

SERFF Tracking Number: AENX-125689898 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 39265
Company Tracking Number: DI AR0032301F01
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: 2008 Group Insurance
Project Name/Number: 2008 Group Insurance/DI AR0032301F01

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2008 Group Insurance

SERFF Tr Num: AENX-125689898 State: ArkansasLH

TOI: H11G Group Health - Disability Income

SERFF Status: Closed

State Tr Num: 39265

Sub-TOI: H11G.005 Combined Short Term and Long Term
Co Tr Num: DI AR0032301F01

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI

Disposition Date: 06/13/2008

Date Submitted: 06/10/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 Group Insurance

Project Number: DI AR0032301F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/13/2008

State Status Changed: 06/13/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

These forms are new, and do not replace any forms previously submitted to your Department. They are in final form, rather than being drafts or proofs. The forms included in this submission represent various changes to our group disability income products and are intended to afford Aetna the flexibility to offer group disability income plans with features currently being offered in the marketplace by its competitors. Some of the changes involve the "test" of disability, waiting period, earnings definition and addition of a number of supplemental benefits.

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Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Affairs CiesielskiJW@Aetna.com

Manager

151 Farmington Avenue (860) 279-1282 [Phone]

Hartford, CT 06156 (860) 952-2069[FAX]

Filing Company Information

Aetna Life Insurance Company

CoCode: 60054

State of Domicile: Connecticut

151 Farmington Avenue

Group Code: 1

Company Type:

Hartford, CT 06156

Group Name: Aetna

State ID Number:

(860) 273-7546 ext. [Phone]

FEIN Number: 06-6033492

Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	06/10/2008	20757274

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/13/2008	06/13/2008

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Disposition

Disposition Date: 06/13/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Form	Short Term Disability Benefit Eligibility	Approved-Closed	Yes
Form	Organ Transplant Benefit	Approved-Closed	Yes
Form	Approved Rehabilitation Benefit	Approved-Closed	Yes
Form	Test of Disability	Approved-Closed	Yes
Form	Approved Rehabilitation Program	Approved-Closed	Yes
Form	Survivor Benefit	Approved-Closed	Yes
Form	Benefit Escalator	Approved-Closed	Yes
Form	Child/Family Dependent Care Benefit	Approved-Closed	Yes
Form	Group Health Coverage Continuation Allowance	Approved-Closed	Yes
Form	Spouse Rehabilitation Benefit	Approved-Closed	Yes
Form	Extended Disability Benefit	Approved-Closed	Yes
Form	Accidental Personal Loss Indemnity Benefit	Approved-Closed	Yes
Form	Accelerated Survivor Benefit	Approved-Closed	Yes
Form	Eligibility, Enrollment and Effective Date of Your Coverage	Approved-Closed	Yes
Form	Continuing Life and Accidental Death & Personal Loss Insurance Coverage	Approved-Closed	Yes
Form	Converting Your Disability Coverage	Approved-Closed	Yes
Form	Glossary (Letter O)	Approved-Closed	Yes
Form	Glossary (Letter P)	Approved-Closed	Yes
Form	Glossary (Letter R)	Approved-Closed	Yes
Form	Short term Disability Schedule of Benefits	Approved-Closed	Yes
Form	Long term Disability Schedule of Benefits	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-9N 05-010 03	Certificate	Short Term Disability Benefit Eligibility	Initial		49	GR-9N 05-010 03.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 05-080 01	Certificate	Organ Transplant Benefit	Initial		57	GR-9N 05-080 01.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 05-085 01	Certificate	Approved Rehabilitation Benefit	Initial		36	GR-9N 05-085 01.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 06-010 03	Certificate	Test of Disability	Initial		53	GR-9N 06-010 03.PDF
			Amendment t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 06-050 02	Certificate	Approved Rehabilitation Program	Initial		36	GR-9N 06-050 02.PDF
			t, Insert Page, Endorsement or Rider				
Approved-Closed	GR-9N 06-090 02	Certificate	Survivor Benefit	Initial		46	GR-9N 06-090 02.PDF
			Amendment				

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t, Insert
 Page,
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Approved- GR-9N 06- Certificate Benefit Escalator Initial 42 GR-9N 06-
 Closed 105 02 Amendmen 105 02.PDF

t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GR-9N 06- Certificate Child/Family Initial 51 GR-9N 06-
 Closed 140 01 Amendmen Dependent Care 140 01.PDF

t, Insert Benefit
 Page,
 Endorseme
 nt or Rider

Approved- GR-9N 06- Certificate Group Health Initial 31 GR-9N 06-
 Closed 145 01 Amendmen Coverage 145 01.PDF

t, Insert Continuation
 Page, Allowance
 Endorseme
 nt or Rider

Approved- GR-9N 06- Certificate Spouse Initial 32 GR-9N 06-
 Closed 150 01 Amendmen Rehabilitation Benefit 150 01.PDF

t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GR-9N 06- Certificate Extended Disability Initial 47 GR-9N 06-
 Closed 155 01 Amendmen Benefit 155 01.PDF

t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GR-9N 06- Certificate Accidental Personal Initial 42 GR-9N 06-
 Closed 160 01 Amendmen Loss Indemnity 160 01.PDF

t, Insert Benefit
 Page,

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Endorsement or Rider

Approved-Closed	GR-9N 06-165 01	Certificate Amendmen t, Insert Page, Endorsement or Rider	Accelerated Survivor Benefit	Initial	20	GR-9N 06-165 01.PDF
Approved-Closed	GR-9N 29-005 03	Certificate Amendmen t, Insert Page, Endorsement or Rider	Eligibility, Enrollment and Effective Date of Your Coverage	Initial	41	GR-9N 29-005 03.PDF
Approved-Closed	GR-9N 31-010 03	Certificate Amendmen t, Insert Page, Endorsement or Rider	Continuing Life and Accidental Death & Personal Loss Insurance Coverage	Initial	44	GR-9N 31-010 03.PDF
Approved-Closed	GR-9N 31-035 02	Certificate Amendmen t, Insert Page, Endorsement or Rider	Converting Your Disability Coverage	Initial	40	GR-9N 31-035 02.PDF
Approved-Closed	GR-9N 34-075 02	Certificate Amendmen t, Insert Page, Endorsement or Rider	Glossary (Letter O)	Initial	47	GR-9N 34-075 02.PDF
Approved-Closed	GR-9N 34-080 04	Certificate Amendmen t, Insert Page, Endorsement or Rider	Glossary (Letter P)	Initial	40	GR-9N 34-080 04.PDF

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Approved- Closed	GR-9N 34- 090 03	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Glossary (Letter R) Initial	40	GR-9N 34- 090 03.PDF
Approved- Closed	GR-9N S- 04-01 03	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Short term Disability Schedule of Benefits Initial	0	GR-9N S-04- 01 03.PDF
Approved- Closed	GR-9N S- 05-01 03	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Long term Disability Schedule of Benefits Initial	0	GR-9N S-05- 01 03.PDF

[Short Term Disability] Benefit Eligibility

You will be considered disabled while covered under this [short term disability] plan on the first day that you are disabled as a direct result of a significant change in your physical or mental condition and you meet all of the following requirements:

- You must be covered by this Plan at the time you become disabled;
- You must be under the regular care of a **physician**. [This means that you must have been seen and treated in person by a **physician** for the **illness, injury** or pregnancy-related condition that caused the disability no more than 31 days after the start of the disability]; and
- You must meet the [short term disability] **test of disability**. (See the *Test of Disability* section)

[Test of Disability]

You meet the **test of disability** if you are not able perform all of the **material duties** of your **own occupation** because of an **illness** or **injury**, or because of a pregnancy-related condition. You are not performing the **material duties** of your **own occupation** if:

- You are only performing some of the **material duties** of your **own occupation**; and
- Your income is 20% or less of your **predisability earnings** solely because of an **illness, injury** or a pregnancy-related condition.

You will be deemed to be disabled only on any day on which solely due to **illness** or **injury** you do not do any work for pay or profit.]

[Test of Disability]

During the waiting period, you meet the **test of disability** on any day if:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- Your work earnings are 10% or less of your **adjusted predisability earnings**.

After the waiting period ends, you meet the **test of disability** on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- Your work earnings are 20% or less of your **[adjusted] predisability earnings**.]

[Test of Disability]

You meet the **test of disability** on any day that:

- You cannot perform all of the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- Your work earnings are 20% or less of your **adjusted predisability earnings**; and
- You do not do any work for compensation or profit.]

[Test of Disability]

You meet the **test of disability** on any day that:

- You are unable to work at any **reasonable occupation** solely because of an **illness, injury** or a disabling pregnancy-related condition; and
- You do not do any work for compensation or profit.]

Important Note:

The loss of a professional or occupational license or certification that is required by your **own occupation** does not mean you meet the **test of disability**. You must meet this Plan's **test of disability** to be considered disabled.

When Benefits are Payable

Once you meet the [short term disability] **test of disability** described above, your [short term disability] benefits will be payable after the [waiting] period, if any, is over. The [waiting] period is the amount of time you must be disabled before benefits start. No benefit is payable for or during the [waiting] period. Your [short term disability] benefits will be payable [for as long as your disability benefit eligibility continues] but not beyond the end of the maximum weekly benefit period. The [waiting] periods and the maximum weekly benefit period are shown in the [Schedule of Benefits].

Premium and Contribution Waiver

[During your disability while weekly benefits are payable:

- You will not have to make any further contributions.
- No premium payments will be required from your Employer.]

[Premium payments shall not be required on any premium due date during your disability for which a benefit has been payable for 90 days or 13 weeks].

Premium/Contribution Refund

[If a decrease in your predisability earnings would result in a lesser weekly benefit at the time your disability starts, any premium payment you paid that were based on a higher weekly benefit will be refunded to you. The amount of any such refund of premium will not be more than the amount of excess contributions paid for the [6 months] period immediately preceding the start of your disability.]

Premium/Contribution Reinstatement

[If you are eligible to continue coverage, premium payments may be resumed on the first premium due date following the end of a period of disability during which premiums were waived.]

Organ Transplant Benefit

If you donate an organ [more than 12 months following your effective date of coverage; weekly benefits will be payable on the same basis as for an **injury** or **illness** on the first day of a period of disability]. [No waiting period will apply.]

[Approved Rehabilitation Program]

[A rehabilitation program will no longer be an **approved rehabilitation program** on the date **Aetna** withdraws, in writing, its approval of the program.]

Aetna has the right to evaluate you for participation in an **approved rehabilitation program**.

[If, in **Aetna's** judgment, you are able to participate, **Aetna** may, in its sole discretion require you to participate in an **approved rehabilitation program**.]

Benefits Available to You When You Participate in an Approved Rehabilitation Program

[This Plan will pay for all of the services and supplies (including but not limited to, those for workplace modifications), approved in advance by **Aetna**, you need in connection with participation in the program, except those for which you can be reimbursed by another payer, including government benefits programs.]

[During your active participation in an **Aetna approved rehabilitation program**, **Aetna** will increase the weekly benefit payable. A 10% increase in the weekly benefit payable (after all applicable reductions for other income benefits) will be paid for up to 9 consecutive weeks for all disabilities, up to a maximum weekly increase of \$50.]

[Test of Disability]

During the waiting period, you will meet the **test of disability**, from the date you first become disabled and until [monthly, weekly] benefits are payable for 12 months. You will be deemed to be disabled on any day if:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- You do not do any work for compensation or profit.
- Your work earnings are 50% or less of your **adjusted predisability earnings**.]

[After the waiting period ends, and [in the first 12 months that any monthly benefit is payable for a] disability] [from the date that you first become disabled and until monthly benefits are payable for 12 months] you meet the **test of disability** on any day that [:

- You cannot perform the **material duties** of your **own occupation** for more than a half day solely because of an **illness, injury** or disabling pregnancy-related condition. However, if you start work at any **reasonable occupation**, you are no longer considered to be disabled; and
- Your earnings are 50% or less of your **adjusted predisability earnings**.]

[*After the first 12 months of your disability* that monthly benefits are payable, you meet this Plan's **test of disability** on any day if

- You are not able (to be consistent with the phrasing below) to work at any **reasonable occupation** solely because of a disease, an **injury**, or a disabling pregnancy-related condition;
- And you do not do any work for compensation or profit.]

[Test of Disability [Total Disability]

From the date that you first become disabled and until monthly benefits are payable for 12 months, you will meet the test of total disability on any day if:

- You cannot perform all the **material duties** of your **own occupation** solely because of: **illness** or **injury** or a disabling pregnancy related condition; and
- You are not able to work at any **reasonable occupation**, solely because of **illness** or **injury** or a disabling pregnancy related condition; and
- You do not work at a **reasonable occupation**.
- You do not do any work for compensation or profit.
- Your work earnings are 20% or less of your **adjusted predisability earnings**.

After the first 12 months that any monthly benefit is payable during a period of disability, you will meet the test of total disability on any day if you are not able to work at any **reasonable occupation** solely because of:

- **Illness**; or
- **Injury**; or
- pregnancy related condition.]

[Test of Disability]

From the date that you first become disabled and until monthly benefits are payable for 12 months, you will meet the test of disability on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or a disabling pregnancy related condition;
- Your work earnings are 50% or less of your **adjusted predisability earnings**; and
- You do not do any work for compensation or profit.

After the first 12 months of your disability that monthly benefit are payable, you will meet the test of disability on any day if:

- You are not able to work at any **reasonable occupation** solely because of an **illness, injury** or pregnancy related condition; and
- You do not do any work for compensation or profit.]

[Test of Disability]

During the waiting period you will meet the test of disability on any day if:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or a disabling pregnancy related condition;
- Your work earnings are 10% or less of your **adjusted predisability earnings**; and
- You do not work for any compensation or profit.

[After the waiting period ends] [and until monthly benefits are payable for 12 months], you meet the test of disability on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or disabling pregnancy-related condition; and
- Your work earnings are 50% or less of your **adjusted predisability earnings**.

[After the first 12 months of your disability that monthly benefits are payable, you meet the test of disability on any day if you are unable to work at any **reasonable occupation** solely because of an **illness, injury** or disabling pregnancy-related condition.]]

[Test of Disability]

You meet the test of disability on any day that:

- You cannot perform the **material duties** of your **own occupation** solely because of an **illness, injury** or a disabling pregnancy related condition;
- Your work earnings are 50 or less of your **adjusted predisability earnings**; and
- Your do not do any work for compensation or profit.

[Test of Disability]

You meet the test of disability on any day that:

- You are unable to work at any **reasonable occupation** solely because of an **illness, injury** or a disabling pregnancy related condition; and
- You do not do any work for compensation or profit.

In addition, your disability must be expected to last one year or result in death.]

[Residual Disability]

You will meet the test of residually disability if:

- You are under age 55 when your disability starts; and
- You met the test of total disability for at least the first 365 days of your disability; and
- You met the test of total disability for a length of time at least equal to the waiting period; and
- A monthly benefit was payable during your total disability for at least 60 months and
- You are able to perform some, but not all, of the material duties of your **own occupation** or able to work at a **reasonable occupation**, solely because of **illness or injury, or a disabling pregnancy related condition**; and
- Your work earnings are 50% or less of your **adjusted predisability earnings**.]

Important Note

The loss of a professional or occupational license or certification that is required by your **own occupation** does not mean you meet the **test of disability**. You must meet this Plan's **test of disability** to be considered disabled.

[Certification of a Disability]

A disability will be certified by **Aetna** if, and for only as long as, **Aetna** determines that you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are covered under this Plan. You must be under the regular care of a **physician**. You will be considered to be disabled when you meet the test of disability as described above.

Under this Plan, *no* benefits are payable for any disability, if that disability has *not* been certified because:

- Certification has not been requested for that disability; or
- Certification for that disability has been requested and denied.

Certification of a disability will be denied if any one of the following apply:

- **Aetna** determines that you are not disabled;
- You are not under the care of a physician;
- You refuse to have an independent medical exam, when required;
- The requested independent medical exam report is not received by **Aetna**, or fails to confirm your disability.

Whether or not a disability is certified, no benefits will be paid for any day of a disability for which benefit payment is excluded by any other terms of this Plan.

To request certification of a disability, you must call the toll-free number provided by **Aetna**. You should make the call at the start of your disability, or as soon as possible thereafter. In any event, to avoid a reduction in benefits as described below, you should make the call before the end of the waiting period. If you are not able to make the call yourself, the call may be made by:

- Your **physician**;
- Your employer; or
- Any member of your family.

The deadline for calling to request certification is [31 days] from the first day you are absent from work due to **illness, injury**, or disabling pregnancy-related condition.

If you fail to meet the deadline, no benefit will be payable:

- Unless you fail to meet the deadline through no fault of your own; and
- The request for certification is made as soon after the deadline as possible, but not later than [1 year] after the deadline unless you are legally incapacitated; and
- **Aetna** is able to certify your disability.

If the call to request certification is made after the waiting period but **Aetna** is able to certify the disability, the benefits otherwise payable for any day before such call is made will be reduced by [20%].

When **Aetna**'s certification of a disability ends, you may request that **Aetna** certify an extension of the certified disability. If you and your **physician** believe you are still not able to work due to the disability, you must contact **Aetna** and should call the toll-free number provided by **Aetna**. This request should be made to **Aetna** no later than the last day for which the disability is presently certified. The call should be made even if the reason you are asking for recertification is due to a different **illness, injury**, or disabling pregnancy-related condition which has occurred during the disability.

Written notice of **Aetna**'s decision will be sent promptly to:

- You;
- Your **physician**; and
- Your Employer.]

[Approved Rehabilitation Program]

[A rehabilitation program will no longer be an **approved rehabilitation program** on the date **Aetna** withdraws, in writing, its approval of the program.]

Aetna has the right to evaluate you for participation in an **approved rehabilitation program**.

[If, in **Aetna's** judgment, you are able to participate, **Aetna** may, in its sole discretion require you to participate in an **approved rehabilitation program**.]

Benefits Available to You When You Participate in an Approved Rehabilitation Program

[This Plan will pay for all of the services and supplies (including but not limited to, those for workplace modifications), approved in advance by **Aetna**, you need in connection with participation in the program, except those for which you can be reimbursed by another payer, including government benefits programs.]

[During your active participation in an **Aetna approved rehabilitation program**, **Aetna** will increase the monthly benefit payable. A 10% increase in the monthly benefit payable (after all applicable reductions for other income benefits) will be paid for up to 6 consecutive months for all disabilities, up to a maximum monthly increase of \$500.]

Survivor Benefit

If you die while [totally] disabled, [and on or after the date you reach age 70] [a single, lump sum] benefit will be paid under this provision if:

- There is an eligible survivor as defined below[; and
- A monthly benefit was payable under this Plan for 12 months; and
- You were disabled for 365 days, or monthly or weekly equivalent or more].

The benefit amount will be [3 times] the [monthly] benefit, [not] reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full [monthly] benefit, however, the benefit will be [3 times] the [monthly] benefit, [not] reduced by other income benefits for which you would have been eligible if you had not died, for the first full month after the month in which you die.

[An eligible survivor is:

- Your legally married spouse at the date of your death.
- Your sole domestic partner.
- If there is no such spouse or domestic partner, your biological or legally adopted child who, when you die:
 - is not married; and
 - is depending on you for support; and
 - is under age 19. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 19.]

[A domestic partner will be determined to be an eligible survivor in accordance with the rules set by your employer.

A domestic partner will no longer be considered to be an eligible survivor as of the date of termination of the domestic partnership.]

[A domestic partner will be determined to be an eligible survivor if you have completed and signed a 'Declaration of Domestic Partnership', and the Declaration is acceptable to your employer.

A domestic partner will no longer be considered to be an eligible survivor as the date of termination of the domestic partnership. In that event, you should provide your employer with a completed and signed 'Declaration of Termination of Domestic Partnership'.]

How the Survivor Benefit Will Be Paid

The benefit will be paid to your eligible surviving spouse [or domestic partner], if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

[If you have no eligible survivor, the benefit will be paid to your estate, unless there is none. In this case, no payment will be made.]

If [monthly] benefit payments are made in amounts greater than the [monthly] benefits that you are entitled to receive, **Aetna** has the right to first apply the survivor benefit to any such overpayment.

Aetna may pay the benefit to anyone who, in **Aetna**'s opinion, is caring for and supporting the eligible survivor; or if proper claim is made, **Aetna** may pay the benefit to an eligible survivor's legally appointed guardian or committee.

[Benefit Escalator

Aetna will pay an additional disability benefit if you are certified as disabled and a monthly benefit has been payable for at least 12 months under the LTD plan and you suffer a functional loss following the date you are covered for this benefit.

For the purposes of this provision, functional loss means that on a given day you meet either of the following requirements:

- Due to a physical incapacity resulting from **illness, injury** or disabling pregnancy-related condition, you are unable to perform (without substantial assistance) at least [two] activities of daily living for a period of at least 90 days; or
- Due to cognitive impairment, you require substantial supervision in order to protect you and others from serious threats to health and safety].

Activities of daily living means: [

Bathing: Washing oneself by a sponge bath; or washing oneself in either a tub or shower, including the task of getting into and out of the tub or shower.

Transferring: Moving into or out of a bed, chair or wheelchair.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet and associated personal hygiene.

Continence: The ability to maintain control of bowel and bladder functions; and when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), or by a feeding tube or intravenously.]

[Cognitive impairment means a deterioration or loss in your intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.]

Aetna will make the determination of the functional loss.

Monthly Additional Benefit

This Plan will pay a monthly additional benefit equal to [\$250] [10% of your monthly **predisability earnings**, up to a maximum benefit equal to \$250] [the lesser of (a) the maximum monthly benefit to which you are entitled under the LTD plan, or (b) \$250].

[If the sum of the monthly LTD benefit payable, other income benefits, and this monthly additional benefit exceeds 50% of your **adjusted predisability earnings**, the amount of your monthly LTD benefit will be reduced by the excess.]

[This benefit is not subject to adjustment because of other income benefits that you may receive.]

[Respite Care Benefit

This Plan will pay a Respite Care Benefit if all of the following conditions are met:

- The additional benefit under this *Benefit Escalator* provision must have been payable for 12 months or more;
- You have received Informal Home Care for at least 12 continuous months.

Informal Home Care means: **medically necessary** custodial care provided at your home or a private residence by an Informal Caregiver. Such care is provided in lieu of confinement in a nursing home, or care received at your home from a paid provider.

Informal Caregiver is: a person who has primary responsibility for caring for or providing assistance to you in your home or a private residence. A person who makes charges for any services is not considered an Informal Caregiver.

- You incur out-of-pocket costs for Companion Care you receive at your home or a private residence during a period of Respite Care when your Informal Caregiver is not attending to your needs.

Companion Care means: **medically necessary** custodial care furnished during a Respite Interval for a minimum of 8 hours per day by a **home health care agency**.

Respite Interval means: a period of one or more consecutive days during which the Informal Caregiver is temporarily relieved of the Informal Home Care duties.

The amount of the Respite Care Benefit will be the lesser of:

- The daily cost incurred for Companion Care; and
- \$50 per day.

The Respite Care Benefit will be payable for up to two Respite Intervals each calendar year. In no event, will a Respite Care Benefit be paid for more than 14 days in any one calendar year.

The Respite Care Benefit is payable to you following submission of proof of your incurred costs for Companion Care during the Respite Interval.]

[Caregiver Training Benefit

This Plan will pay a Caregiver Training Benefit if all of the following conditions are met:

- The additional benefit under this *Benefit Escalator* provision must have been payable for 12 months or more;
- You or an Informal Caregiver incur out-of-pocket costs, while the Benefit Escalator benefit is payable, for training the Informal Caregiver to care for you in your home or a private residence. The Caregiver Training must be provided by a **home health care Agency**, by a **skilled nursing facility** or by a **hospital**.
- If you are in a **skilled nursing facility** or in a **hospital**, the Caregiver training must make it possible for you to return to your home where you can be cared for by the Informal Caregiver.

The amount of the Caregiver Training Benefit will be the lesser of:

- The cost incurred for the Caregiver Training; and
- \$250.

The Caregiver Training Benefit is payable to you following submission of proof of incurred costs for Caregiver Training.

The Caregiver Training Benefit will only be paid once for each disability.]

[Emergency Alert System Benefit

This Plan will pay an Emergency Alert System Benefit if all of the following conditions are met:

- The additional benefit under this *Benefit Escalator* provision must have been payable 12 months or more;
- You incur out-of-pocket costs to rent, lease, purchase, install, service, maintain, repair or replace an Emergency Alert System which allows you to remain in your home alone.
- Emergency Alert System means services designed to provide a 24 hour per day emergency communication link to assistance outside the home. This does not include a home security system;
- Because of your functional loss, you are not permitted to be left alone without the presence of the Emergency Alert System;

The amount of the Emergency Alert System Benefit will be the lesser of:

- The actual cost incurred to rent, lease, purchase, install, service, maintain, repair or replace the Emergency Alert System; and
- \$25 per month.

The Emergency Alert System Benefit is payable to you every 12 months following submission of proof of actual costs incurred.]

[We will not pay for any charges to purchase, install, service, maintain, repair or replace the Emergency Alert System.]

Termination of Benefit Escalator

Benefits under the Benefit Escalator will end on the first of the following to occur:

- The date **Aetna** determines you no longer suffer a functional loss[;
- The date when this Benefit Escalator has been payable for 12 months; or
- The date your certified disability ends under any of the terms of the LTD plan.]

[Child/ Family/Dependent] Care Benefit

If:

- You [or your spouse] are a participant in an **approved rehabilitation program**; and
- You [or your spouse] have a dependent [child/family member];

The benefit payable under this Plan may be increased as described below.

[Starting after the first 6 months of a disability, due to the same or related causes, for which a monthly benefit is payable, the benefit payable will be increased by an amount equal to the new or additional amount charged by a licensed day care provider for the care of such dependent [child] [family member] while you or your spouse are a participant. In no event will the increase in any one month be more than:

- \$250 for each dependent [child, family member]; or
- \$500 for all dependents [children, family members]]

Not more than [12] such increases will occur during any one [certified] disability due to the same or related causes.

During any month in which a [child, family, dependent] care benefit is payable to a person, the maximum [monthly] benefit for that person will be increased by the amount of the [child, family, dependent] care benefit payable for that month.

["Dependent child" means a child who is under age [13] and who lives with you [and is either:

- Your or your spouse's biological child.
- Your or your spouse's legally adopted child.
- A child for whom you are legal guardian.]

[The dependent child age limit will not apply if the child is not capable of providing his or her own care on a daily basis because of a mental or physical handicap.]

["Dependent [family member]" means a child who is under age [13] or a person who, as a result of a mental or physical handicap, is incapable of self-care living and who is:

- Living with you as part of your household; and
- Chiefly dependent on you for support.]

["Dependent [family member]" means:

- A child who is under age [13] for whom you can claim an exemption on your tax return;
- Your spouse, if he or she is physically or mentally incapable of self-care; or
- Any person who is physically or mentally incapable of self-care and for whom you can claim an exemption on your tax return.]

A "licensed day care provider" will **not** include:

- One who is a member of your immediate family; or
- One who lives in your residence.]

Group Health Coverage Continuation Allowance

A Group Health Coverage Continuation Allowance will be payable if all of the following conditions are met:

- Your coverage under [your employer-sponsored] group health plan ceases because:
 - [your employment ends; or
 - your work hours are reduced; and]
- Your health coverage ceases during a period of disability under the terms of this Plan; and
- [Your health coverage ceases while a monthly LTD benefit is payable under the terms of this Plan; and
- You are not eligible for or entitled to Medicare;
- You are not eligible for coverage under any other group health plan that does not contain a pre-existing condition limitation or exclusion that applies to you;]
- You elect to continue health coverage under [your employer-sponsored] group health plan as permitted under the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA) or State law; and
- You incur out-of-pocket premium expenses as a result of your election to continue health coverage.

The monthly amount of the Group Health Coverage Continuation Allowance will be the lesser of:

- The monthly premium you paid to continue health coverage for you [and any dependents] under [your employer-sponsored] group health plan, as permitted under COBRA or State law; and
- [\$250].

The Group Health Coverage Continuation Allowance reimburses you for premium expenses incurred for monthly periods of health coverage beginning with:

- The month continued health coverage is effective[; or, if later,]
- [The month a LTD benefit is first payable under this Plan;] or
- [The month following the date a LTD benefit is first payable under this Plan.]

The Group Health Coverage Continuation Allowance continues until the first to occur of:

- [The date you become eligible for Medicare (whether or not you become covered);]
- [The date you become eligible for coverage under any other group health plan that does not contain a pre-existing condition limitation or exclusion that applies to you;]
- [The date as of which 6monthly Group Health Coverage Continuation Allowance payments have been made;]
- The date your period of disability under this plan ends for any reason;
- The date continuation of your coverage under [your employer-sponsored] group health plan ends for any reason.

Written proof that out-of-pocket premium expenses were incurred for continued health coverage must be furnished to **Aetna**.

This Group Health Coverage Continuation Allowance benefit is subject to all other conditions, provisions and limitations under this Plan.

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[Spouse] Rehabilitation Benefit

While you are disabled and receiving benefits under the [LTD] Plan, **Aetna** may, at its option, provide services necessary for a rehabilitation program for your [spouse].

To be eligible for this Benefit, the following conditions must be met:

- You must have been continuously disabled for at least [24 consecutive] months.
- [Your spouse's earnings must be 80% or less than your predisability earnings.]
- Your [spouse] must be determined by Aetna to be a suitable candidate for rehabilitation.
- You must be determined by **Aetna** to not be functionally capable of completing any rehabilitation program that would result in your being able to return to work [on a full-time basis].
- You must request this benefit in writing from **Aetna**.

Your [spouse's] rehabilitation program may include payment for the following:

- [Education expenses.
- Job placement expenses.
- Family moving expenses.
- Family care expenses, if you are functionally unable to provide such family care and such care is necessary for your [spouse] to be retrained under the Plan.]

[The Maximum Amount Payable is \$500].

If your [spouse's] earnings are more than [10%] of your [adjusted] predisability earnings as a result of participation in the rehabilitation program, the amount of your LTD Monthly Benefit will be reduced by [80%] of your [spouse's] earnings from participation in the rehabilitation program.

If your [spouse] was already working before the [Spouse] Rehabilitation Benefit begins, and your [spouse's] earnings increase by more than [10%], your LTD Monthly Benefit will be reduced by [80%] of any increase in your [spouse's] earnings that result from participation in the rehabilitation program.

Aetna may withdraw its approval of the rehabilitation program for your [spouse] at any time.

Extended Disability Benefit

An Extended Disability Benefit will be payable if all of the following conditions are met:

- A [monthly] benefit has been payable for a period of disability under the terms of the [LTD] Plan; and
- Your eligibility for disability benefits would otherwise end because you have reached the end of the Maximum Benefit Duration; and
- You continue to be disabled, as defined by the **test of disability**, and suffer a Functional Loss past the end of the Maximum Benefit Duration; and
- You are either:
 - confined as an inpatient in a **skilled nursing facility**; or
 - receiving care under a **home health care plan** or **hospice care program**; and
- You submit to Aetna a written request for the Extended Disability Benefit. Such request must be made within [15 days] of the end of the Maximum Benefit Duration.

Monthly Extended Disability Benefit

The Plan will pay a monthly Extended Disability Benefit equal to [50%] of the [LTD] Monthly Benefit that was payable for the [calendar month] in which you reached the end of the Maximum Benefit Duration. The maximum benefit payable is [\$400]. [Such amount will be reduced by "other income benefits."] No other benefits, additional benefits or benefit increases, as may be described in the Booklet-Certificate, are payable.

Termination of Extended Disability Benefit

The Extended Disability Benefit will end on the first of the following to occur:

- The date **Aetna** finds you are no longer disabled;
- The date **Aetna** determines you no longer suffer a Functional Loss;
- The date you fail to furnish proof that you are disabled and suffer a Functional Loss;
- The date you are no longer confined in a **skilled nursing facility**; or receiving care under a **home health care plan** or a **hospice care program**;
- The date when this Extended Disability Benefit has been payable for [6] months; or
- The date of your death.

Exclusions

No Extended Disability Benefit is payable if any of the following conditions apply:

- Your eligibility for disability benefits ends earlier than the Maximum Benefit Duration due to one or more reasons stated in the *Period of Disability* section of your Booklet-Certificate;
- Your eligibility for disability benefits was limited according to the *Limitations Which Apply to Long Term Disability Coverage* section of your Booklet-Certificate;
- [A monthly benefit was not payable because your disability is caused by a pre-existing condition;]
- Your disability is excluded by any other term of this [LTD] Plan.

Additional Provisions

The sections *If you Become Disabled Again (Successive Disabilities)* and *Converting Your [Disability Coverage]* will cease to apply to you after the end of the Maximum Benefit Duration.

If monthly benefit payments are made in amounts greater than the monthly benefits that you are entitled to receive before the end of the Maximum Benefit Duration, **Aetna** has the right to first apply the Extended Disability Benefit to any such overpayment.

For the purposes of this provision, the following definitions apply:

"Functional Loss" means: that on a given day you meet either of the following tests:

- Due to a physical incapacity resulting from **illness** or **injury**, you are unable to perform (without substantial assistance) at least [two] Activities of Daily Living; or
- Due to a Cognitive Impairment*, you require substantial supervision in order to protect you and others from serious threats to health and safety.

Aetna will make the determination of the Functional Loss.

"Activities of Daily Living" means:

- [Bathing: washing oneself by a sponge bath; or washing oneself in either a tub or shower, including the task of getting into and out of the tub or shower.
- Transferring: Moving into or out of a bed, chair or wheelchair.
- Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Toileting: Getting to and from the toilet, getting on and off the toilet and associate personal hygiene.
- Continence: The ability to maintain control of bowel and bladder functions; and when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), or by a feeding tube or intravenously.]

*"Cognitive Impairment" means: a deterioration or loss in your intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short or long memory; orientation as to person; place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

[Accidental Personal Loss Indemnity Benefit]

The Plan pays a monthly Accidental Personal Loss Indemnity Benefit if, while covered under the LTD Plan, you suffer an accidental **injury** and, within [90] days of the accident and as a direct result of the injury, you lose:

- A hand, by actual severance at or above the wrist joint.
- A foot by actual severance at or above the ankle joint.
- An arm, by actual severance at or above the elbow joint.
- A leg, by actual severance at or above the knee joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.
- Your speech or hearing that is total and deemed permanent. A total loss of speech or hearing will be deemed permanent if the loss has been present for [18] consecutive months, unless an attending **physician** states otherwise.
- [The loss of a thumb and index finger of the same hand, by actual severance of entire digit.]

The Accidental Personal Loss Indemnity Benefit is payable in lieu of the [LTD] Monthly Benefit.

The [monthly] amount of the Accidental Personal Loss Indemnity Benefit is the lesser of:

- the Scheduled [Monthly] Benefit; and
- the Maximum [Monthly] Benefit

as shown in the Booklet-Certificate's *Schedule of Benefits*.

This benefit is not reduced by any "other income benefits" or subject to any other benefit adjustments applicable under the Plan.

The [monthly] Accidental Personal Loss Indemnity Benefit is payable, after the [Waiting Period] ends, for the number of [months] shown in the following Schedule. No benefits accrue or are payable during the [Waiting Period].

Schedule of Accidental Personal Loss Indemnity Benefit	
<u>For Loss of:</u>	<u>Number of Indemnity Payments</u>
Both hands	[12 Months]
Both feet	[12 Months]
Entire sight of both eyes	[12 Months]
Hearing in both ears	[12 Months]
Speech	[12 Months]
One hand and one foot	[12 Months]
One hand and entire sight of one eye	[12 Months]
One foot and entire sight of one eye	[12 Months]
One arm	[12 Months]
One leg	[12 months]
One hand	[12 months]
One foot	[12 months]
Entire sight of one eye	[12 months]
Hearing in one ear	[12 months]
[The Thumb and Index Finger of the same hand, by actual severance of entire digit (a loss of thumb and index finger means a complete severance through or above the metacarpophalangeal joint of both digits.)]	[12 months]

If more than one loss results from any one **injury**, the number of indemnity payments will be limited to those of the loss for which the greatest number of [monthly] payments is provided.

No other benefits, additional benefits, or benefit increases, as may be described in the Booklet-Certificate are payable while the indemnity benefit is payable.

Your disability is deemed to continue while the Accidental Personal Loss Indemnity Benefit is payable. If after the total number of [monthly] indemnity benefits payments have been made, you meet the [LTD] Test of Disability under the terms of the [LTD] Plan, the [LTD] [Monthly] Benefit is payable subject to any remaining Maximum Duration period shown in the *Schedule of Benefits*. All other provisions of the Booklet- Certificate will apply. If after the total number of [monthly] indemnity benefits have been made, you do not meet the [LTD] Test of Disability under the terms of the [LTD] Plan, your disability benefit eligibility will end.

If death occurs after the Accidental Personal Loss Indemnity Benefit is payable, but before the total number of [monthly] benefits have been paid, the remaining monthly indemnity benefit payments will be paid, in a single sum, to your estate. However, **Aetna** may, at its option, pay the balance of such indemnity benefit to any one or more of the following of your surviving relatives: wife; husband; mother; father; child; or children. Any amount so paid will discharge **Aetna's** obligation with respect to the amount of indemnity benefit so paid.

No Accidental Personal Loss Indemnity Benefit is payable if your disability is excluded by any other terms of the [LTD] Plan.

Accelerated Survivor Benefit

[You may request that **Aetna** pay an Accelerated Survivor Benefit if, while a Monthly Benefit is payable under this LTD Plan for at least 12 months, you become **terminally ill** on or after the date you reach age 70.]

[You may request that **Aetna** pay an accelerated Survivor Benefit if, your disability benefit eligibility continues for 365 days, or monthly or weekly equivalent or more and you become **terminally ill**.]

Your request for an Accelerated Survivor Benefit may be submitted to **Aetna** at any time by completing [an **Aetna** request for Accelerated Survivor Benefit Form.] Your request must include the statement of a currently licensed United States **physician** that you are **terminally ill**.

The **physician's** statement must include:

- [All medical test results;
- Laboratory reports; and
- Any other information on which the statement is based, including the generally accepted prognostic protocol used by the **physician** to determine your expected remaining lifespan.]

Upon **Aetna's** approval of such request, **Aetna** will pay to you an amount equal to the Survivor Benefit that would otherwise be payable to an Eligible Survivor upon your death; subject to all of the following terms:

You are considered **terminally ill**.

[The amount of Accelerated Survivor Benefit payable to you will be reduced by an interest charge equal to the sum of daily interest that would have accrued on such amount during the 6 months which begin on the date the Accelerated Survivor Benefit is paid.

The interest rate used to calculate the interest charge will not exceed the current yield on 90-day United States Treasury bills on the date the Accelerated Survivor Benefit payment is requested.]

In considering your request for an Accelerated Survivor Benefit, **Aetna** will take into account the expected remaining duration of your disability payments. **Aetna** may require you, at its expense to submit to an independent medical exam by a **physician** of its choice. **Aetna** may suspend its review of your request until it has received the complete results of the exam.

No Accelerated Survivor Benefit is payable if your disability benefit eligibility ends for any reason before our approval and payment is made.

Upon approval by **Aetna**, the Accelerated Survivor Benefit will be paid to you [in a lump sum.]

You may request an Accelerated Survivor Benefit under this Plan only once. If an Accelerated Survivor Benefit is paid, no Survivor Benefit will be payable upon your death.

Eligibility, Enrollment and Effective Date of Your Coverage

Throughout this section you will find information on who can be covered under the plan, [how to enroll and what to do when there is a change in your life that affects coverage.] [In this section, 'you', 'your' and 'yours' means the [you and your covered dependents] to whom this Booklet Certificate is issued and whose insurance is in force under the terms of this group insurance policy.

Who is Eligible

[Your employer determines the criteria that are used to define the eligible class for insurance coverage under this plan. Such criteria are based solely upon the conditions [related to your employment] [established by your employer.] **Aetna** will rely upon the representation of the employer as to your eligibility for coverage under this plan and as to any fact concerning such eligibility.]

[Employees

To be covered by this plan, the following requirements must be met. You are eligible for coverage under this plan if you are **actively at work** and:

- You are in an eligible class [as defined below] [as determined by your employer];
- You have reached your eligibility date ; and
- You have completed any waiting period or probationary period required by your employer.]

[Probationary Period

Once you enter an eligible class you will need to complete the probationary period before your coverage under this plan begins. The probationary period is [XXXXXX months] of continuous service that you must satisfy with your employer following the date you are hired or following the date you enter an eligible class.]

[Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer, who is scheduled to work [XX] hours per week on a regular basis; and
- You are a part-time, temporary, or seasonal employee, as defined by your employer, and if such coverage is selected by your employer, who is scheduled to work [XX] hours per week on a regular basis; and who is scheduled to work 52 calendar weeks in 12 consecutive calendar months; and
- You are a member in good standing of Local [XXX] of [XXX] union; and

- You are in a job class covered under a collective bargaining agreement between the employer and the association, and your employer is required to pay monies to the policyholder for the purchase of group insurance for those in this job class; and
- You are a member of a collective bargaining unit with which your employer has entered into a collective bargaining agreement; and
- You are a member of [XXX] association; and
- You work or reside in [XXXX], and the plan's **service area**.
- You are employed at your employer's [XXXX] location;
- You are employed at one of the following subsidiaries or divisions of the employer sponsoring this plan:
 - Name of subsidiary or division
 - Name of subsidiary or division.
- You are a resident of the state of [XXXX] and within the **service area** of an **Aetna** HMO based plan sponsored by your employer; and
- You have not elected coverage under an **Aetna** HMO based plan.
- You are a retired employee of an employer participating in this plan, and you:
 - Retired before the effective date of this plan and were covered under the prior plan for life insurance and health care coverage on the day before you retired; or
 - Retired before the effective date of this plan;
 - Are a legal resident of the state of [XXXX]; and
 - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
 - Have completed [XX years] of service and are age [XX] or over.
 - Retire under your employer's IRS-qualified retirement plan.
- You are the severed employee of an employer participating in this plan for the severance period agreed upon by you and that employer.
- You are a full-time or part-time seasonal employee who is not otherwise eligible to participate in any health and welfare plan sponsored by your employer.
- You are working within the United States, Canada; or
- You are working within the United States, or assigned to work outside the United States for less than one month, you must remain on the United States payroll.]

[You are not in an eligible class for Life Insurance coverage if you have reached age [XX].]

[In addition, to be in an eligible class you must be:

- Scheduled to work on a regular basis at least [XX] hours per week during your employer's work week; and
- Working within the United States.]

[If you are or become subject to any temporary disability or cash sickness benefits act or like law of any jurisdiction, you will not be eligible for benefits payable on a weekly basis.]

[Eligibility For Life Insurance if Permanently and Totally Disabled

You may remain eligible for Life Insurance coverage, subject to change or termination as provided elsewhere in the group contract, if your employer determines that, prior to reaching age 65, you have become permanently and totally disabled, if the total disability starts:

- While you are insured; and
- On or after the date this subsection applies to you; and
- Before you retire; and
- Your employer continues premium payments for this coverage.

This eligibility ceases at the first to occur of:

- The date your employer determines that you are no longer permanently and totally disabled; and
- The date you reach age 65.

Report a disease or **injury** to your employer as soon as you can. Your employer will help you determine if you qualify.]

[Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of your plan, your eligibility date is the later of:

- The date you complete [XXX months] of continuous service with your employer; and
- The effective date of the plan. This is defined as the probationary period.

If you have already satisfied the probationary period with your employer before you enter the eligible class, your eligibility date is the date you enter the eligible class.

After the Effective Date of the Plan

If you are in an eligible class on the date of hire, your eligibility date is [the date you are hired] [the date you complete [XX months] of continuous service with your employer. This is defined as the probationary period].

If you enter an eligible class after your date of hire, your eligibility date is the date you complete [XX months] of continuous service with your employer. This is defined as the probationary period. If you have already satisfied the probationary period with your employer before you enter the eligible class, your eligibility date is the date you enter the eligible class.]

[Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows:

If you are in an eligible class on the effective date of this plan, and you had previously satisfied the plan's probationary period, your coverage eligibility date is the effective date of this plan.

If you are in an eligible class on the effective date of this plan, but you have not yet satisfied the plan's probationary period, your coverage eligibility date will be the 15th day of the month next following the date you complete the Plan's probationary period.

If you are hired or enter an eligible class on or after your date of hire, your coverage eligibility start date is the 15th day of the month next following the date you complete this plan's probationary period.

If you had already satisfied this Plan's probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.]

Continuing Life [and Accidental Death & Personal Loss] Insurance Coverage

You may continue this insurance coverage [for you and your dependents] if coverage ends because one of the following:

- [You voluntarily end your employment;]
- Your employment ends involuntarily, except due to gross misconduct; or
- Your employment has not ended, but you are no longer in an eligible class [because of an involuntary reduction in hours worked].

Any reduction rules due to retirement or age will apply. [The premium contribution may change for any insurance in force for you or your dependents under this provision on the date continuation begins.] To elect coverage under this provision, you will need to make a written request [and pay the first premium contribution] within [31] days from the date when your insurance would otherwise end.

If you elect coverage as described above, your coverage begins on the date your insurance would have ended.

In no event will the terms of this provision apply if:

- [Your employment ended because you retired;
- You were covered under the group policy for less than one year;
- Your or your dependent's life insurance has been continued by the plan's *Life Insurance Portability Provision*;
- You are a severed employee whose insurance ends due to the end of the severance period.
- Your or your dependent's life insurance coverage has been converted to an individual policy in accordance with the life plan's conversion privilege.]

This insurance will not be continued beyond whichever of the following events occurs first:

- The end of a [3] month period, which starts on the date when your coverage would otherwise end.
- The date you become covered for any group life insurance under another group policy, whether issued by **Aetna** or another insurance company.
- [You do not make any required contributions.]
- The date the group policy terminates in its entirety or as to this continuation coverage.

[Coverage for a dependent will not be continued beyond the date it would otherwise terminate.]

[If your life insurance coverage ends under the terms of this provision, it may be:

- Converted as described in *Converting to an Individual Life Insurance Policy* section; or
- Provided as described in the *Life Insurance Portability* section.]

[Continuing Short Term or Long Term] Disability Insurance Coverage

Continuation of Coverage during a Leave of Absence

Your coverage will be continued during a [sabbatical leave for training and educational purposes and military leave], providing you meet the following requirements:

- Your leave is approved by [your Employer] and is scheduled to last less than [3 months];
and
- Your written request for continuation of coverage under this plan is approved by **Aetna**;
and
- Your premium continues to be paid.

If [your Employer] grants you an approved Leave of Absence for a period in excess of the period shown above, any continuation of coverage during that excess period will be subject to prior written agreement between **Aetna** and [your Employer].

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date [your Employer] determines your approved Leave of Absence is terminated.
- The date the coverage involved discontinues as to your eligible class.
- The date the Group Policy terminates.

If you become disabled, predisability earnings will have the same meaning as the definition found in the *Glossary*, except that it will be determined as of the [day] before your leave started.

[If your coverage is continued during a military leave of absence, this Plan does not cover any disability which is caused by or arises out of active duty in the military service, including, but not limited to war or act of war (whether declared or undeclared). Any other exclusions listed in the *Exclusions that Apply to Long Term Disability* provision also apply while coverage is continued.]

Converting Your [Disability Coverage]

Eligibility

You may be eligible to convert the [monthly benefits of your managed disability] [long term disability] coverage to a group conversion policy [if coverage under your group plan ends because you terminate your employment.]

To qualify, you must:

- Have been insured under [your employer's] group plan for [24] consecutive months immediately prior to [employment termination]. To determine your eligibility to convert, the length of time that you were covered under the plan and any other plan of [your employer's] will be considered; and
- Apply for conversion coverage in writing and submit the first premium payment to **Aetna** within [30] days after your coverage under the group plan ends.

[You will not need to submit evidence of good health to convert to the conversion policy.]

[You can become insured for an amount of disability coverage in excess of \$2,000 only if you submit evidence of good health at your own expense to **Aetna** and such evidence is approved by **Aetna**.]

Features of the Conversion Policy

The amount of disability coverage and the benefit features in your conversion policy will not be the same as the coverage and features in [your employer] group plan.

The converted coverage for [long term disability] [managed] disability benefits and the amount of disability coverage you will be eligible for will be those offered by **Aetna**, [in accordance with its established guidelines and practices] at the time of your application.

When Coverage Under The Group Conversion Policy Becomes Effective

Your policy will begin after **Aetna** has processed your completed application and your premium payment. Coverage under the group conversion policy will take effect on the day after coverage under this plan ended.

Your Premiums and Payment

Premium cost for the converted policy will be **Aetna's** customary rates in effect at the time the policy is issued for like classes of individuals. You will be responsible for making premium payments on a timely basis.

Limitations

Conversion rights are not available under this plan if:

- You were not covered under the [managed disability] [long term disability] plan for [24] consecutive months. To determine your eligibility to convert, the length of time that you were covered under the plan and any other [managed disability] [long term disability] plan offered by [your employer] will be considered;
- Coverage under the group plan stopped for any of the following reasons:
 - [Your employer's group plan terminates.
 - The group plan is amended to exclude the class of employees to which you belong.
 - You no longer are in a class of employees eligible for coverage under the plan.
 - You retire under your employer's retirement plan.
 - You fail to make any required contribution when due.
 - Your certified disability ends and you do not return to work with the employer.
 - You are unable to work due to a mental or physical condition.
 - You are on leave of absence.]
- You become covered for [long term disability] [managed disability] coverage under another [employer's] group plan within 31 days of when your group plan ends.

[Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.]

[Occurrence

This means a period of **illness** or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for an **illness** or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for an **illness** or **injury**.]

[Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.]

[Other Health Care

A health care service or supply that is neither **Network Service(s) or Supply(ies)** nor **Out-of-Network Service(s) and Supply(ies)**. **Other health care** can include care given by a provider who does not fall into any of the categories in your provider **directory** (or in DocFind® at Aetna's web site).]

[Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP** or **PCD**; or
- Not **other health care**.]

[Out-of-Network Provider

A health care provider, a **pharmacy** or **dental provider** who has not contracted with **Aetna** to furnish services or supplies at a **negotiated charge.**]

[Own Occupation

For employees in an own-specialty class: This is the occupation that you are routinely performing when your period of disability begins. If your occupation is limited to a recognized specialty within the scope of your degree or license, your specialty will be deemed to be your occupation.

For all other classes of employees:

The occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- For your specific employer; or
- At your location or work site; and
Without regard to your specific reporting relationship.]

[Own Occupation (Physician)

If you are a **physician, own occupation** means the general or sub-specialty in which you are practicing when your disability begins, for which:

- There is a specialty or sub-specialty recognized by the American Board of Medical Specialties or;
- You are a member of a board recognized by the American Dental Association.

If the specialty or sub-specialty in which you are practicing is not so recognized, **Aetna** will consider you to be practicing in the general specialty category.]

[Own Job

This is the job that you are routinely performing when your period of disability begins. Your job will be viewed as it is normally performed for your specific employer but without regard to your specific reporting relationship, location or work site.]

[Partial Confinement Treatment]

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**. The plan must meet these tests:

- It is carried out in a **hospital; psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.]

[Partial Disability Employment Program]

A period of part-time work at your **own occupation** or a **reasonable occupation** that is not expected to result in your return to full-time work. This may also be a period of part-time or full-time work at other than a **reasonable occupation**. **Aetna** must review the program and approve it in writing.

A **partial disability employment program** will cease to be an approved **partial disability employment program** on the earliest to occur of:

- The date you are able to perform the **material duties** of your **own occupation** or work at any other **reasonable occupation**;
- The date you begin an **Approved Rehabilitation Program**; or
- The date **Aetna** withdraws, in writing, its approval of the program.]

[Passenger Restraint]

This is a restraint that is:

- An unaltered seat belt or lap and shoulder restraint installed by the manufacturer of the **motor vehicle**; or
- A seat belt or lap and shoulder restraint:
 - Provided by the manufacturer of the **motor vehicle**; and
 - Installed by an authorized **motor vehicle** dealer; and
- Any child restraint device that is properly secured in the **motor vehicle** and meets the definition of the law of the state in which the **motor vehicle** is licensed and registered.]

[Pharmacy]

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.]

[Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition; and
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, a **mental disorder**, or a **serious mental illness**.
- A **physician** is not you or related to you.

For the purposes of Short Term Disability and Long Term Disability coverage, regular care of a **physician** means you are attended by a **physician** who:

- Is not you or related to you;
- Is practicing within the scope of his or her license;
- Has the medical training and clinical expertise suitable to treat your disabling condition;
- Specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- Whose treatment is:
 - Consistent with the diagnosis of the disabling condition;
 - According to guidelines established by medical, research and rehabilitative organizations; and
 - Administered as often as needed.]

[Precertification, Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.]

[Predisability Earnings]

[The amount of salary or wages you were receiving from an employer participating in this Plan on the [Month & Day] that precedes the date a period of disability started, calculated on a monthly basis. If not employed on the preceding [Month & Day], it is the monthly amount of salary or wages you were receiving from an employer participating in this Plan on your date of hire.

Your predisability earnings will be figured from the rule below that applies to you.

- 1) If you are paid on an annual salaried basis, your monthly salary is [1/12th of your annual salary.] [your annual salary divided by the number of months you were scheduled to work (excluding summer break).]
- 2) If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate less shift differential multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.
- 3) If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 173 hours per month.

Included in salary or wages are:

- Monthly average of commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of awards and bonuses paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of differential pay paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12-60 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of overtime pay based on the average number of overtime hours worked [over the last three months of actual employment or such shorter period if actual employment was for fewer than 3 months [during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years), but not more than 10 hours].
- The amount of net tips you report to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form) averaged over the last three full months of actual employment or such shorter period if actual employment was for fewer than three full months.

- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[This is one-twelfth of the amount of salary or wages you received from an employer participating in this plan for the last two full calendar years before a period of disability started. If you were not employed for all of the last two full calendar years, it will be the average monthly salary or wages for the last 12 months before the period of disability started. If you were not employed for all of the last 12 months, it will be the average monthly salary or wages for the months employed.]

Included in salary or wages are:

- Commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw.
- Awards and bonuses.
- Differential pay.
- Overtime pay based on the average number of overtime hours worked, but not more than 10 hours.
- Net tips reported to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form).
- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[For purposes of the following definition, the determination period is the [Month & Day through Month & Day that precedes the date your disability started.]

- [one month or week equivalent period ending on the Month & Day that precedes the date your disability started.]
- [last one monthly or weekly equivalent pay period ending on the Month & Day that precedes the date your disability started.]

Predisability Earnings is the monthly average of the amount of salary or wages you received from an employer participating in this plan for the determination period. If you were not employed during all of the determination period, it will be the average monthly salary or wages for the last one month or equivalent weeks before the period of disability started. If you were not employed for all of the last one month or equivalent weeks, it will be the average monthly salary or wages for the months employed.]

Included in salary or wages are:

- Commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw.
- Awards and bonuses.
- Differential pay.

- Overtime pay based on the average number of overtime hours worked, but not more than 10 hours.
- Net tips reported to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form).
- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[This is one twelfth of the amount of ["Medicare Wages"] [Wages, tips, other compensation] reported by your employer on Internal Revenue Service Form W-2, Wage and Tax Statement, for the last full calendar year before a period of disability started. If you were not employed for all of the last two full calendar years, it will be the average monthly income for the last 12 before the period of disability started. If you were not employed for all of the last 12 months, it will be the average monthly income for the months you were employed.]

Added to your W-2 salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

[The following is for sole proprietor, partners, members of a limited liability company taxable as a partnership under the Federal income tax laws, or shareholders in an S-Corporation.]

[This is one-twelfth of the amount of salary or wages reported as "net earnings from self-employment" for Federal income tax purposes from your Employer for the last two full tax years before a period of disability started (as shown on Internal Revenue Service Schedule K-1, Form 1065, or its successor form). If you were not employed for all of the last two full tax years, it will be the average net earnings from self-employment for the last 12 months before the period of disability started. If you were not employed for all of the last 12 months, it will be the average net earnings from self-employment for the months employed.]

Included in salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

[The following applies to employees with an ownership interest in the employer participating in this plan such as sole proprietor, partners, members of a limited liability company taxable as a partnership under the Federal income tax laws, or shareholders in an S-Corporation.]

This is one-twelfth of your salary or wages determined by adding the following amounts as reported on the applicable Internal Revenue Service Schedule K-1, Schedule C, Form W-2, or S-Corporation Federal income tax return or any successor form or schedule, for the last two full tax years before a period of disability started]

- Your ordinary income (loss) from trade or business activities.
- Your guaranteed payments, if you are a partner.
- Net earnings from self-employment.
- Your compensation (as an officer), salary, or wages, if you are an S-Corporation shareholder.

If you did not have ownership interest for all of the last two full tax years, it will be your average earnings for the number of months, up to 12, that you were a sole proprietor, partner, member of a limited liability company, or an S-Corporation shareholder.

Included in salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

Salary or wages do not include:

- § [Commissions, Awards and Bonuses, Overtime Pay, Shift Differential Pay, Tips.
- § Commissions, awards, and bonuses received during the calendar year in which your disability started.
- § Overtime pay in excess of 10 hours.
- § Payments under any stock option plan or similar equity program.
- § Payments made for unused paid time off.
- § Sign-on bonuses or any other payment made upon acceptance of employment with the Employer.
- § Any non-cash compensation.
- § Severance.
- § Salary continuation payments or benefits.
- § Lump sum vacation payments.
- § Transfer or relocation payments.
- § Travel and entertainment expenses.
- § Tuition reimbursement.
- § Any stay or retention bonus.
- § Any bonus which is paid pursuant to a deferral agreement or program.
- § Taxable cost of group term life or disability insurance.
- § Dividends, capital gains, and returns of capital
- § Fringe benefits.
- § Contributions made by your employer to any deferred compensation arrangement or pension plan.
- § Extra compensation such as payments for revenue sharing, housing allowances, stipends, relocation incentives or buyouts of unused vacations, professional fees, non qualified income.]

[A retroactive change in your rate of earnings will not result in a retroactive change in benefits/coverage.

In no event will a change in your salary or wages be considered if it occurs:

- On or after the date a period of disability started
- On or after the determination period
- Between separate disabilities which are considered one disability under the *If You Become Disabled Again* section.]

[Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.]

[Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.]

[Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.]

[Primary Care Dentist (PCD)

This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Dentists** in the **directory**;
- Supervises, coordinates and provides initial care and basic dental services to a person;
- Initiates **referrals** for **specialist dentist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **primary care dentist**.

If you do not choose a **PCD**, **Aetna** will have the right to make a selection for you. You will be notified of the selection.]

[Primary Care Physician (PCP)]

This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
- Initiates **referrals** for **specialist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **PCP**.]

[Psychiatric Hospital]

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.]

[Psychiatric Physician]

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.]

[Reasonable Occupation]

This is any gainful activity for which you are, or may reasonably become, fitted by education, training, or experience and which results in, or can be expected to result in:

- A substantial income as determined by the Social Security Administration; or
- An income of more than:
 - 40% of your **adjusted predisability earnings**
 - your **adjusted predisability earnings** multiplied by the Scheduled Monthly LTD Benefit percentage or, if less,
 - the amount of the Maximum Monthly Benefit.]

[Recognized Charge]

Only that part of a charge which is less than or equal to the **recognized [charge]** is a **covered benefit**. The **recognized [charge]** for a service or supply is the lowest of

- The provider's usual charge for furnishing it; and
- 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, billed or coded; or

[a.for non-facility charges:] [**Aetna** uses [50% of] the [Medicare Resource Based Relative Value Scale (RBRVS)] [**Aetna** Market Fee Schedule (AMFS)] [**negotiated charge**] [Provider charge data from the [Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 50th percentile of PHCS data. This PHCS data is generally updated at least every six months. [charge **Aetna** determines to be the prevailing charge level made for it in the geographic area where it is furnished].]

[b.for facility charges: **Aetna** uses [50% of the [average of the] [**Aetna** Market Fee Schedule (AMFS)] [**negotiated charge**] [**Aetna** Facility Fee Schedule [for the geographic area where the service is furnished] [for the state of issuance of the **Aetna** Group Policy]] [the charge **Aetna** determines to be the usual charge level made for it in the geographic area where it is furnished].]

- [The charge **Aetna** determines on an annual basis to be at the 50th Percentile made for that service or supply.]
- [For **prescription drugs**: 50% of the [**Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons] [Medi-Span weekly price updates (or any other similar publication chosen by **Aetna** on the day that a **pharmacy** claim is submitted for adjudication.)]
- [As to Dental Expense Insurance, the charges **Aetna** determines on an annual basis to be at the 90th percentile of the Medicare Medical Data Research Tables.]

In determining the **recognized [charge]** for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic area;

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the **provider**;
- [The range of services or supplies provided by a facility;] and
- The **recognized charge** in other geographic areas.

[In some circumstances, **Aetna** may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.]

[As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.]

[Referral]

This is a written or electronic authorization made by your **Primary Care Physician (PCP)** or **Primary Care Dentist (PCD)** to direct you to a **network provider**, for **medically necessary** services or supplies covered under the plan.]

[Referral Care]

Covered services given to you by a **specialist dentist** who is a **network provider** after **referral** by your **primary care dentist** and provided **Aetna** approves coverage for the treatment.]

[Rehabilitation Facility]

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.]

[Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.]

[Rehabilitation Training Program

A program of physical, mental or vocational rehabilitation which:

- Is expected to result in maximizing your employability with your Employer; and
- Is designed to assist you to return to your **own occupation** or to any **reasonable occupation** with your employer which you are, or may reasonable become fitted for by completion of a rehabilitative training program.
- Provides access to at least weekly sessions with a **psychiatric physician** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Is managed by a licensed **behavioral health provider** who functions under the direction and supervision of a **psychiatric physician**.]

[Residential Treatment Facility (Alcoholism and Drug Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an **R.N.** or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours perday/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours/7 days a week.]

[Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an **R.N.** or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy;
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.]

[R.N.

A registered nurse.]

[Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.]

Aetna Life Insurance Company
[Short Term] Disability [Income] Coverage Plan
Schedule of Benefits]

PLAN FEATURES

[Waiting Period]

[Benefits start after the 91st calendar day.]

[Benefits start after the 91st calendar day] for a disability period due to **illness** or a disabling pregnancy-related condition. Benefits start after the 91st calendar day for a disability period due to **injury**.]

[Benefits start after the greater of:

- The 91st calendar day of a disability; or
- The time period that disability benefits are payable from any of the following benefit programs sponsored by your employer: any short term disability benefits, with the exception of any statutory disability benefits; accumulated sick time or salary continuation; or
- The day following the time period when salary or wages are paid, in whole or in part, for sick, vacation and personal leave under the paid time-off program sponsored by your Employer.

[Benefits start after the later to occur of:

- The first day following the expiration of the 91st calendar day of a disability; or
- The first day following the day you are scheduled to return to work after summer break.]

[If a certified disability due to **illness**], disabling pregnancy-related condition or **injury**] continues for 60 days or longer, benefits will start retroactively to the 30th calendar day.]

[If you are a full-time inpatient in a **hospital**, no waiting period will apply to the day of confinement or any day thereafter for the certified disability. In addition, if you undergo surgery which does not require a **hospital** confinement, no waiting period will apply to the day of surgery or any day thereafter for a certified disability.]

Schedule of [Short Term] Disability [Income] Benefits	
Weekly Benefit	
[Classification]	[Weekly Benefit][Amount You Receive*]
[Hourly] [Salaried] [All other employees]	[30% of your weekly predisability earnings [up to \$50 plus 30% of your weekly predisability earnings in excess of \$25,000]
[Hourly] [Salaried]	[\$50] [\$50]

[Schedule of Benefits]

Schedule of [Short Term] Disability [Income] Benefits (continued)	
[Hourly] [Salaried] [All other employees]	[\$50 per week*] [30% of your predisability earnings] [\$50]
[Maximum Weekly Benefit (weekly benefits plus all other Income benefits)]	[\$100]
[Minimum Weekly Benefit]	[\$25]

[Maximum Weekly Benefit Period]	[4 weeks, after any elimination period, unless it ends earlier for one or more of the reasons stated in your Booklet-Certificate.]
--	--

[*Your weekly benefit amount may not be more than 40% of your **predisability earnings**. At any time that other Income benefits are payable, your weekly benefit amount may be reduced when it is combined with other Income benefits, so the total does not exceed more than 40% of your **predisability earnings**. For additional information regarding other income benefits, see your Booklet-Certificate.]

[*For time lost from work, the benefits amount will be reduced by the eligible weekly amount under any worker's compensation or other similar law.]

[You may elect any one of the available options shown above for Short Term Disability Income Coverage. If you want to make a change, your employer will provide you with the information on how and when changes can be made.]

[**Evidence Requirements**]

Refer to your Booklet-Certificate for information about when evidence of good health is required and what your responsibilities are to provide this information to **Aetna**.

[You can become insured for Disability Coverage for an amount in excess of \$100 or 40% of your **predisability earnings** only if you submit evidence of insurability at your own expense to **Aetna** and such evidence is approved by **Aetna**.]

[If you elect to increase your Disability Coverage by more than \$25 or 5% of your **predisability earnings** or [one level, you can become insured for the new amount only if you submit evidence of insurability at your own expense to **Aetna** and such evidence is approved by **Aetna**. This applies even if **Aetna** has approved evidence of your insurability in the past.]

[Schedule of Benefits]

[If, on the Effective Date of this plan, you elect to increase the amount of your Short Term Disability coverage that was in effect under prior coverage by more than \$25 or 5% of your **predisability earnings** or one level, you can become insured for the new amount only if: you submit evidence of insurability, at your own expense, to **Aetna**; and such evidence is approved by **Aetna**. This applies even if **Aetna** has approved evidence of your insurability in the past.]

[Benefits Actually Payable

Any weekly benefit actually payable to you by **Aetna** will be reduced by other income benefits. For additional information regarding other income benefits, see your Booklet-Certificate.]

General

This *Schedule of Benefits* replaces any similar *Schedule of Benefits* previously in effect under your plan of long term disability benefits. Requests for coverage other than that to which you are entitled in accordance with this *Schedule of Benefits* cannot be accepted. This Schedule is part of your Booklet-Certificate, and should be kept with your Booklet-Certificate. Coverage is underwritten by Aetna Life Insurance Company.

Aetna Life insurance Company
[Long Term] Disability [Income] Coverage Plan
[Schedule of Benefits]

PLAN FEATURES

[Waiting Period]

[Benefits start after [15 months] (or equivalent days or weeks) of a certified disability.]

[Benefits start after [460] calendar days of a certified disability due to **illness** or a disabling pregnancy-related condition. Benefits start after [460] calendar days of a certified disability due to **injury**.]

[Benefits start after the greater of:

- First 12 months of a certified disability; or
- The time period that disability benefits are payable from any of the following benefit programs sponsored by your employer: any short term disability benefits, with the exception of any statutory disability benefits; accumulated sick time or salary continuation.
- The time period when salary or wages are paid, in whole or in part, for sick, vacation and personal leave under the paid time-off program sponsored by your Employer.]

[Benefits start after the later to occur of:

- The first day after the expiration of the first 460 calendar days of a certified disability; or
- The first day after you are scheduled to return to work after summer break.]

[If a certified disability due to **[illness]**, a disabling pregnancy-related condition or **[injury]** continues for 60 days or longer, benefits will start retroactively to the 30th calendar day.]

[If you are a full-time inpatient in a **hospital**, no waiting period will apply to the day of confinement or any day thereafter for the certified disability. [In addition, if you undergo surgery which does not require a **hospital** confinement, no waiting period will apply to the day of surgery or any day thereafter in the same certified disability.]

[Scheduled Monthly Benefit]	[30% of your monthly predisability earnings up to \$400 but not more than 30% or your monthly predisability earnings in excess of \$400]
[Classification] [Hourly] [Salaried] [All other employees]	[Amount You Receive] 30%- of your predisability earnings calculated on a monthly basis [\$200]
[Hourly] [Salaried] [All other employees]	[\$200] [\$200] [\$200]
[Hourly] [Salaried] [All other employees]	[\$200 per month [30% of your predisability earnings]

[Schedule of Benefits]

[Secondary Governmental Benefits Limit]	[30% of your predisability earnings]
[Non-duplication Limit]	[30% of your predisability earnings]
[Maximum Monthly Benefit Under this Plan (plus all other Income benefits)]	[\$400]
[Minimum Monthly Benefit:]	[\$50] [The greater of: (a) \$100; and (b) 10% of your scheduled monthly benefit or, if less, 10% of the maximum monthly benefit]

[You may elect coverage under any one of the available options shown above for Long Term Disability Income Coverage. If you want to make a change, your employer, will provide you with the information on how and when changes can be made.]

[Evidence Requirements]

Refer to your Booklet-Certificate for information about when you will be required to submit **evidence of good health** and what your responsibilities are to complete and submit this information to **Aetna**.

[You can become insured for Disability Coverage for an amount in excess of \$500 and 40% of your **predisability earnings** only if you submit evidence of good health at your own expense to **Aetna** and such evidence is approved by **Aetna**.]

[If you elect to increase your Disability Coverage by more than \$100 and 5% of your **predisability earnings** and 1 level, you can become insured for the new amount only if you submit evidence of good health at your own expense to **Aetna** and such evidence is approved by **Aetna**. This applies even if **Aetna** has approved evidence of your good health in the past.]

[If, on the Effective Date of this plan, you elect to increase the amount of your Long Term Disability coverage that was in effect under prior coverage [by more than \$100 and 5% of your **predisability earnings** and 1 level, you can become insured for the new amount only if: you submit evidence of good health, at your own expense, to **Aetna**; and such evidence is approved by **Aetna**. This applies even if **Aetna** has approved evidence of your good health in the past.]

[Benefits Actually Payable]

Any monthly benefit actually payable to you by **Aetna** [will] be reduced by other income benefits. For additional information regarding other income benefits, see your Booklet-Certificate.]

[Schedule of Benefits]

[Maximum Benefit Duration]

Unless your certified disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your maximum benefit duration is [3 months] after the waiting period is met.

If your certified disability starts prior to your [60th] birthday, it will end when the first of the following events occurs:

- After 24 months of disability after the waiting period is met; and
- The day of your 62nd birthday.

If your certified disability starts on or after your 60th birthday, it will end with the expiration of the number of months of disability, after the waiting period is met, based on the following schedule:

Maximum Benefit Duration Schedule	
Age When Period of Disability Starts	Months of Disability
60 but less than 61	21 months
61 but less than 62	18 months
62 but less than 63	15 months
63 but less than 64	12 months
64 but less than 65	12 months
65 but less than 66	12 months
66 but less than 67	12 months
67 but less than 68	12 months
68 but less than 69	12 months
69 and over	12 months]

[Your disability, which is due to the same or related causes, will end when the later of the following events occur:

- The calendar month when you reach normal retirement age, as determined by the 1983 Amended Social Security Normal Retirement Age; or
- When the total number of months for disability is reached, after the waiting period is met as figured from the following Schedule. This is only if your disability period starts on or after your 60th birthday.
- The expiration of the number of months of disability, after the waiting period is met as figured from the following Schedule, if your disability starts on or after the date you reach age 60.]

[Schedule of Benefits]

Maximum Benefit Duration Schedule	
Age When Period of Disability Starts	Months of Disability
60 but less than 61	21 months
61 but less than 62	18 months
62 but less than 63	15 months
63 but less than 64	12 months
64 but less than 65	12 months
65 but less than 66	12 months
66 but less than 67	12 months
67 but less than 68	12 months
68 but less than 69	12 months
69 and over	12 months]
[1983 Amended Social Security Normal Retirement Age	
Year of Birth	Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 to 1954	66]
[1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67]

[Unless your certified disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your coverage will end[on the day of your 62nd birthday].

[Schedule of Benefits]

[Maximum Benefit Duration

Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your disability will end when the later of the following events occur:

- You reach age 65-; and
- You reach normal retirement age, as determined by the 1983 Amended Social Security Normal Retirement Age; and
- The expiration of the number of months of disability, after the waiting period is met, as figured from the following Schedule, if your disability starts on or after the date you reach age 60]:

[Maximum Benefit Duration Schedule	
Age When Disability Starts	Months of Disability (after the waiting period is met)
60 but less than 61	60 months
61 but less than 62	48 months
62 but less than 63	36- months
63 but less than 64	24 months
64 but less than 65	12 months
65 but less than 66	12 months
66 but less than 67	12 months
67 but less than 68	12 months
68 but less than 69	12 months
69 and over	12 months]

[1983 Amended Social Security Normal Retirement Age	
Year of Birth	Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 to 1954	66]
[1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67]

[Schedule of Benefits]

[Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your maximum benefit duration is: 3 after the waiting period is met.]

[Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your maximum benefit duration is based on the following schedule:

- If your disability starts before the date you reach age 60, your disability will end when you reach age 65.
- If your disability starts before the date you reach age 60, your disability will end 3 months after the waiting period is met.
- If your disability starts between the date you reach age 60 and the date you reach age 61, your disability will end 3 after the waiting period is met.
- If your disability starts between the date you reach age 60 and the date you reach age 61, your disability will end when you reach age 65.
- If your disability starts on or after the date you reach age 61, your disability will end 3 months after the waiting period is met.
- If your disability starts on or after the date you reach age 61, your disability will end with the expiration of the number of months of disability, after the waiting period is met, as figured from the following Schedule:

Maximum Benefit Duration Schedule	
Age When Disability Starts	Months of Disability (after the waiting period is met)
61 but less than 62	12 months
62 but less than 63	12 months
63 but less than 64	12 months
64 but less than 65	12 months
65 but less than 66	12 months
66 but less than 67	12 months
67 but less than 68	12 months
68 but less than 69	12 months
69 and over	12 months]

[Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate, your maximum benefit duration is based on the following schedule:

[Schedule of Benefits]

Maximum Benefit Duration Schedule	
Age When Disability Starts	Months of Disability (after the waiting period is met)
Less than 60	24 months
60 but less than 61	12 months
61 but less than 62	12 months
62 but less than 63	12 months
63 but less than 64	12 months
64 but less than 65	12 months
65 but less than 66	12 months
66 but less than 67	12 months
67 but less than 68	12 months
68 but less than 69	12 months
69 and over	12 months]

General

This *Schedule of Benefits* replaces any similar *Schedule of Benefits* previously in effect under your plan of long term disability benefits. Requests for coverage other than that to which you are entitled in accordance with this *Schedule of Benefits* cannot be accepted. This Schedule is part of your Booklet-Certificate, and should be kept with your Booklet-Certificate. Coverage is underwritten by Aetna Life Insurance Company.]

<i>SERFF Tracking Number:</i>	<i>AENX-125689898</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39265</i>
<i>Company Tracking Number:</i>	<i>DI AR0032301F01</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>2008 Group Insurance</i>		
<i>Project Name/Number:</i>	<i>2008 Group Insurance/DI AR0032301F01</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-125689898 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 39265
Company Tracking Number: DI AR0032301F01
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: 2008 Group Insurance
Project Name/Number: 2008 Group Insurance/DI AR0032301F01

Supporting Document Schedules

Bypassed -Name: Application **Review Status:** Approved-Closed 06/13/2008
Bypass Reason: not applicable
Comments:

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 06/13/2008
Comments:
Attachments:
AR - READABILITY CERTIFICATION.PDF
AR - NAIC TRANSMITTAL DOC.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Aetna Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GR-9N 05-010 03	49.3
GR-9N 05-080 01	57.3
GR-9N 05-085 01	35.5
GR-9N 06-010 03	52.9
GR-9N 06-050 02	35.5
GR-9N 06-090 02	45.5
GR-9N 06-105 02	42
GR-9N 06-140 01	51
GR-9N 06-145 01	31.1
GR-9N 06-150 01	31.6
GR-9N 06-155 01	47
GR-9N 06-160 01	42.3
GR-9N 06-165 01	20.5
GR-9N 29-005 03	40.6
GR-9N 31-010 03	43.7
GR-9N 31-035 02	40.5

STATE OF ARKANSAS
READABILITY CERTIFICATION

Form Number	Score
GR-9N 34-075 02	46.7
GR-9N 34-080 04	40
GR-9N 34-090 03	39.5
GR-9N S-04-01 03	0
GR-9N S-05-01 03	0

Signed: _____

Name: _____

Title: _____

Date: _____

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT		001	60054	06-6033492	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	DI AR0032301F01
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7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H11G Group Health - Disability Income
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10. Product Coding Matrix Filing Code	H11G.005 Combined Short Term and Long Term
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11. Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	
	These forms are new, and do not replace any forms previously submitted to your Department. They are in final form, rather than being drafts or proofs. The forms included in this submission represent various changes to our group disability income products and are intended to afford Aetna the flexibility to offer group disability income plans with features currently being offered in the marketplace by its competitors. Some of the changes involve the "test" of disability, waiting period, earnings definition and addition of a number of supplemental benefits.	

16.	Certification (If required)	
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u> .		
Print Name <u>John Ciesielski</u> Title <u>Product and Regulatory Affairs Manager</u>		
Signature _____ Date _____		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		DI AR0032301F01
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Short Term Disability Benefit Eligibility	GR-9N 05-010 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Organ Transplant Benefit	GR-9N 05-080 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Approved Rehabilitation Benefit	GR-9N 05-085 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Test of Disability	GR-9N 06-010 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Approved Rehabilitation Program	GR-9N 06-050 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Survivor Benefit	GR-9N 06-090 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	Benefit Escalator	GR-9N 06-105 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08	Child/Family Dependent Care Benefit	GR-9N 06-140 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09	Group Health Coverage Continuation Allowance	GR-9N 06-145 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10	Spouse Rehabilitation Benefit	GR-9N 06-150 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11	Extended Disability Benefit	GR-9N 06-155 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		DI AR0032301F01
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
12	Accidental Personal Loss Indemnity Benefit	GR-9N 06-160 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
13	Accelerated Survivor Benefit	GR-9N 06-165 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
14	Eligibility, Enrollment and Effective Date of Your Coverage	GR-9N 29-005 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
15	Continuing Life and Accidental Death & Personal Loss Insurance Coverage	GR-9N 31-010 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
16	Converting Your Disability Coverage	GR-9N 31-035 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
17	Glossary (Letter O)	GR-9N 34-075 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
18	Glossary (Letter P)	GR-9N 34-080 04	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
19	Glossary (Letter R)	GR-9N 34-090 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
20	Short term Disability Schedule of Benefits	GR-9N S-04-01 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
21	Long term Disability Schedule of Benefits	GR-9N S-05-01 03	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	