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Employee Benefits from Aetna California **Administrative Handbook**

www.aetna.com

.....
Your benefits administration tool kit



Dear Plan Sponsor:

Welcome! We're pleased you've chosen Aetna and look forward to working with you.

By providing information and tools that are accessible, simple and clear, we're committed to giving you what you need to make better decisions for your business and your people.

To that end, this handbook summarizes the information you'll need to administer your Aetna plan. It is important that you understand the provisions of the plan, particularly the need to submit timely and accurate data and other information described in the handbook. Refer to the Contact List on pages 2 and 3 for phone numbers and addresses of the Aetna departments you may need to contact.

As you **read through this handbook, you may come across terms or references that do not apply to the plan of benefits you have selected. The actual terms of your group plan are detailed in the plan documents** (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet certificate, Group Policy) **we have already given you.**

As such, the information contained in this handbook is in no way part of, nor a waiver to, the actual terms of your group plan or any other agreement you may have with Aetna.

Thank you for choosing Aetna. It is our privilege to serve you.

Sincerely,

Aetna

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Contact List

This section provides information and instructions for contacting Aetna when you have a question or a problem with your group plan. It also provides instructions for ordering forms when needed.

Important: When contacting Aetna, please be prepared to give certain information specific to your group plan, for example, your plan's control, suffix and account number or group number. If you are calling about an employee matter, have the employee's Social Security number ready to avoid delays in customer service.

Plan Sponsor Services

As the benefits administrator, you may contact the Aetna Small Group Service Center to speak with a representative trained to address your unique concerns. This group of individuals will be able to answer your questions regarding enrollment, billing and group setup. In addition, you may order replacement membership cards for employees or additional enrollment supplies.

Phone: 1-877-249-7235, available 8 a.m. to 5 p.m. PT, Monday through Friday.

Choose the following numbers, when prompted, to access the information you need:

1. Renewals
2. Claims
3. Billing & Enrollment

Billing

For premium remittance and lockbox information see customer invoice.

You can pay your bill online at www.aetna.com/employer or by phone at 1-866-350-7644.

Enrollment

Aetna
P.O. Box 24005
Fresno, CA 93779-4005
Online access to enrollment is available at www.aetna.com/employer
Email: enrollmentsgw@aetna.com
Phone: 1-877-249-7235

Member Grievance

Your employees should consult their member handbooks and/or their applicable plan documents for clarification of how the plan works; for covered services, limitations and exclusions; and for a description of the Aetna grievance and appeals process.

Our process gives members the added option of requesting an objective and timely external review of certain coverage denials for members covered under our insured products.

Your employees may call Member Services for more information.

Aetna Voice Advantage

Aetna Voice Advantage (AVA) is our toll-free phone service available for members and providers. Our state-of-the-art interactive voice response (IVR) system offers callers:

- **Fewer questions to get information** – minimizing steps and increasing satisfaction
- **A choice of self-service options** – for simple and common inquiries
- **Seamless routing** – providing direct access to the most appropriate customer service professional
- **Member Information passing directly to our customer service professionals (CSP)** – so we can focus on the specific issues in the least amount of time.

Aetna Voice Advantage uses natural speech recognition technology that recognizes what callers say and responds in a conversational manner. Members benefit because it is proven to help them complete simple transactions on their own, 24 hours a day, 7 days a week. When CSPs are needed they are ready to focus on more complex member needs.

These self-service functions allow members to:

- Check eligibility and benefits coverage
- Check the status of a claim
- Request a replacement ID card, physician directory or claim form
- Review flexible spending account activity
- Obtain contact information

Claims

Member Services

For benefit questions or claims inquiries for Aetna HMO Plan:

Phone: 1-888-70-AETNA
or 888-702-3862
Fax: 1-866-474-4040

For benefit questions or claims inquiries for Aetna PPO Plan, Aetna Choice® Plan (MC) or Aetna Indemnity Plan:

Phone: 1-888-80-AETNA
or 888-802-3862
Fax: 1-866-474-4040

Claims Addresses Health Plans

For Aetna HMO Plan, Aetna PPO Plan, Aetna Choice Plan (MC), or Aetna Indemnity Plan:

Aetna Life Insurance Company
P.O. Box 981106
El Paso, TX 79998-1106

Dental

Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094
Phone: 1-877-238-6200

Life

Aetna Life Insurance
P.O. Box 14549
Lexington, KY 40512-4549
Phone: 1-800-523-5065

Disability

Aetna Life Insurance
P.O. Box 14552
Lexington, KY 40512-4549
Phone: 1-866-282-8495

Pharmacy

Aetna Pharmacy Management
Attn: Claims Processing
P.O. Box 14024
Lexington, KY 40512-4024
Phone: 1-800-AETNA RX or
1-800-238-6279
Enter 0; Prompt 2 (Member or
calling on behalf of a member)

Mail-Order Drug

Ordering Address:
Aetna Rx Home Delivery
P.O. Box 417019
Kansas City, MO 64179-7019
Phone: 888-792-3862

Other Program Vendors

Find information on Aetna Natural Products and ServicesSM, and Aetna FitnessSM programs on our website at www.aetna.com.

HSA Vendor: Health Equities

Member Services: 1-866-382-3512
Employer Services: 1-866-382-3510

Aetna VisionSM Discounts

Call for closest eye care provider, or use the DocFind® directory to find a participating vendor.
Phone: 1-800-793-8616

Informed Health® Line

Phone: 1-800-556-1555 24-Hour Nurse Help Line

Aetna Behavioral Health

Phone: 1-800-424-5702

HRA Vendor: Flex Benefits

Member Services
10275 W Higgins Road, Ste 500
Rosemont, IL 60018
Phone: 1-866-472-0897

What to do in an Emergency

Members who need emergency care are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is “one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman, the health of the woman and her unborn child.” In or out of our service areas, members should follow the guidelines below when they need emergency care.

1. Call the local emergency hotline (e.g., 911) or go to the nearest emergency facility. If a delay would not be detrimental to his or her health, the member should call his or her PCP first. If not, the member should notify his or her PCP as soon as possible after receiving treatment.
2. After assessing and stabilizing the member’s condition, the emergency facility should contact the member’s PCP to assist the treating physician by supplying information about medical history and authorizing any follow-up care. Please advise your employees to review their plan documents to determine any time limits for notification.
3. If a member is admitted to an inpatient facility, the member, a family member or friend should notify the member’s PCP on his or her behalf as soon as possible.
4. All follow-up care should be coordinated by the PCP.

What to do outside the Aetna service area

Members who are traveling outside their service area or students who are away at school are covered for emergency and urgently needed care. Members can get urgent care from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting or fever, are considered “urgent care” outside Aetna service areas and are covered in any of the above settings.

If, after reviewing information submitted to us by the health care professional who supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary for the member to provide us with additional information. We will send the member an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

Follow-up care after emergencies

All follow-up care should be coordinated by the member’s PCP. Follow-up care with nonparticipating health care professionals is covered only with a referral from the member’s PCP and prior authorization from Aetna. Whether the member was treated inside or outside his or her Aetna service area, he or she must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Aetna Plan Features

Aetna Website

Our website, www.aetna.com, provides a variety of group and member education tools that allow you and your employees to support and enhance their group health benefits.

Employers & Organizations Website

Visit the site to download your Product Overview Brochure and forms for employee changes. You may also update your contact information so that we have up-to-date information in order to contact you. You may also use the “contact us” feature if you should have questions regarding your plan.

Secure Member Website

The Aetna Navigator® website, www.aetna.com, helps members and their covered dependents manage health and financial information – 24 hours a day, 7 days a week.

When registered, members can:

Review plan information

- Lookup who is covered, primary care physician (PCP) or primary care dentist (PCD) selections, claims status, and explanation of benefits (EOB) statements.
- Review pharmacy benefits, including the Medication Formulary Guide, participating pharmacies and the mail-order drug program.
- Check health care account status(es) and account balance(s).

Find helpful resources to manage health care

- A personalized health history report provides summarized claim information organized by categories, such as names of doctors, medical care, and dental care that members may share with their health care providers
- Our Cost of Care tool compares the estimated costs for health care services including medical procedures, office visits, medical diseases and conditions, prescription drugs and dental procedures.
- The Price Transparency Tool allows members to compare actual providers' prices to his or her peers and view quality and efficiency ratings (available in certain markets).
- The Hospital Comparison Tool helps members review hospitals based on selected criteria.
- An online survey for members lets them rate their health care professional.

Perform transactions

- View and print temporary medical/dental ID cards and request new cards.
- Get Member Services contact information and send an email to Member Services (also available in Spanish).
- Search the DocFind® directory in English or Spanish.
- Download claims to a personal PC to keep track of health care spending.
- Print Aetna standard forms.
- Request email alerts on the home page when new EOBs, health care reminders or flexible spending account (FSA) payments are available.

Gain Access to sources of health information

- Review Aetna IntelliHealth® our award-winning website to look up credible health, dental and wellness information.
- Consult Healthwise® Knowledgebase, a user-friendly online information tool.

DocFind

When a member searches for a Doctor on DocFind through the Navigator portal it automatically populates the plan for them so they don't have to fill in that information. New employees who have not yet enrolled can access DocFind on www.aetna.com to search for doctors, dentists, pharmacies, hospitals, facilities and other health care professionals before making their final plan selection.

Enrollment Settings and Changes

Certain group settings can impact employee eligibility and the enrollment process. For most companies, enrollment and benefits change activity constitutes the biggest piece of the administration process. As such, we recommend you familiarize yourself with this section and pay particular attention to the information that must be included on an enrollment or change form in order to prevent potential claims problems caused by delayed enrollment or missing information.

So we can provide you with accurate billing statements and effectively administer the benefits under your health benefits plan, please submit timely and accurate information on any eligibility changes that may occur. These include but are not limited to the following:

- Employees and/or dependents being added to the plan
- Employees and/or dependents being deleted from the plan
- Group address change
- Employee address change
- Change in plans
- Change in Medicare eligibility
- Change in COBRA or Cal-COBRA status for employees
- Employees turning age 65
- Change in ownership of the group
- Employee changes within the group in the event of an acquisition
- Change in the number of employees within the group that would affect the group's eligibility for COBRA, Cal-COBRA, or Medicare payor status
- Change in dependent student status

All changes must be received within 31 days of the event, at:

Aetna

Attn: Billing & Enrollment

P.O. Box 24005 Fresno,

CA 93779-4005

Phone: 1-877-249-7235

Email: enrollmentsgw@aetna.com

Online access to enrollment and billing transactions

is available at www.aetna.com/employer

Group Enrollment

Anniversary Dates

Your anniversary date will be 12 months after your original effective date. It is on this date that you will receive your annual renewal from Aetna.

Annual Renewal

The annual renewal period is the time of year when you and your employees can reevaluate our health benefits needs, select the plan(s) that best meets those needs and make contract changes.

The timing of the annual renewal greatly affects the service your members receive. Aetna will provide the renewal materials 60 days in advance of the renewal date. Plan changes must be submitted to Aetna within the specified time frame on your renewal letter. Plan changes will not be accepted after the date noted on the renewal letter.

Changes to your plans can be made at New Business or at Renewal. Please contact your broker to facilitate these changes.

How to Enroll in Life and Dental Insurance

We have a variety of Life and Dental products to meet your small group needs. Please contact your broker or Aetna at 1-877-249-2472 to get a quote for Aetna's Life and Dental products.

Non-Renewal of Coverage

Aetna reserves the right to terminate the group health benefits plan for reasons including, but not limited to, the following:

- Material misrepresentation
- Non-payment of premium
- Failure to meet the minimum contribution and/or participation requirements
- Failure of the group to provide accurate eligibility information or other breach of contract

Cancelling Group Coverage

Renewal policy cancellations require written notification of intent to cancel within 30 days of the renewal. Cancellations other than at renewal require 60 days advance notice. If advance notice is not provided, we will cancel the account with the next billing cycle, and you will be liable for all premiums billed through that date.

Member Notification Due to Non-Payment of Premium

California requires the employer to demonstrate a notice of cancellation was mailed to each employee enrolled in a medical or dental plan at the employee's current address. The most common reason Aetna terminates coverage is due to non-payment of premium. In many instances, this is the way Aetna is notified if a group has secured coverage through another carrier. However, because Aetna did not receive notification from the employer that other coverage is in place, the employees must be notified.

Aetna is taking on the responsibility of notifying employees when coverage is terminated. If Aetna does not receive premium for coverage at the end of the grace period, a letter will be mailed to the employee's home address.

In order to prevent a letter being mailed to the employee, Aetna needs to be notified if other coverage is replacing the existing coverage. If we are notified before the end of the grace period, Aetna will not send a letter to the employee.

Termination notices should be sent to:

Aetna
Attn: Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available at www.aetna.com/employer

Address Changes

A group move to a new rating area may affect the billing and premiums for the employee and or dependents.

Group Address Changes

Submit a group address change in writing to the address below or by fax:

Aetna Sales Support Team
PO Box 24004
Fresno, CA 93779-4004
Fax: 1-888-258-4530

Changes to your plans can be made at New Business or at Renewal. Please contact your broker to facilitate these changes.

Employee Address Changes

Submit an employee address change in writing to the address or fax number below. Employee address changes are also accepted over the phone by calling Plan Sponsor Services.

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available at www.aetna.com/employer

Changing Your Broker

If you'd like to change your broker, please fax your request on company letterhead to Aetna at 1-888-258-4530.

The letter should include the following:

- List all account numbers for all of your products (Medical, Out of State Medical, Dental and Life)
- Name of the new broker or agency
- Effective date of the new broker or agency

Changes in Ownership

When an in-force group has been sold, the case should normally be terminated. However, there are a few instances when the new owner may want to continue to offer benefits to the employees.

The case may remain in force as long as it is the same business, at the same location with the same employees. The new owner must provide the following:

- Buyers agreement showing new owner, name change, and date of purchase.
- List of employees currently working for the company and number of hours worked. This can be sent over with the new owner's signature and does not have to be from an attorney or CPA.

However, if the tax ID number of the existing group changes, we reserve the right to medically underwrite.

Enrollment Settings and Changes

(continued)

eEnrollment

Our eEnrollment tool makes the benefits enrollment process much more efficient. eEnrollment replaces time-consuming, expensive and paper-based enrollment with a comprehensive electronic benefits and administration enrollment solution that is secure and eliminates many of the paper processes.

eEnrollment allows Aetna administrators and brokers to manage benefits through an easy-to-use application and gives employees the ability to view and make changes to their benefits. Group administrators and/or brokers can maintain total control of any information sent to Aetna.

eEnrollment provides group administrators with increased control, speed and accuracy for benefits enrollment. A few advantages for employers are:

- Faster, more accurate enrollment administration
- Improved intra-company communication
- All data is secure and confidential
- High level of control – employee changes must be approved by the broker or plan administrator before sending changes to Aetna
- Easy-to-use reports

Plus, eEnrollment improves the benefits experience for members:

- Better understanding of benefits
- More secure than paper
- Easier to submit changes to human resources or the broker
- Simplified decision-making
- Online access to enrollment is available at www.aetna.com/employer

Pick-A-Plan Portfolio

Pick-A-Plan is our suite of plans designed specifically with the small employer in mind. These plans provide choice, flexibility and simplicity.

Pick-A-Plan allows employers with 2 or more eligible employees to select as many medical plans as they wish, and build a customized portfolio by selecting from any of our available products.

By offering Pick-A-Plan at enrollment, current employees can switch to any plan at the plan sponsor's anniversary, without medical underwriting. If employers do not have the suite of Pick-A-Plan products in place, employees may have to go through medical review to determine if they qualify for the new plan. If Pick-A-Plan is in place, all new hires will be able to select any plan at the time of enrollment.

Open Enrollment

A period of time when:

- Insured employees and dependents may transfer medical coverage from HMO to Traditional Products and vice versa, if applicable.
- Uninsured employees and their dependents may enroll for medical benefits.

All enrollment applications must be:

- Signed no later than 31 days after the renewal or open enrollment date, and
- Received by Aetna no later than two months after the renewal or open enrollment date.

Note: Open enrollment for life insurance is different than open enrollment for medical benefits in that it does not allow late applicants who have no existing life coverage to elect any type of coverage. Evidence of Insurability is required to be enrolled.

Enrollment Period

Enrollment applications should be dated, signed and returned by the employee to the employer within 31 days of the person's (employee or dependent) eligibility date.

HIPAA Special Enrollment Periods

Employees or dependents may be eligible for enrollment under a Special Enrollment Period if they did not elect coverage because they were already covered under another group plan and later lost coverage due to one of the HIPAA Qualifying Events listed below. Employee and/or dependents are generally allowed to enroll in your group plan without delay provided they elect coverage within 31 days of the date they lose coverage. Other limitations and exceptions to your plan's late enrollee rules are discussed in your plan documents.

An applicant who experiences a qualifying life status change, such as marriage, birth, or adoption, may also be able to enroll under a Special Enrollment period.

HIPAA Qualifying Events:

- Cessation of COBRA or state-mandated continuation (18/29/36 months must be exhausted)
- Cessation of incapacitated children coverage (handicap coverage)
- Change from full-time to part-time status
- Company out of business resulting in loss of coverage for spouse/dependent
- Death
- Divorce or legal separation
- Employer termination of medical plan
- Employer termination of combined medical and dental coverage
- Layoff
- Loss of Medicaid
- Retirement of spouse
- Termination of employment
- Plan ceased to offer dependent coverage
- Loss of dependent status per plan terms
- Termination of benefit packages options, unless a substitute is offered

For non-medical coverages (for example, life insurance and accidental death and dismemberment coverage), employees may be allowed to enroll before the annual open enrollment provided they are able to satisfy Aetna's evidence of insurability requirements. Please refer to the Life Insurance section on page 30 of this manual for information on evidence of insurability requirements.

If you have any questions concerning late enrollment or if you have any questions concerning the Health Insurance Portability and Accountability Act of 1996 (HIPAA), call the toll-free number shown on your statement. Please refer to the Contact List section of this manual for more information.

Participation Requirements

Employees of 3 or fewer

Enrollment in an Aetna plan must be equal to 100% of total eligible employees excluding valid waivers, such as coverage through a spouse. Waiver forms are required.

Employees of 4 to 50

Enrollment in an Aetna plan must be equal to or at least 75% of eligible employees excluding valid waivers, such as coverage through a spouse. Waiver forms are required.

Contributory Coverage/ Noncontributory Coverage

Medical

For single option plans, the employer must contribute at least 50% of the employee rate.

For Pick-A-Plan options, an employer has two choices, a single contribution or a defined contribution.

- **Single contribution** – The employer must contribute at least 50% of the employee rate.
- **Defined contribution** – The employer may choose to offer a defined contribution of at least \$80 or the actual cost of the plans picked, whichever is less.

Dental

The employer must contribute at least 50% of the employee-only cost or 25% of the total cost of the plan.

Life

In groups with fewer than 10 eligible employees, the employer must contribute 100% of the cost of the plan.

In groups with 10 to 50 eligible employees, the employer must contribute at least 50% of the cost of the plan (excluding the Optional Dependent Life).

Enrollment Settings and Changes

(continued)

Probationary Period/Waiting Period

New employees will be required to serve a probationary period before their benefits will take effect. As the employer, you have the discretion to decide whether or how long new employees (or if you choose to, existing employees) must wait in order to be eligible for coverage. If employees are required to serve a probationary period, it must be administered to apply equally to all employees in that class (for example, full time, part time).

This waiting period can be changed upon the plan administrator's request. The benefit waiting period can only be changed once in a rolling 12-month period and this does include the annual renewal. All benefit waiting period changes are subject to approval by Aetna. Retroactive changes to the benefit waiting period are not allowed.

If you selected a probationary period, depending on the group's effective date, the eligibility date will be the first or the 15th day of the month following satisfaction of the probationary period.

If the probationary period is zero days, depending on the group's effective date, the eligibility date will be the first or the 15th day of the month following their hire date. **In order to be eligible for coverage, the employee must sign and return the enrollment form within 31 days of the employee's eligibility date.** If medical coverage is waived by the employee and/or dependents, it is recommended the employer obtain a signed waiver and submit to Aetna (see enrollment/change form) and keep on file. Otherwise, the employee will be treated as a "late enrollee" and will be subject to the requirements outlined in the Late Applicant section.

If the employee elects coverage before the end of his or her probationary period, coverage will take effect on the eligibility date. Otherwise, coverage will take effect on the date the employee returns the signed enrollment form, provided it is within 31 days of the eligibility date.

Note: If you employ part-time employees but only provide coverage for full-time employees, part-time employees who become full-time employees **do not have to serve** a probationary period, provided the employee has been working for the length of the probationary period. If only part of the probationary period has been served, only the remainder of the probationary period must be served as a full-time employee. Also, employees who terminate employment and who are subsequently rehired within one year do not have to serve a new probationary period.

Example: Employee is hired 02/15. The benefit waiting period is the first of the month following 90 days. $02/15 + 90 = 05/16$, first of the following month makes the effective date 06/01. Eligibility period is 06/01 through 06/30.

Life and Disability applicants are subject to medical underwriting.

Dental applicants can be enrolled at any time, but are limited to Preventive and Diagnostic services for the first 12 months (24 months for Orthodontics).

Duplicate Coverage

Your group plan may not allow individuals to be covered both as an employee and as a dependent. In addition, no person may be covered as a dependent of more than one employee. Please contact your Aetna service representative for information on your group plan.

Enrollment Checklist

Has the employee Included:

- his or her benefits selection?
- his or her full name and address?
- his or her Social Security number?
- his or her date of birth?
- his or her dependent's name(s), relationship code and date of birth?
- his or her PCP selection and network ID (if applicable)?
- his or her signature and date? **VERY IMPORTANT!!!**

Have you Included:

- the effective date of the transaction?
- the employee's hire date?
- the control, suffix and account numbers or group number?
- the name and address of your company?

Enrollment Preparation

New Employee, First Steps

Benefits enrollment can be made an integral part of the hiring process for new employees. By providing enrollment material and benefits literature to your employees when they first begin work, you are allowing them to make informed benefits decisions. This also helps prevent potential claims problems caused by delayed enrollment or missing information.

Employee Eligibility

When your company enrolled with Aetna, you selected eligibility rules to reflect your company's policy. You may confirm these rules or any other eligibility concerns with the Aetna Small Group Service Center by calling 1-877-249-7235 anytime Monday through Friday from 8 a.m. to 5 p.m. PT.

Full-Time Employee

A full-time employee is defined as a permanent employee who is actively engaged on a full-time basis in the conduct of the small employer with a normal work week of at least 30 hours per week.

Part-Time Employee

A part-time employee is defined as a permanent employee who works at least 20 hours but no more than 29 hours per week. In order for part-time employees to be eligible for coverage there are four categories that must be met by the employer.

- The employer offers the employee health coverage under a health benefits plan.
- All similarly situated individuals are offered coverage under the health benefit plan.
- The employee otherwise meets the definition of an eligible employee except for number of hours worked.
- The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

Sole Proprietors/Partners/Corporate Officers

Sole Proprietors, Partners, and Corporate Officers must be actively engaged in the conduct of the business on a full-time, permanent basis working no less than the minimum number of hours required by the applicable state laws.

1099 Employees

Aetna does not provide coverage to 1099 employees.

Ineligible Employees

Temporary, substitute, and seasonal (defined as employees who have a planned termination date in the future) employees, are not eligible for Aetna benefits plan.

Employees Residing Outside California

For out-of-state employees, we will offer the in-state portfolio and rating structure to employees that live in an out-of-state network area. Out-of-state employees that do not live in an out-of-state network area will be eligible for the in-state indemnity plans. HMO and EPO are not available products for employees who live outside California. To be eligible for the in-state portfolio, a small group must have 51% of its employees enrolling in California. The out-of-state PPO plans are available to those groups that do not qualify for the in-state portfolio solution.

Live/Work Guidelines

Employees enrolled in medical or dental plans who reside in a Non-HMO/AVN/HMO HRA/HMO Deductible and/or DMO network code may enroll in an HMO/DMO product offered by their employer if they live within a 30 miles radius of their work site that is within the HMO/DMO service area. The product availability for group benefit offerings are always determined by the zip code of the employer. If the employee resides at a distance further than the 30 mile radius, exception requests should be directed to Aetna Underwriting for a feasibility determination. Employees who are enrolling using the Live/Work Guidelines should include their home address and zip code as well as the work site address and zip code. All correspondence will be mailed to the employee's home address as listed on the application.

Enrollment Preparation

(continued)

Pre-Existing Conditions

Pre-existing conditions are defined as an illness, physical condition or disease for which an employee and/or dependent would have received medical advice, care, or treatment, including the use of prescription drugs, from a licensed health care provider within 180 days immediately preceding the effective date of the new policy or the benefit waiting period.

Employees who select HMO products are not subject to pre-existing conditions; however, they do apply to those employees who have selected any of the Traditional products.

Employees who do not submit prior coverage information with the Enrollment/Change form may be subject to pre-existing condition rules. Failure to provide proof of prior coverage may subject an employee and his or her dependents to the full pre-existing conditions limitation with no credit for prior coverage.

Credit for Prior Coverage and Pre-existing Conditions Exclusions

Acceptable forms of proof are:

- Certificate of Creditable Coverage from prior carrier.
- Copy of ID card from prior carrier.
- Copy of recent payroll stub showing medical coverage deduction.
- Copy of most recent medical premium bill from the prior carrier.

Proof of prior coverage must show creditable coverage within 180 days immediately before the employee's effective date of coverage.

Where to Submit Proof of Prior Coverage

Submit proof of prior coverage along with completed enrollment/change form to:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment and billing transactions is available at www.aetna.com/employer

Deductible Credit

Deductible Credit does apply to Small Group new business. In certain limited situations, we allow for deductible amounts accrued with a previous insurance carrier to be credited to the current-year deductible.

If both the prior carrier plan and the Aetna plan run on a calendar year (January 1 thru December 31) the following scenarios will apply:

- If the effective date with Aetna is January 1, deductible credit does not apply because there is not an overlapping benefit period.
- If the effective date is other than January 1, Aetna will give credit for prior carrier deductible accumulations incurred in the current calendar year.

The prior carrier runs on a plan year (any benefit period other than Jan 1 – Dec 31), and Aetna runs on a calendar year (Jan 1 – Dec 31).

- If the effective date with Aetna is January 1, deductible credit does not apply because there is not an overlapping period.
- If the effective date is other than January 1, Aetna will give credit for prior carrier deductible accumulations incurred in the current calendar year.

For all products, new hires to an existing group are not eligible for deductible credit. Only employees covered by the prior carrier at the time of takeover are eligible for deductible credit.

Proof of deductible credit, such as Explanation of Benefits from the prior carrier, should be faxed to the Claims Department at 1-859-455-8650.

Selecting a PCP for HMO

Under an Aetna HMO benefits plan, the primary care provider (PCP) plays an important role in a member's care. This doctor is not only responsible for managing health care needs, but for providing referrals to other qualified specialists and providers.

Each member who has Aetna HMO coverage should select a PCP

In California, for HMO plans only, if a member does not select a PCP or the submitted PCP number is invalid, a provider will be assigned for the member. The selection is a random process based on the PCP's proximity to the member's residence, allowing the member to access the full range of covered benefits under the plan. Members are free to change this selection at any time by calling Member Services at the toll-free number on their ID cards. However, you should encourage your employees to select PCPs for themselves and any eligible dependents at the time of enrollment. Contact your broker or the Aetna Small Group Service Center if you have questions about this policy.

Coverage Effective Dates for Rehired Employees

For HMO and Traditional products, if an employee is rehired within one year of the termination from the same group, it is not required that he or she begin the benefit waiting period again unless specifically requested. If rehired after one year from the termination date, the benefit waiting period must be met.

An employee is considered a rehire only if he or she has been previously on the Aetna health plan with the same employer prior to termination.

Enrolling Dependents

It is important to notify Aetna when an employee wishes to add or delete dependents due to a change in family status. Make these changes on the appropriate Enrollment/Change form with the proper box checked off.

Eligible Dependents

Dependent coverage is not automatically included with Aetna coverage unless offered by the employer. If you offer coverage for dependents, you must also extend this coverage to all eligible or enrolled employees who may have dependents.

Effective 10/1/2010, for new and renewing business, the following persons are considered eligible dependents:

- Eligible dependents include an employee's spouse. If both husband and wife work for the same company they may enroll together or separately. Children can only be covered under one parent's plan.
- Domestic partners are eligible.
- Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26.
- For dependent life, dependents are eligible from 14 days up to their 19th birthday, or up to their 23rd birthday, if in school.
- Dependents are not eligible for AD&D or disability coverage.
- For medical and dental, dependents must enroll in the same benefits as the employee (participation is not required).
- Employees may select coverage for eligible dependents under the dental plan even if they select single coverage under the medical plan. See product-specific life/AD&D and disability guidelines under product specifications.
- Individuals cannot be covered as an employee and dependent under the same plan.
- Children eligible for coverage through both parents cannot be covered by both parents under the same plan.

New Spouse

We allow 31 days from the date of marriage to add a new spouse.

- **Traditional** – New spouse will be added on the date of marriage or the first of the following month to be determined by the plan sponsor.
- **HMO** – First day of the month (FOM) following the event.

Enrollment Preparation

(continued)

Children

Includes unmarried/married children from birth to age 26 (includes natural, stepchildren, foster, legally adopted children, proposed adoptive children, and a child under court order).

- **Students who attend school outside an Aetna HMO service area** – are covered for emergency care and urgently needed care, including follow-up emergencies and specialty care when medically necessary.
- **Dependents who reach the limiting age** – It is the responsibility of the employee and employer to notify Aetna once a dependent reaches the limiting age or is no longer a full-time student. Failure to do so could result in unpaid claims and an overpayment of premium.
- **Incapacitated Dependents** – Dependent children over the limiting age who cannot support themselves because of a disability are covered as dependents as long as the condition existed before the child reached the limiting age and is documented by a physician. The Request for Continuation of Medical Coverage for Disabled Student or Handicapped Child form must be submitted and approved. An Aetna medical director must approve all exceptions. The form can be found on www.aetna.com.

Newborns

Ideally, when a baby is born, the plan sponsor will advise Aetna to add the newborn with appropriate information, such as name, date of birth, etc., prior to receipt of a claim for the newborn. A Social Security number is required to enroll the newborn. However, in most instances, the claim for the newborn is received before the newborn is added to the policy. A newborn child is automatically covered for 31 days from the date of birth. In order to continue coverage beyond this initial period, an application adding the dependent child must be received within the initial 31-day period. The addition of the newborn for 31 days may result in a premium increase for the employee. Aetna will routinely bill and collect any additional premium charges resulting from the newborn addition.

Adoptions

Aetna does not require legal documentation. The adopted child would be handled the same as a biological newborn. The effective date of the adopted child should be the date of the adoption or the date the child is placed with the adoptive parents with the intent to adopt.

Qualifying Event

In accordance with HIPAA, an employee who has previously waived or declined coverage due to a spousal waiver may enroll in the health benefits plan when the subscriber's spouse loses coverage due to layoff or employment termination.

- **Traditional** – The effective date can be the date of the event or first day of the month following the qualifying event.
- **HMO** – The effective date is the first of the month following qualifying event.

To enroll, the subscriber must submit within 31 days of the date of loss of coverage, verification of a spouse's previous insurance coverage, proof of layoff or employment termination and a new enrollment form.

Waiver of Coverage

Under California State Law AB 1672, any member (employee and/or dependent(s)) who declines coverage for any reason when first offered coverage must state the reason for waiving coverage in writing.

An enrollment application should be completed and submitted to Aetna for those employees and eligible dependents who wish to decline coverage.

NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so that pages 3, 4 and 5 are not visible.



California Small Group Business (2 - 50 Eligible Employees) Employee Enrollment/Change Form

TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages.

Group Number
Applicant Social Security Number

Company Name		INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. If enrolling, please be sure to sign and date Employee Signature on Page 6. If waiving coverage, please complete Sections B and Declination/Waiver of Coverage on Page 6 only.			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Change of Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/Cal-COBRA for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date	
Date of Hire					Qualifying Event

A. Coverage Selection – Please print clearly, using black ink.

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.
1. Medical - Check one. HMO: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> Deductible 1000 <input type="checkbox"/> Deductible 1500 <input type="checkbox"/> Coinsurance 70% <input type="checkbox"/> Coinsurance 60% Value NetworkSM HMO: <input type="checkbox"/> 10/20 <input type="checkbox"/> 20/30 <input type="checkbox"/> 30/40 <input type="checkbox"/> 40/50 Vitalidad Mexico HMO: <input type="checkbox"/> 10 Vitalidad Plus HMO: <input type="checkbox"/> 10/5 <input type="checkbox"/> 30/10 MC: <input type="checkbox"/> 250 90/70 <input type="checkbox"/> 2000 80/50/50 <input type="checkbox"/> 250 80/60 <input type="checkbox"/> 2500 75/50 <input type="checkbox"/> 500 80/60 <input type="checkbox"/> 3500 65/50 <input type="checkbox"/> 1000 70/50 <input type="checkbox"/> 4500 60/50 <input type="checkbox"/> 750 80/50/50 <input type="checkbox"/> 7500 75/50 <input type="checkbox"/> 1250 80/50/50 <input type="checkbox"/> 10,000 100/50 <input type="checkbox"/> Value 2250 60/50 <input type="checkbox"/> Value 3750 50/50 <input type="checkbox"/> HSA HDHP 2000 80/50 <input type="checkbox"/> HSA HDHP 3000 90/50 <input type="checkbox"/> HSA HDHP 3500 80/50 <input type="checkbox"/> HRA HDHP 3000 70/50 PPO: <input type="checkbox"/> 750 80/60 Indemnity <input type="checkbox"/>				2. Dental - Check one (if applicable). Standard Plans: <input type="checkbox"/> Aetna Dental® Plan – Plan Option: _____ For FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Voluntary Plans: <input type="checkbox"/> Aetna Dental® Plan – Plan Option: _____ For FOC, choose: <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				3. Life <input type="checkbox"/> Basic Life/AD&D Ultra® <input type="checkbox"/> Optional Dependent Life Beneficiary Designation - Full Name (First, Middle, Last) Beneficiary Social Security Number Relationship to Employee				
<p>Whether you are enrolling or declining coverage, you must sign Page 6 of the application.</p>												

B. Employee Information - Must be completed by the employee.

Member Aetna ID Number (if available)	Last Name, First Name, M.I.		Job Title	Home Telephone
Home Address	Apt. No.	City, State		ZIP Code
Work Address	City, State		ZIP Code	Work Telephone
Salary: \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly	Primary Language Spoken (Optional)	Number of Hours Worked Per Week <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Check One <input type="checkbox"/> 1099 <input type="checkbox"/> Retiree <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
				Number of Dependents Including Spouse

ID Cards

An identification (ID) card enables physicians, hospitals and other health care professionals to verify coverage and to bill Aetna for services rendered. ID cards vary according to the plan selected and state legislation. A member must present the ID card to access care from a medical, dental or pharmacy provider. The cards may contain the following information:

- Customer name (employer)
- Control, suffix and account number or group number
- Employee's name/dependent's name
- Member number
- Primary care physician telephone number (if applicable)
- Copay amounts (if applicable)
- Claims office address and phone number
- Member Services toll-free number

Timely submission of completed enrollment forms will expedite ID card processing

In California, a PCP is assigned to members who do not select one at the time of enrollment. The PCP selection is a random process based on proximity to the member's residence. Members are free to change this selection at any time, however retroactive PCP changes are not allowed.

The ID cards are mailed directly to employee homes.

A subscriber who has a covered spouse or partner will automatically receive two copies of their family ID card; medical and dental cards will be separate, so a family with both coverages will receive both medical and dental family cards. The ID card will hold up to five names. Larger families will receive a second card or a set of cards.

Additional or replacement ID cards may be obtained by calling the Member Services phone number on the ID card. Members may also visit Aetna's website, www.aetna.com, to make this request.

Members usually receive their ID cards within 10 days of receipt of their enrollment. A copy of the Enrollment form may be used for 30 days from the effective date for PCP office visits only. The member can also print a temporary ID card from Aetna Navigator.

Other ID Card Information

Through the year, enrollment changes are submitted to Aetna. Certain changes will cause an ID card to generate. They include:

- Addition of new employee
- Provider change
- Addition of new dependent(s)
- Effective date change
- Name change
- ID card request

ID Cards on Renewal

ID cards are automatically generated upon renewal if there have been any change to the benefit plans.

ID Cards and Pharmacy

If you provide prescription coverage, please note that many pharmacies will not dispense medications without payment unless the member presents the ID card. Members may have their prescriptions filled at a participating pharmacy and pay for the prescription if they have not yet received their ID cards. Upon receipt of the cards, members should mail a copy of the prescription receipt with their member ID clearly marked on it to Aetna. Aetna will then reimburse them for the cost less their copayment. A list of local participating pharmacies can be found on DocFind.

Physician listing and changes: Members may also change their PCP selections, update their home address and request extra ID cards by visiting Aetna's website, www.aetna.com. Members may also locate a participating physician, dentist or other health care professional simply by linking to DocFind, Aetna's extensive online directory. In addition, members may change their PCP and dentist selections by calling Member Services or completing a PCP change form at their new doctor's office. New ID cards listing the new physician's office telephone number will be issued when a new PCP is selected.

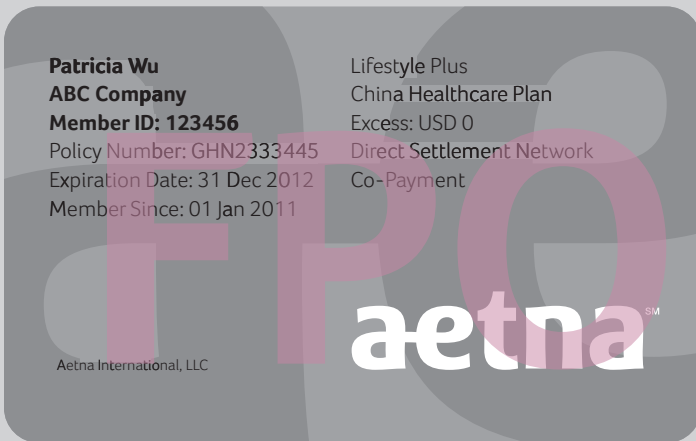
Sample ID Cards

Note: There are no Member ID cards for the Aetna Indemnity plan.

Dental Maintenance Organization (DMO) fixed dollar copay and coinsurance



Aetna Open Access™ (MC)



Making Changes in Coverage Status

Terminating Employees

Employee and dependent coverage under Aetna plans terminate for circumstances that include the following:

- The employee leaves his or her place of employment.
- Your company or group covers the employee under an alternative health benefits plan offered.
- The member misrepresents himself or herself in enrollment or fraudulently uses his or her Aetna ID card.

The employee must be cancelled from the plan when the following events occur (if applicable):

- Employee is terminated either voluntarily or by the employer willfully.
- An eligible full-time employee moves from full time to part time and the group's health benefit plan does not offer coverage to part-time employees.
- An eligible part-time employee's hours are reduced to less than the number of hours in which a part-time employee is eligible for coverage, below 20 hours per week.
- An employee is on a leave of absence and the period in which the employer covers employees on leave has expired.
- An employee moves to one of the following ineligible statuses: temporary, contract, leased, seasonal, substitute, or when compensation is reported on an IRS 1099 form.
- Employee wishes to no longer continue coverage under federal COBRA coverage.
- Employee becomes ineligible for any other reason to participate in the health benefits plan.

Submit the Enrollment/Change form to:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment and billing transactions is available at www.aetna.com/employer

HIPAA certificates will be automatically generated and sent to members at their home address upon member termination.

The health care reform law puts new restrictions in place for terminations. This means plan sponsors and insurers can only terminate a member's coverage retroactively in specific circumstances. This affects all plans that are subject to the health care reform law, regardless of funding or grandfathering status. It is in effect as of each plan's first renewal or effective date after September 23, 2010.

Here's what you need to know about the new rules concerning administrative retroactive terminations.

The plan sponsor can't terminate coverage effective with a date in the past if:

- The member was covered through plan error, and
- The member paid premium or contributed to the cost of the plan.

In these cases, the plan sponsor can only terminate the member's coverage with a future effective date of termination.

The plan sponsor may terminate coverage retroactively as part of a monthly reconciliation of eligibility data if:

- The member did not pay any premium or contribution for coverage past the termination date.

How Aetna will handle retroactive terminations under the new rules

- If a plan sponsor submits a retroactive termination to Aetna (or you submit it on the customer's behalf), it must ensure that employees/dependents did not pay premiums/contributions during the retroactive termination time period.
- When retroactive terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Aetna's policies related to time limits for retroactive terminations continue to apply.

Removing Employees Who Remain Eligible but Discontinue Coverage

An employee may request to terminate his or her participation in the health benefits plan because he or she chooses to enroll with a spouse. However, this person remains as an eligible employee. In this case, the employee should use an Enrollment/Change form.

This form will then be used at a later time, if needed, to determine if a qualifying event has occurred in the likelihood the employee determines at a later date to return to his or her employer's health plan.

Removing COBRA Members

Aetna does not automatically remove members from COBRA. Use an Enrollment/Change form to notify Aetna that the member's period of continuation has ended. Failure to submit this form to Aetna on a timely basis will not modify the date coverage is scheduled to terminate as prescribed by law and/or contract for the particular qualifying event, that is, 18-, 29- or 36-months. Any terminations will be retroactive to the termination date not exceeding more than 105 days.

Eligibility and Enrollment Forms

To access enrollment forms, visit www.aetna.com/employer/smallgroup/resource_small/forms_small/smallgroup.html

Consolidated Billing

Premium Rates

As a carrier, Aetna is required to abide by the provisions within the state law that determine both the frequency of any rate increase in the base rates and the risk adjustment factor. Changes in the Standard Employee Risk Rate are based on rising health care costs and economic conditions within geographic areas. These costs cannot be predicted as to when or if they may change. If your group is in your guarantee period, your rates cannot change until your next renewal period.

Rates may be affected at the group level in which all employees are impacted based on products selected and the Risk Adjustment Factor issued to the group. Rates may also be affected at the employee level due to changes in age (tier changes), adding or deleting dependents, or when eligible to change benefits.

- Standard Employee Risk Rate (SERR) – This is the base premium rate which Aetna has filed with the State of California for specific products and rating areas. You will be notified within 30 days of any changes to your SERR.
- Risk Adjustment Factor (RAF) – This is based on the medical and prescription information submitted at new business and will be calculated based on claims information at each renewal. This factor cannot be more than 10% above or below the SERR.
- In the evaluation of your annual renewal Aetna will determine the RAF that should be assigned to your group but will not change more than once in a 12-month period. You will be notified within 30 days of any change to your RAF.

Note: Effective April 1, 2008, the Standard Employee Risk Rate is based on the employer's zip code.

Tabular Billing Policy

Aetna will apply the increase for an employee's move into a higher rating category during the month following the employee's birthday.

Please note there are no changes to the tabular rates and age bands at this time. They are:

Under 30
30 – 39
40 – 49
50 – 54
55 – 59
60 – 64
65+

Groups with composite rates and groups that don't have employees moving to a higher rating category will not have any changes to their rates until their next renewal date.

Premium Payments

Billing Cycle

Monthly invoices are produced and mailed approximately two weeks before the premium due date.

Example:

Cycle 1 – Invoice for June 1 premium due date is produced May 15.

Cycle 2 – Invoice for June 15 premium due date is produced June 1.

The total premium is due on the first day of the monthly coverage period. If not received by the end of the grace period, the contract may be terminated. You will be liable for the premium for all periods of coverage (including the grace period) unless you provide at least a 30-day advance written notice of your intent to terminate.

In the event that your premium does become delinquent, your next billing statement will reflect any past due amounts to bring your account current. A billing statement consists of the following sections:

- Invoice Summary and Payment Stub
- Current In-force Charges
- Retroactivity/Other Adjustments
- Benefit Snapshot

PSUID# is the Plan Sponsor Unique Identifier. This number combines all Aetna group and control numbers into one and may be seen on premium statements and renewal packages.

Adjustments to Your Bill

Please pay the billed amount as it is the group's responsibility to verify and check each monthly statement for accuracy.

Please do not submit Enrollment Forms with your bill, as the premiums are mailed to the lockbox of the bank and they cannot be processed. This may also cause a delay in processing your payment.

Questions on Your Bill

If you find discrepancies on the bill, you should call the Aetna Small Group Service Center at 1-877-249-7235 promptly so they can be resolved in a timely manner. Billing and coverage is based on the member information that you provided to Aetna.

Therefore, you are responsible for notifying Aetna in a timely manner of any changes in coverage and/or member status. Employers are responsible for payments for the coverage when member terminations are not reported in a timely manner.

Consolidated Billing

(continued)

Where to Mail Your Payment

Payments should be mailed by using the window envelope provided with your statement. Enclose your check and payment stub to ensure prompt and accurate posting to the correct account.

Enrollment transactions should be sent to the:

Aetna Small Group Service Center
Attn: Enrollment Department
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment and billing transactions is available at www.aetna.com/employer

Important Remittance Information: To ensure uninterrupted claims service, the total amount due reflected on your payment stub should be mailed to Aetna by the due date. **Checks should be made payable to Aetna.** Your check should also include your invoice and/or account numbers. Remove the payment stub portion from the statement and mail it with your check to the remittance address shown on the stub.

What To Include	When To Include It
Write your group number on the face of the check	Always
Send your remittance slip with your check	Always
Write the amount you are	When payment is different remitting on the slip from the billed amount

This is a lockbox arrangement, which means your premiums are being delivered to the bank for automatic deposit. Deposit of your premium check does not necessarily mean acceptance of the payment or a guarantee of coverage.

Medicare Rates

Medicare rates are based on employee's information only and are subject to final review. Dependent Medicare status may cause rates to change at final enrollment (for example, a Medicare Primary group with an employee who is over age 65 with a spouse that is under age 65).

Collections

Late Payment Notice

Reminder calls are made on or around the 21st of each month if premium payment has not been received. If your account remains unpaid, the group contract could be terminated and outstanding balances referred to Aetna's collections department. If the group contracted is terminated for non-payment, Aetna will only allow one reinstatement.

After all efforts have been made to collect premium due on a terminated group, Aetna will report all terminated small employer groups with past due or outstanding balances to Dun & Bradstreet Credit Services. Dun & Bradstreet (D&B) maintains the world's largest business database containing information about 64 million businesses worldwide, including 13 million in the United States. D&B is the leading provider of business information for credit, marketing and purchasing decisions worldwide.

For questions about collections, please contact Aetna's collections department at 1-866-497-2855.

The Consolidated Bill Statement

Your group plan is Consolidated Billed. You will be billed in advance of the statement due date. Under the Consolidated Bill process, statements are produced based on the benefits, the rate for each benefit, and the number of employees and dependents lives that our administrative system indicates are enrolled in your group plan as of a given date. The Consolidated Bill process also maintains a list of your members for claims verification within our administrative billing system.

If you have any questions regarding the information shown on your statement, please contact your Aetna service representative.

A Consolidated Bill statement consists of the following sections:

1. Invoice Information

Prepared Date – The date the statement was generated.

Invoice Number – A unique bill identifier.

Triad Number – The number representing the service center assigned to your account.

Account Number – This number is a unique plan sponsor identifier. It should be included on all correspondence and forms.

Bill Package – The account number assigned at plan setup.

Coverage Period – The time period for which you are being billed for coverage.

Customer Name and Address – The name and address of the customer to which the invoice will be sent.

2. Summary of Account

The summary of account shows all due and paid activity that occurs on your account and that may be produced with your statement.

Opening Balance – The balance due from prior months.

Current In-Force Charges – The current charges based on active membership as of the prepared date.

Retroactivity/Other Adjustments – Charges for activity that was not previously billed, or adjustments to previously billed amounts.

Net Charges – The total of Current In-force Charges plus Retroactivity/Other Adjustments.

Paid Date – The deposit date of payment(s) received. The number of entries displayed in this section may vary as it is based on the number of payments received since the last invoice.

Payment ID – The identifier associated with the payment(s) received. This is usually a check or wire transfer number.

Total Payments Received Since Last Invoice – The total of payments received since the last invoice.

Amount Due – The total amount due on the account as a result of the cumulative balance.

3. Message Section

This section of your statement contains any messages that would be applicable to your account. This may include important information regarding payment terms and agreement.

4. Payment Stub and Remittance

The payment stub recaps the invoice information and the total amount due. You should return this portion with your payment. The following is a brief summary of each item found on the payment stub.

Billing Questions – The Aetna service center and phone number assigned to your account

Remittance Address – The address where payments should be mailed.

Please Pay By – The payment due date.

Amount Due – The total amount that should be remitted.

5. Plan Key

The Plan Key, located on the back of the Invoice Summary Page, lists the Products and Plan Types in which your membership is enrolled. Specific Plan Types are associated with a three-digit Plan Type Code that is used to reference individual members throughout the remainder of the invoice. The Plan Key also lists the transaction category (new, term, change, etc.) for retroactive membership transactions.

There is also a section where you may insert any changes to your address.

6. Current In-Force Charges

The Current In-Force Charges section of your statement reflects all subscribers currently insured for that billing month. The following is a summary of the items displayed in this section.

Name, Subscriber ID – Indicates the name and Social Security number (SSN) of each subscriber. The SSN is presented in a masked format (XXX-XX-6789) to protect the privacy of each enrollee.

Product Type and Premium – The product and total premium charged per subscriber.

Total Sub – The total amount of premium per subscriber for all products.

Total Current Charges – The total amount by product and the total current charges.

Consolidated Billing

(continued)

Retroactivity/Other Adjustments

The Retroactivity/Other Adjustments portion of the statement displays enrollments, changes and terminations that have been processed during the current billing period. Information on this section is detailed here.

1. **Name, Subscriber ID** – Indicates the name and Social Security number of each subscriber. The SSN is presented in a masked format (XXX-XX-6789) to protect the privacy of each enrollee.
2. **Trans** – The type of transaction (for example, N = new enrollment, C = change, T = termination).
3. **Eff Date** – The effective date of the transaction.
4. **Mths Imp** – The number of months impacted by the transaction.
5. **Product Type and Premium** – The product and total premium charged per subscriber.
6. **Total Retroactivity** – The total of all subscriber retroactive changes. **Note:** If the effective date of the enrollee transaction occurs on a date other than a statement due date, Aetna will not charge or credit for the days in the short month.
7. **Other Adjustments** – A list of other adjustments made at an account level. Debit and credit adjustments will be displayed separately by date. Credits or debits will be given for no more than three months.
8. **Total Retroactivity/Other Adjustments** – The total net amount of the retroactive and other adjustment transactions.

Benefits Snapshot

The benefits and service analysis section of your statement displays a summary of benefits for active subscribers and/or dependents on your account. The following is an explanation of this portion of the statement.

1. **Product** – Displays only those products with active membership.
2. **Plan Type** – The unique identifier code associated with those products with active membership.
3. **Singles** – (Subscriber Only) The number of single-only subscribers enrolled in the plan.
4. **Premium** – The total premium for single subscribers enrolled in the plan.
5. **Couples** – (Subscriber + Spouse) The number of couples enrolled in the plan.
6. **Premium** – The total premium for couples enrolled in the plan.
7. **Parent/Child(ren)** – (Subscriber + 1 or More Children) The number of parent/child(ren) enrolled in the plan.
8. **Premium** – The total premium for parent/child(ren) enrolled in the plan.
9. **Families** – (Subscriber + Spouse + 1 or more children) The number of families enrolled in the plan.
10. **Premium** – The total premium for families enrolled in the plan.

Continuation of Coverage

In some instances, employees can be given an opportunity to continue their group coverage for a limited period of time following certain qualifying events.

Some of the group plan provisions that allow for continuation are state or federally mandated (for example, FMLA, COBRA); others are standard features of your Aetna group plan (for example, continuation due to disease or injury).

The following pages detail the various continuation options, under federal and state law or the group plan contract, that may be available to your employees and their dependents, along with instructions for completing any forms that Aetna may require in order to continue coverage.

Disease or Injury

If an employee is absent from work due to an extended disease or injury, coverage may be continued for a limited period of time (for example, 3 - 12 months) as stated in your Employee Handbook. If the employee does not return to work when this “administrative” continuation period ends, the employee (and any covered dependents) may be eligible for any other continuation provision of your group plan (for example, COBRA) for terminated employees.

If your group plan includes life insurance, coverage for a totally disabled employee may be continued beyond any of the limits shown in your plan documents if your group plan includes a separate disability feature applicable to life insurance coverage.

If your group plan discontinues while the employee’s (and any dependents’) coverage is being administratively continued, coverage will end on the date your group plan discontinues.

Important: As the employer, you have the discretion to decide whether you will allow coverage to continue up to the limits stated in your Employee Handbook or whether you will continue coverage at all. In this case, Aetna will rely on you to notify us when you terminate the employee. Please refer to the Enrollment section of this manual for instructions for terminating coverage.

Layoff or Leave of Absence

If an employee stops working due to a temporary layoff or leave of absence, his or her coverage may be continued at the employer’s sole discretion until the end of the month following the month in which the layoff or leave began. Premium payments must continue to be made to Aetna on behalf of the employee.

Example: If the employee takes a short term leave of absence beginning on February 10, coverage can continue until March 31.

If the group plan discontinues while the employee’s coverage is being continued, the continuation coverage will cease on the date the plan discontinues.

Example: If the employee takes a short-term leave of absence beginning on February 10 and the group plan discontinues on February 28, the employee’s coverage will cease on February 28.

If you elect not to allow the employee to continue coverage, or if the employee decides he or she does not want to pay for coverage to be continued, the employee’s coverage would be immediately discontinued. Please refer to the Enrollment section of this manual for instructions for terminating coverage.

Handicapped Dependent Child

If an employee has a child who is fully handicapped or who becomes fully handicapped before reaching the limiting age for dependent children, as outlined in your group plan, the child’s life and health coverage may be continued beyond the limiting age (for example, age 19; age 26 if attending school), provided the child has not been issued a policy of individual insurance.

In order to be eligible to have coverage continued beyond your plan’s limiting age, the child must be fully handicapped due to mental illness or physical handicap.

A child is deemed to be fully handicapped if he or she is not able to earn his or her own living because of mental illness or physical handicap and must depend primarily on the employee for support and maintenance.

If the child meets the definition of a fully handicapped child, Aetna will have the right to require proof of such handicap condition. Aetna also reserves the right to require examination of the child as often as necessary to determine ongoing eligibility.

Coverage for a fully handicapped dependent child will cease on the first to occur of:

- The date the handicap ceases.
- The date the employee or child fails to provide proof that the handicap continues, when requested.
- The date the child fails to have a required exam.
- The date dependent coverage ceases under your group plan (except for reaching the limiting age).
- The date any required premiums cease.

If the handicapped child is eligible, the Request for Continuation of Medical Coverage for Handicapped Child and the Handicapped Child Attending Physician’s Statement forms must be completed. The forms are located on www.aetna.com

Continuation of Coverage

(continued)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The following is a basic summary of some of the general rules and procedures governing continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This summary is for informational purposes only; it contains partial and general descriptions of the process and obligations from the COBRA statutes and rules.

COBRA is an employer-directed law rather than a carrier-directed law. It is the employer's responsibility to abide by its mandates and obligations. Employers must consult their own legal counsel regarding compliance and any other circumstances related directly or indirectly to COBRA. Failure to comply with COBRA can result in substantial penalties, including the imposition of an excise tax of \$110 per day for each qualified beneficiary affected by the non-compliance.

Aetna offers COBRA direct billing services for a fee to plan sponsors. Our Individual Billing Administration (IBA) offers an efficient way to manage and bill COBRA continues, as well as retirees, surviving spouses, employees on leave or medical continuation — any off-payroll employee you identify who receives benefits from your group plan. IBA administers the billing and collection of individual premiums, maintains member eligibility data, disseminates funds to customers and carriers (including non-Aetna carriers), and provides many additional related services for members and customers alike.

For more information about Individual Billing Administration, call your local Aetna service representative.

Employers Impacted by COBRA

COBRA and subsequent amendments require certain employers that provide group health coverage to allow certain individuals (called qualified beneficiaries) to continue such coverage when coverage terminates because of a specified qualifying event. The employer may choose to make coverage under COBRA available at the individual's expense.

The following employers are exempt from the provisions of COBRA:

- Maintain church plans (within the meaning of Section 414(e) of the Internal Revenue Code (IRC)).
- Maintain governmental plans (within the meaning of Section 414(d) of the Internal Revenue Code (IRC)).
- Employers considered small employers under COBRA. Under COBRA, "small employer" is an employer that employed fewer than 20 employees on at least 50 percent of its typical business days during the preceding calendar year. Both full-time and part-time common-law employees are considered for this purpose. Self-employed individuals, independent contractors, and directors are not considered for this purpose. It is important to understand that the same rules of the Internal Revenue Code (IRC) for controlling employers will apply to COBRA. Employees working for employers under common control must all be aggregated for making this determination under COBRA.

Qualifying Event

COBRA provides that continuation of coverage be made available to covered employees (and anyone else who performs services for the employer and is covered by the group health plan), their spouses and dependent children who would otherwise lose coverage under the group health plan because of any of the following qualifying events:

- Termination of employment, either voluntarily or involuntarily, for reasons other than gross misconduct, which must be identified as such by the employer (termination includes strikes, layoffs and walkouts).
- Voluntary or involuntary reduction in hours of a covered employee's employment that results in the loss of coverage (a change from full-time to part-time employment or an increase in premium or contribution that results in a loss of coverage).
- Death of the covered employee.
- Divorce or legal separation of a covered employee from the employee's spouse or a spouse's divorce or legal separation from the covered employee.
- Employee's entitlement to (enrollment in) the Medicare program, leaving spouse or dependent children without coverage.
- Dependent children who become ineligible for coverage under a provision of the employer's group health plan (for example, loss of student status or attainment of maximum age for coverage).
- An employer that files for bankruptcy under Chapter 11, but only with respect to retirees, their spouses and dependents who lose coverage. This is not discussed in detail in this manual. If you want more information about this qualifying event, please contact your legal counsel.

Continuation Duration Guide (Length of COBRA)

Continuation of group coverage begins on the date of the qualifying event (for example, the date an employee is terminated, the date an employee dies, the date an employee becomes divorced) or the date of the loss of group coverage if the plan so provides. The period of COBRA continuation of group coverage varies, based on the type of qualifying event as follows:

- Eighteen months in the event of loss of coverage due to the termination of employment or reduction in hours.
- Twenty-nine months for a qualified beneficiary who is determined under Title II (OASDI) or Title XVI (SSI) of the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage, provided he or she submits notification of the Social Security Administration's disability determination to the plan administrator within 60 days of the determination and before the end of the 18-month period. It is also the responsibility of the qualified beneficiary to notify the plan administrator of a final determination that he or she is no longer disabled within 30 days of the determination.
- Thirty-six months in the event of loss of coverage due to any other qualifying event (for example, employee's death, divorce or legal separation, employee's enrollment in Medicare, children reaching limiting age).

In certain situations a second qualifying event could occur that could extend the COBRA period for up to 36 months.

Coverage may terminate before the end of the 18-, 29- or 36-month period if any of the following occurs:

- The qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition exclusion.
- A qualified beneficiary fails to make timely payments of the premiums for continuation of coverage.
- A qualified beneficiary becomes enrolled in the Medicare program after the date of his or her COBRA election.
- A qualified beneficiary becomes covered after the date of his or her COBRA election as an employee or dependent under another group health plan maintained by an employer, unless the new coverage contains any exclusion or limitation with respect to a pre-existing condition of that beneficiary.
- The employer ceases to provide any group health plan coverage to any employees (including successor plans).
- In the case of a disabled qualified beneficiary who recovers from the disability before the end of the 29-month period, coverage may be terminated as of the first of the month that starts at least 30 days after a final determination by the Social Security Administration that the beneficiary is no longer disabled.
- The Aetna contract terminates.

Right of Continuation Notice, Premium and COBRA Election Requirements

Aetna recommends you immediately notify us of all terminated employees and/or dependents when a qualifying event occurs. If the employees and/or dependents later elect COBRA continuation, you must notify Aetna again. Please refer to the Enrollment section of this manual for details on terminating coverage. If a terminated person subsequently elects COBRA, coverage will be reinstated retroactive to the termination date. Canceling coverage on a timely basis for terminated employees and/or dependents will minimize the risk of inappropriate claims payments during the election period, should the employee and/or dependent not elect COBRA continuation.

It is unnecessary to process a termination followed by a subsequent change when prompt notification to qualified beneficiaries can be made and their timely election secured. Simply process one change indicating that the employee and/or dependent is terminated and is electing COBRA.

If you are not using our direct-bill feature, you are responsible for monitoring the continuation and canceling coverage as appropriate. Although billed group charges are to be paid for anyone on continuation, the actual cost reimbursement arrangement you have with the qualified beneficiaries is up to you.

Right of Continuation Notice Requirements

If COBRA applies, the plan administrator (if different from employer) has 14 days after being informed of a qualifying event to send a Right of Continuation Notice to all qualified beneficiaries. Aetna recommends such notice be provided to the qualified beneficiary immediately, since the 60-day COBRA election period does not begin until the later of the date the qualified beneficiary is notified or the date of the qualifying event. The Right of Continuation Notices for both HMO and Traditional customers is discussed on the pages that follow.

The employee and/or dependents then have 60 days from the date they are notified or from the date of the qualifying event (whichever is later) to elect and notify you of their decision to continue the group health coverage. If they fail to elect within the proper time frame (and fail to pay in full and on time), they lose their rights to elect COBRA coverage. If the employee and/or dependents elect COBRA continuation, your company should maintain the original copy of the election form on file. You do not need to send a copy of the Right of Continuation Notice to Aetna.

The employee and/or dependents then have 45 days from the election date to pay the initial premium. Your company should receive subsequent payments within 31 days of their due date.

Continuation of Coverage

(continued)

Premium Requirements

The qualified beneficiary is responsible for paying for continuation coverage, and coverage may cease if premium payments are not made in a timely manner. The employer may pay for part or all of such premiums, but COBRA does not require employers to contribute to the cost of the coverage. Employees and dependents must be given 45 days after their election to pay the initial premium covering the period from the qualifying event or loss of coverage, if later, through the month in which the initial retroactive premium payment becomes due.

Premiums may not exceed 102 percent of the cost for other similarly situated active employees. However, in the case of a qualified beneficiary who is entitled to the 11-month extension of continuing coverage on account of a disability, the premium for the 19th through the 29th month of continuing coverage can equal up to 150 percent of the group rate.

If non-disabled family members of the disabled qualified beneficiary continue coverage after the first 18 months of COBRA coverage, but the disabled qualified beneficiary does not elect to continue the COBRA coverage, the plan cannot charge more than 102 percent of the applicable premium, depending on how the plan determines the cost of the coverage. The employer may retain the additional premium (above 100 percent) to cover administrative expenses.

Under the American Recovery and Reinvestment Act of 2009, certain assistance-eligible individuals who become entitled to elect COBRA between September 1, 2008 and December 31, 2009, may be eligible for a COBRA premium subsidy for up to 9 months. There are also additional election opportunities.

COBRA Eligible Dependents

In the event a dependent becomes eligible for federal COBRA, an Enrollment/Change form that includes the date of COBRA eligibility should be completed and submitted to Aetna. Those dependents that would be eligible for COBRA coverage are:

- Children who meet their limiting age of 19 and are not full-time students.
- Children who meet the full-time student limiting age of 26.
- Former spouse after divorce.
- Surviving dependents after death of the employee.
- Dependents after employee becomes eligible for Medicare.

It is the employer's responsibility to notify us when a change has occurred in their COBRA and Medicare status, as this does affect rates.

Effective Date

Continuation of group coverage commences on the date of the qualifying event if the plan so provides. The maximum period of COBRA continuation of group coverage varies from 18 to 36 months based on the type of qualifying event and the participant. **Note:** When a qualifying event occurs and an employee or dependent loses coverage, you must notify Aetna to terminate benefits for the employee and/or dependent(s). Aetna reserves the right to limit credit for terminations not reported in a timely manner.

Cal-COBRA

California Health & Safety Code applies to groups of 2 to 19 eligible employees.

Aetna administers Cal-COBRA for employers not subject to COBRA. Every California employer who provides group health coverage and who employed 2 to 19 employees on at least 50 percent of its working days during the preceding calendar year or, if the eligible employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, is subject to Cal-COBRA.

For these employer groups, we will administer Cal-COBRA. Under Cal-COBRA, employers are required to notify us within 31 days when an employee terminates employment or is no longer eligible due to a reduction of work hours. Employees that are terminated for "gross misconduct" are not eligible for Cal-COBRA. To notify us, you must complete the Cal-COBRA Notification form. After receipt of the notification, we will forward information regarding benefits, rates and a Cal-COBRA notification to the employee at his or her last known address.

Note: If your company is utilizing Aetna's direct bill feature, please confirm that the premium collection is taking place. In this case, the employee and/or dependents will remit payments directly to our COBRA Direct Bill unit. The use of the direct bill feature does not exempt you as the employer from your obligation under COBRA, including the immediate discontinuance of payment for the qualified beneficiary already paying directly to the COBRA – Direct Bill unit.

HIPAA

Terminated employees and/or their dependents who have exhausted or are not eligible for COBRA or Cal-COBRA coverage, may be able to continue coverage in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and any state-specific requirements or the Aetna conversion plan.

When advising employees or dependents of their rights to continue coverage under COBRA or Cal-COBRA, the employer must be sure they understand if they do not elect COBRA or Cal-COBRA continuation, they will NOT be entitled to the HIPAA guaranteed option.

Supplemental Cal-Cobra

California provides an extension under Cal-COBRA for those who have exhausted their 18 months on federal COBRA for groups with 20 or more lives, for a total extension that cannot exceed 36 months. For the special Cal-COBRA extension to apply, you must have become eligible for COBRA after January 1, 2003, and the employer's master policy must be issued in California.

To request the Supplemental Cal-Cobra benefit, the Employer is responsible for:

- Completion of the California Employer Notice of Occurrence for Supplemental Cal-COBRA Upon Exhaustion of Federal COBRA form within 31 days of exhausting federal COBRA or 60 days prior to the exhaustion of federal COBRA.
- The completed form is to be sent to the Plan Sponsor Services Cal-COBRA Unit at the following address:

Aetna Inc.
Plan Sponsor Services Cal-COBRA
1385 E. Shaw Avenue
Fresno, CA 93710
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com

Upon receipt of the form Aetna will:

- Review the eligibility of member(s) electing coverage.
- Verify that member has been enrolled in Federal COBRA and that their COBRA is exhausting or has exhausted, if possible.
- Within 14 days of receipt of the California Employer Notice of Occurrence of Qualifying Event, the Cal-COBRA Unit will prepare and send the appropriate Election form for the Supplemental Cal-COBRA to the qualified beneficiary at his or her address.

Conversion

HMOs and Traditional policies shall provide that an employee or member whose coverage under the group policy has been terminated by the employer shall be entitled to convert to nongroup membership. Employees and/or dependents who have exhausted their COBRA or Cal-COBRA rights should contact Member Services themselves to elect coverage.

Extension of Benefits

If a covered person is "totally disabled" when medical health coverage ends (that is, after any administrative, state or COBRA continuation ends), the person may be eligible to have his or her health benefits extended, without payment of premium, for a limited period of time after termination from your group plan or upon discontinuance of your group plan.

Generally, a person who is totally disabled will be covered up to 12 months, but only for expenses related to the injury or disease that caused such total disability. Some group plans will cover all injuries or diseases, not just those expenses incurred with respect to the injury or disease that caused the total disability. Please check your plan documents for the specific terms that apply to your group plan.

A covered person will be deemed "totally disabled" if:

- **Employee** – He or she is not able to engage in his or her customary occupation and is not working for pay or profit.
- **Dependent** – He or she is not able to engage in most of the normal activities of a person of like age and sex in good health.

To be considered for extension of benefits under your group plan, the covered person's attending physician must provide evidence of the disability to the claims office that processes your company's medical claims. Such evidence must be reviewed and approved by the claims office before any benefits will be paid under this provision.

Coverage under any Extension of Benefits provision becomes effective after any other continuation of coverage period, if elected, ceases. An employee or dependent cannot be on extension of benefits and subsequently elect any continuation provisions, such as any state or COBRA continuation.

Important: If a person is eligible to convert his or her coverage to a policy of individual insurance, and such conversion is offered and available under his or her group health plan, he or she must do so when applying for any extension of benefits. Failure to do so may prohibit him or her from being issued an individual policy later.

Medicare

Medicare is a federal health insurance program established for people age 65 and over and qualified disabled individuals who meet certain eligibility requirements. When an employee or dependent spouse approaches age 65, the Age Discrimination and Employment Act (ADEA) requires that an employer counsel these individuals regarding Medicare benefits. Individuals should be informed of eligibility requirements, how to apply for Medicare and how Medicare coverage operates in relation to your group health plan. Please consult with your legal counsel regarding your Medicare responsibilities.

Aetna considers a person eligible for Medicare if he or she is covered under it or is not covered under it because of having refused it, having dropped it or having failed to make proper request for it. Please refer to your plan documents for the specific terms that apply to your group plan.

Change in Coverage

A change in medical coverage may be an option when an employee and/or the employee's dependent spouse reaches age 65, and at least one of the following conditions applies:

- Your group plan is not subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and the employee/spouse has not already changed to Medicare as primary coverage.
- The employee is retired but has not already changed to Medicare as primary coverage.

A reduction in the amount of life insurance may also be required at age 65, 70 or 75.

As an employee and/or the employee's dependent spouse approaches age 65, it must be determined who will become the primary and secondary health insurer, or if the employee and/or dependent spouse will remain enrolled under your Aetna group plan. (Members already on COBRA when becoming entitled to Medicare will lose COBRA coverage, and certain retired members may lose coverage.)

Coverage is determined in part by the employee's current employment status (active or retired), whether you are subject to ADEA, and the amendments enacted as part of TEFRA, the Deficit Reduction Act of 1984 (DEFRA), COBRA, the Omnibus Budget Reconciliation Act of 1986 (OMBRA), and the Omnibus Budget Reconciliation Act of 1993 (OBRA). Please consult with your legal counsel regarding applicability of these laws.

The following general guidelines will help you determine when an individual is eligible for Medicare primary health coverage and what administrative changes, if any, must be made to provide the appropriate health coverage for the employee and/or the employee's dependent spouse. Please refer to the section that applies to your group plan.

If your group plan is subject to TEFRA

The following rules apply to employers with more than 20 eligible employees.

Aetna is primary for the *employee* if:

- The employee is active.
- The employee is retired and under 65 years of age.

Medicare is primary for the *employee* if:

- The employee is retired and is 65 years of age or older, unless the retiree has coverage under an active group plan – that is, his or her spouse is covering him or her as a dependent.

Aetna is primary for the *dependent* if:

- The employee is active.
- The employee is retired and the dependent is under 65 years of age.

Medicare is primary for the *dependent* if:

- Medicare End Stage Renal Disease (ESRD) COB rules are affected by the ESRD "coordination period."
- The employee is retired and the dependent is 65 years of age or older.

If your group plan is not subject to TEFRA:

- **Aetna is primary** for the *employee* if the employee is under 65 years of age.
- **Medicare is primary** for the *employee* if the employee is 65 years of age or older.
- **Aetna is primary** for the *dependent* if the *dependent* is under 65 years of age.
- **Medicare is primary** for the *dependent* if the dependent is 65 years of age or older.

If the member is entitled to Medicare because of disability, various factors are considered in determining the primary payer. These include, but are not limited to, the type of disability, age and retirement status. Please do not make this change without first contacting Aetna because there are circumstances that would require Aetna to be primary to Medicare, even if the person is on Medicare because of disability. To request help, contact Member Services using the toll-free number on your Aetna ID card.

Determination of primary payer is governed by different laws if the member has end-stage renal disease. Please contact the Member Services office using the toll-free number on your Aetna ID card for assistance.

Reporting the Change

If the employee and/or spouse are now eligible for Medicare as primary coverage, please refer to the Enrollment section of this manual for the information you must send Aetna when changing from Aetna primary to Medicare primary.

Dental

Enrolling New Employees

Employees should complete the Enrollment/Change form selecting the dental plan desired. Employees should also list all dependents that are to be enrolled as well.

Changes in Coverage

Employees should complete the Enrollment/Change form identifying what change in coverage is to occur. This can be either the addition of a child under the age of 5 (for their first visit) or adding or declining dependents.

Ending Coverage

Employee and dependent coverage under our plans terminate for circumstances that include:

- The subscriber leaves his or her place of employment or loses group membership.
- Your company or group covers the subscriber under an alternative health benefits plan.
- The member misrepresents himself or herself in enrollment or fraudulently uses his or her Aetna ID card.

Indicate the termination effective date and reason for termination on the Enrollment/Change form and submit to:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005 Fresno,
CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available
at www.aetna.com/employer

Late Applicants

An employee or dependent may enroll at any time.

Waiting Periods

There is no waiting period for non-voluntary dental plans for new groups with 2 to 50 employees that have credible coverage before becoming an Aetna member.

Waiting periods will be administered at the plan sponsor level based on the type of prior coverage. These two examples illustrate both prior coverage situations:

- **2 to 50 lives – The prior carrier covered major but excluded orthodontia:** the waiting period will not apply to covered major services but will apply to orthodontia (if the new Aetna plan covers orthodontia) for existing members and new hires.
- **2 to 50 lives – The prior carrier covered major and orthodontia:** the waiting periods will not apply to covered major or orthodontic services for existing members and new hires.

Note: This provision does not apply to existing groups.

Employer Contribution

The employer must contribute at least 50 percent of the employee-only cost or 25 percent of the total cost of the plan.

Participation

Groups with 2 to 3 eligible lives – 100 percent participation is required, excluding those with other qualifying existing dental coverage.

Groups with 4 to 50 eligible lives – 75 percent participation is required, excluding those with other qualifying existing dental coverage. A minimum of 50 percent of total eligible employees must enroll in the dental plan.

100 percent participation is required in plans that are non-contributory (employer paid 100 percent). All employees, excluding those with other qualifying dental coverage, must enroll.

Employees may select coverage for eligible dependents under the dental plan, even if they selected single coverage on the medical plan or vice versa.

Open Enrollment

Open enrollment is prohibited for dental insurance.

Voluntary Dental Options

The Voluntary Dental options provide a solution to meet the individual needs of members in the face of rising health care costs. Administration is easy and members benefit from low group rates and the convenience of payroll deductions. Employers choose how the plan is funded. It can be entirely member paid or employers can contribute up to 50 percent. Please contact your broker if you would like to add one of our Voluntary Dental plans.

Life Insurance

Premiums

Premiums for life insurance are age banded and are guaranteed for two years.

Enrolling New Employees

For new hires enrolling into the Guarantee Issue amount of life insurance, an Enrollment/Change form is needed in which beneficiary information should be included. For new hires enrolling into an amount higher than the Guarantee Issue amount, the employee needs to complete the Enrollment/Change form to include the medical information. At the time of submission the employee is subject to Evidence of Insurability (EOI).

Late Applicants

Late applicants without a qualifying event (i.e. marriage, divorce, newborn child, adoption, loss of spousal coverage) are not allowed and must wait for the group's next renewal date to enroll.

Late applicants are subject to Evidence of Insurability regardless of if the group has only elected the Guarantee Issue amount. Employees that are late entrants must qualify for life insurance at any amount.

Employer Contribution

For groups with less than 10 eligible employees, the employer must contribute 100 percent of the cost of the plan.

For groups with 10 to 50 eligible employees, the employer must contribute at least 50 percent of the cost of the plan (excluding Optional Dependent Life).

Participation

For groups with less than 10 eligible employees, 100 percent participation is required.

For groups with 10 to 50 eligible employees, 75 percent participation is required if the plans are at least partially contributory. If the plans are non-contributory 100 percent participation is required.

Changing Coverage

If the employer chooses to increase coverage at the anniversary/renewal period, or if this amount is above the Guarantee Issue amount, then all employees are subject to EOI. Employees need to complete the Enrollment/Change form to include all sections (medical is required).

Ending Coverage

Employee and dependent coverage under Aetna plans terminate for circumstances that include the following:

- The subscriber leaves his or her place of employment or loses group membership.
- Your company or group covers the subscriber under an alternative health benefits plan.
- The member misrepresents himself or herself in enrollment.

Indicate the termination effective date and reason for termination on the Enrollment/Change form and submit to:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available at www.aetna.com/employer

Job Classification (Position) Schedules

Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to three separate classes are allowed (with a minimum requirement of 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employees. The class with the richest benefit cannot have greater than five times the benefit amount as that of the lowest class.

Example:

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

Beneficiary Designations

Life insurance beneficiaries are not required; however, if not listed on the employee Enrollment/Change form, this will cause a delay in payment.

Checklists

New Hire Checklist

Benefits Description

Include a copy of the plans that are available to the employee. This includes medical, dental, life, etc.

Indicate the date the employee is eligible for benefits based on the company's Employee Waiting Period.

Include information about the cost of the benefits for the employee. This amount will vary if the employee is covering a spouse, child or children. Explain "pre-tax" if applicable.

Enrollment Form

Send a completed application to Aetna within 31 days of the requested effective date. Make sure the employee answers all the questions to ensure the application is processed timely and accurately.

If the employee is enrolling in an HMO plan, make sure he or she chooses a primary care physician (PCP).

If the employee is enrolling in a MC/PPO plan and has not had coverage for at least six months, he or she may be subject to a pre-existing condition.

If the employee is declining coverage, make sure you get a waiver form.

Send Enrollment/Change forms to:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available at www.aetna.com/employer

DocFind

Give the employee the Aetna website or DocFind address so he or she can find network doctors or, if applicable, choose a PCP.

Submit Enrollment Form

Submit completed enrollment form(s) to Aetna before the effective date. Keep a copy of the enrollment form(s).

Make sure the new hire's name appears on the first bill after the effective date.

Employee Termination Checklist

Complete the Enrollment/ Change form.

Submit form

It is important that you do this as soon as possible to avoid having to pay premium for the terminated employee:

Aetna
Attn: Billing & Enrollment
P.O. Box 24005
Fresno, CA 93779-4005
Phone: 1-877-249-7235
Email: enrollmentsgw@aetna.com
Online access to enrollment is available at www.aetna.com/employer

Confirm the employee's name is deleted from the next billing cycle.

Send applicable COBRA statements.

All employers who had 20 or more employees on 50 percent of its typical business days during the preceding calendar year must comply with federal COBRA.

Glossary

Benefits Waiting Period

The probationary period or the amount of time a new hire must wait to become eligible for coverage with Aetna. Determined by the plan sponsor at the time benefits are elected and set up.

HMO

Health Maintenance Organization

IPA

Independent Physician Association

Indemnity

Traditional plans for areas within a state that do not have participating HMO or PPO health care providers.

MOD

Mail-order drug

PCP

Primary care physician. For HMO plans, members must choose a primary care physician (PCP) to receive benefits. PCPs are family practitioners, general practitioners, internists and pediatricians.

Preferred Provider

Doctors, hospitals and other health care providers that participate in the Aetna PPO network. To receive maximum benefits, an employee should visit providers who are preferred or in the network.

PPO

Preferred provider organization

Provider

Doctors, hospitals, labs and other health care professionals and facilities.

Traditional Products

PPO and indemnity medical, dental, life and disability plans:

- MC – Managed Choice®
- HDHP – High Deductible Health Plan
- HRA – Health Reimbursement Arrangement

HMO Products

- AVN – Aetna Value NetworkSM
- HRA – Health Reimbursement Arrangement
- HSA - Health Savings Account

Privacy Policy

The Notice of Aetna's Privacy Practices describes our privacy policy. We distribute the required notices to members as required by law. This Notice is required by the Federal HIPAA Privacy Rule and also by individual state Gramm-Leach-Bliley Privacy Regulations. The notice may differ based on the insured product. Product-specific versions of the Notice are available on our website at www.aetna.com/about/privacy.html.

These Privacy notices are not applicable to employees in self-funded benefits plans. Instead, plan sponsors may be obligated to develop and provide employees in self-funded benefits plans with their privacy notice. Please consult your counsel and/or consultants to develop any such required privacy notice.

Additional Privacy Information

While not a formal part of the employee Booklet or Certificate, the following Confidentiality Notice is included along with employee Booklets/ Certificates to comply with state requirements.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payers (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third-party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include: claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance

measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third-party administrators; underwriting activities; and due-diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans.

To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our website at www.aetna.com/about/privacy.html.

Your Right of Access and Correction

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information that relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment or deletion of personal information. This can be done in states that provide such rights and that grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna
Executive Response Team MCAF
151 Farmington Avenue
Hartford, CT 06156

For more information about Aetna plans,
visit www.aetna.com

Benefits, limitations, service areas and premiums are subject to change on January 1 of each year. This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. The Aetna Personal Health Record ("PHR") should not be used as the sole source of information about the member's medical history. Discount programs provide access to discounted prices and are NOT insured benefits. Information is believed to be accurate as of the production date; however, it is subject to change.

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