 50 Life Simplified plans

Life benefits	2–9 eligible lives	10–50 eligible lives
<b>Benefit amount</b>	Flat dollar amounts: \$10,000, \$15,000, \$20,000 or \$50,000	Flat dollar amounts: \$10,000, \$15,000, \$20,000, \$25,000, \$30,000, \$50,000, \$75,000, \$100,000, \$125,000, \$150,000, \$175,000, \$200,000 OR 1 or 2X basic annual earning (BAE) (rounded to next higher \$1,000)
<b>Minimum/maximum amounts</b>	\$10,000/\$50,000	Flat dollar amounts: 10,000/\$200,000 Salary-based amounts: \$10,000/\$200,000
<b>Guaranteed issue</b>	\$20,000	\$200,000
<b>Participation requirement</b>	100%	100% employer pays all, 50% employee contributes
<b>Contribution requirement</b>	100% employer paid	50% – 100% employer paid
<b>Eligible/minimum hours</b>	Active employees/20 hrs./wk.	Active employees/20 hrs./wk.
<b>Rate structure</b>	Age-graded rates	Contributory: age graded Noncontributory: composite
<b>Rate guarantee</b>	Two years	Two years
<b>Age reduction schedule</b>	65% at age 65, 40% at age 70, 25% at age 75	<b>Option 1:</b> 65% at age 65, 40% at age 70, 25% at age 75 <b>Option 2:</b> 65% at age 70, 40% at age 75, 25% at age 80 <b>Option 3:</b> 50% at age 70 <b>Option 4:</b> 65% at age 65, 50% at age 70
<b>Waiver of premium</b>	Premium waiver 60	Premium waiver 60
<b>Funding</b>	Prospective	Prospective
<b>Conversion</b>	Included	Included
<b>Portability</b>	Not included	Not included
<b>Value added services</b>	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services	Aetna Life Essentials Beneficiary Solutions Everest Funeral Services
<b>Accelerated death benefit</b>	Up to 75% of life benefit	Up to 75% of life benefit amount
<b>AD&amp;D Ultra amount</b>	Matches life benefit amount	Matches life benefit amount
<b>Optional spouse life</b>	Not available	Flat dollar amount: \$25,000
<b>Optional child life</b>	Not available	Flat dollar amount: \$10,000 (child covered birth to age 26)
<b>Spouse/child life rate structure</b>	Not available	Spouse: per \$1,000 – age graded; Child: per \$1,000, per family unit
<b>Spouse/child life guarantee issue</b>	Not available	Spouse: \$25,000 Child: \$10,000
<b>Spouse/child AD&amp;D</b>	Not available	Spouse: 50% employee amount (40% if child included) Child: 15% employee amount (10% if spouse included)
<b>Supplemental life</b>	Not available	Up to \$400,000 (increments \$10,000 or \$25,000) OR 1–5 X basic annual earnings (BAE) rounded to next \$1,000
<b>Supplemental AD&amp;D</b>	Not available	Matches supplemental life benefit; automatically included in supplemental life rate
<b>Class schedules</b>	Only one class allowed	Up to three classes (minimum three employees in each class)

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

# Short Term Disability\*: 2 – 9 Standard QRS and 10 – 50 Simplified plans

Short term disability benefits*	2–9 eligible lives	10–50 eligible lives
<b>Weekly benefit</b>	\$100–\$500 flat amount in \$100 increments	50% or 60% of earnings
<b>Elimination period – injury/illness</b>	1/8 or 8/8	1/8, 8/8 or 15/15
<b>Maximum benefit</b>	\$500	\$500, \$750, \$1,000, \$1,500 or \$2,000
<b>Maximum benefit period</b>	26 weeks	13 weeks or 26 weeks
<b>Maternity benefit</b>	Maternity is treated same as illness but subject to preexisting condition exclusion. If pregnant before plan effective date, pregnancy is not covered unless employee has prior credible coverage.	Maternity is treated same as illness
<b>Types of disability covered</b>	Non-occupational	Non-occupational
<b>Pre-existing condition rule</b>	3/12	3/12 for late applicants and voluntary plans
<b>Actively-at-work rule</b>	Applies	Applies
<b>Other income offset integration</b>	None	Full offsets, including family SSDI
<b>Definition of disability</b>	Own occupation, 20% earnings loss	Own occupation, 20% earnings loss
<b>Separate periods of disability</b>	15 days	15 days
<b>Funding</b>	Prospective	Prospective
<b>Minimum participation requirement</b>	100%	Contributory: 50% Noncontributory: 100%
<b>Contribution requirement</b>	100% employer paid	Contributory: 50%–99% employer paid Noncontributory: 100% employer paid
<b>Eligible/minimum hours</b>	Active employees/20 hrs./wk.	Active employees/20 hrs./wk.
<b>Rate structure</b>	Age-graded rates	Age-graded rates
<b>Rate guarantee</b>	Two years	Two years
<b>Class schedules</b>	Only one class allowed	Up to three classes (with a minimum requirement of three employees in each class) available for groups of 10 or more employees

\*For 2 to 50 lives: short term disability is not available in CA, NJ, NY, HI or RI. These states have mandated state cash disability plans. Life insurance policies and disability insurance plans/policies are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

# Long Term Disability: 10–50 Simplified plan

Long term disability benefits	10–50 eligible lives
<b>Monthly benefit</b>	50% or 60% of earnings
<b>Elimination period–injury and illness</b>	30 days, 90 days or 180 days
<b>Maximum benefit</b>	\$2,000, \$3,500, \$5,000, \$6,000 or \$8,000
<b>Maximum benefit period</b>	Two years or five years
<b>Maternity benefit</b>	Maternity is treated same as illness
<b>Types of disability covered</b>	Occupational and non-occupational
<b>Pre-existing condition rule</b>	3/12 for new coverage and increases in coverage
<b>Actively-at-work rule</b>	Applies
<b>Other income offset integration</b>	Full offsets, including family SSDI
<b>Definition of disability</b>	Own occupation for 24 months 80%; after 24 months, any reasonable occupation 60%
<b>Separate periods of disability</b>	30-day EP: 15 days during EP, three months after 90-day EP: 15 days during EP, three months after 180-day EP: 15 days during EP, six months after
<b>Work incentive benefit adjustment</b>	Proportional loss after 12 months
<b>Limitations – mental/nervous and drug/alcohol</b>	24 months of benefits per disability; 90 day extension if hospital confined
<b>Waiver of premium</b>	Included
<b>Vocational rehabilitation* and incentive</b>	Mandatory; 10%
<b>Survivor benefit</b>	Included – three months
<b>Conversion</b>	Not included
<b>Funding</b>	Prospective
<b>Minimum participation requirement</b>	Contributory: 50% Noncontributory: 100%
<b>Contribution requirement</b>	Contributory: 50%–99% employer paid Noncontributory: 100% employer paid
<b>Eligible/minimum hours</b>	Active employees/20 hrs./wk.
<b>Rate structure</b>	Age-graded rates
<b>Rate guarantee</b>	Two years
<b>Class schedules</b>	Up to three classes (with a minimum requirement of three employees in each class) available for groups of 10 or more employees

\*Mandatory vocational rehabilitation is prohibited in CA and NJ. CT prohibits mandatory vocational rehabilitation if the plan is contributory or voluntary

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

# Packaged Life and Disability\*: 2–9 and 10–50 QRS Standard plans

Life plan design	Low option	Low option 2	Medium option	Medium option 2	High option
<b>Benefit</b>	Flat \$10,000	Flat \$15,000	Flat \$20,000	Flat \$25,000	Flat \$50,000
<b>Guaranteed issue</b>					
<b>2–9 lives</b>	\$10,000	\$15,000	\$20,000	\$20,000	\$20,000
<b>10–50 lives</b>	\$10,000	\$15,000	\$20,000	\$25,000	\$50,000
<b>Reduction schedule</b>	Employee's original life amount reduces to 65% at age 65; 40% at age 70; 25% at age 75				
<b>Premium waiver</b>	Premium waiver 60	Premium waiver 60	Premium waiver 60	Premium waiver 60	Premium waiver 60
<b>Conversion</b>	Included	Included	Included	Included	Included
<b>Accelerated death benefit</b>	Up to 75% of benefit; 24-month acceleration				
<b>Dependent life</b>	Spouse \$5,000 Child \$2,000	Spouse \$5,000 Child \$2,000	Spouse \$5,000 Child \$2,000	Spouse \$5,000 Child \$2,000	Spouse \$5,000 Child \$2,000
<b>AD&amp;D Ultra</b>					
<b>AD&amp;D ultra schedule</b>	Matches basic life benefit				
<b>AD&amp;D ultra extra benefits</b>	Passenger restraint use and airbag deployment, education benefit for your child and/or spouse, child care and repatriation of mortal remains.				
<b>Disability plan design</b>					
<b>Monthly benefit</b>	Flat \$500 No offsets	Flat \$1,000; offsets are workers' compensation, any state disability plan and primary and family Social Security benefits.			
<b>Elimination period</b>	30 days	30 days	30 days	30 days	30 days
<b>Definition of disability</b>	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	Own occupation; earnings loss of 20% or more	First 24 months of benefits: own occupation; earnings loss of 20% or more; any reasonable occupation thereafter; 40% earnings loss
<b>Benefit duration</b>	24 months	24 months	24 months	24 months	60 months
<b>Pre-existing condition limitation</b>	3/12	3/12	3/12	3/12	3/12
<b>Types of disability</b>	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational	Occupational & non-occupational
<b>Separate periods of disability</b>	15 days during elimination period; six months thereafter				
<b>Mental health/substance abuse</b>	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions	Duration same as all other conditions
<b>Waiver of premium</b>	Included	Included	Included	Included	Included
<b>Other plan provisions</b>					
<b>Eligibility</b>	Active full-time employees	Active full-time employees	Active full-time employees	Active full-time employees	Active full-time employees
<b>Employer contribution</b>	2–9 lives: 100% employer paid 10–50 lives: 50–100% employer paid				
<b>Minimum participation</b>	2–9 lives: 100% 10–50 lives: 75%	2–9 lives: 100% 10–50 lives: 75%	2–9 lives: 100% 10–50 lives: 75%	2–9 lives: 100% 10–50 lives: 75%	2–9 lives: 100% 10–50 lives: 75%
<b>Class schedules</b>	2–9 lives: not available 10–50 lives: Up to three classes (with a minimum requirement of three employees in each class) — the benefit amount of the highest class can not be more than five times the benefit amount of the lowest class even if only two classes are offered.				
<b>Rate guarantee</b>	One year	One year	One year	One year	One year
<b>Rates PEPM</b>	\$8.00	\$10.00	\$15.00	\$16.00	\$27.00

\*For 2 to 50 lives: packaged life and disability plans are not available in CA, NJ, NY, HI or RI. These states have mandated state cash disability plans.

Life and disability products are underwritten or administered by Aetna Life Insurance Company (Aetna).

# Limitations and exclusions

## HMO/QPOS/Health Network Option plans

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

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs, including injectable infertility drugs
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

## PPO/Indemnity plans

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

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

## Dental, AD&D Ultra and disability

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

## Dental

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

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

## Employee and dependent life insurance:

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

## AD&D Ultra®

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

- Air or space travel, unless a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)
- Bodily or mental infirmity
- Commission of or attempt to commit a criminal act.
- Illness, ptomaine or bacterial infection\*
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Ligature strangulation resulting from auto-erotic asphyxiation
- Intentionally self-inflicted injury
- Medical or surgical treatment\*
- Third-degree burns resulting from sunburn
- Use of alcohol
- Use of drugs, except as prescribed by a physician
- Use of intoxicants
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident the member or covered dependent was:
  - Operating the motor vehicle while under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
  - Operating the motor vehicle while under the influence of an intoxicant or illegal drug; or
  - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician; or
  - Operating the motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions
- Suicide or attempted suicide (while sane or insane)
- War or any act of war (declared or not declared)

\*These do not apply if the loss is caused by:

- An infection that results directly from the injury
- Surgery needed because of the injury

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

## Disability

Disability coverage also does not include any disability that:

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

Disability plans do not cover any disability on any day that the member is confined in a penal or correctional institution for conviction of a criminal act or other public offense. The member will not be considered to be disabled, and no benefits will be payable.

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

## Vision

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (nonprescription) lenses and/or contact lenses; Nonprescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand-name vision materials in which the manufacturer imposes a no-discount policy; or services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

**This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan if you are a member, call the number on your ID card; all others, call 1-888-98-AETNA (1-888-982-3862).**

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. Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules and are unfunded liabilities of your employer. Fund balances are not vested benefits. Investment services are independently offered through HealthEquity, Inc. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. 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 may vary, may be unavailable in some states, and are subject to change. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to hospitals and specialists that are affiliated with the delivery system or physician group. Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna 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](http://www.aetna.com).

[www.aetna.com](http://www.aetna.com)

