

Administrative Handbook

Small Business Employers



**For groups with
2 – 50 eligible employees**

Dear Plan Sponsor:

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

At Aetna, we want you to know. 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 manual provides a summary of the administrative information you'll need to help you 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 manual. The Customer Service Information sections, immediately following this letter, contain phone numbers and addresses for the Aetna departments you will need to contact.

As you read through this manual, 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 we have already provided to you.

Thank you for choosing Aetna. It's our privilege to serve you.

Sincerely,

Aetna

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Customer service — here to help

Here are the information and instructions you'll need for contacting us when you have a question or a problem with your group plan. We've also provided instructions for ordering additional forms, as you may need them.

Note: When contacting Aetna, please be prepared to provide certain information specific to your group plan, such as your plan's control, suffix and account number or group number. If you are calling about an employee, be prepared to provide the employee's Social Security number. Having this information readily available will help avoid delays.

How to make general inquiries

For questions or problems concerning your billing statement (e.g., Summary Statement or Service Fee Invoice) or any other aspect of the administration process not covered in this manual, or for which a specific address or phone number has not been provided, contact one of these parties, in this order:

- Your servicing Aetna claims office (for a claims issue)
- Your Aetna service representative*
- The Customer Service Unit or contact name as it appears on your billing statement**
- Or, you can write to the Aetna Plan Sponsor Services location that services your group plan

Information on eligibility and enrollment

Forward completed application information to the designated address on the application. To ensure timely processing and accurate billing information, applications should be forwarded as soon as possible. Questions regarding eligibility may be directed to Plan Sponsor Services.

Payments:

Payment of monthly billing statements should be forwarded to the address on the invoice. To expedite the processing of your payment, please include a copy of the invoice.

How to file for claims and reimbursements

PPO/Indemnity claims and reimbursements

If a member receives a bill for covered services, she or he should send the itemized bill for payment, with his or her member ID number clearly marked, to Claims Reimbursements as indicated on the employee's ID card, or to:

Attn: Claims Reimbursement
Aetna Health Inc.
P.O. Box 14079
Lexington, KY 40512-4079***

For questions about claims, members are asked to call the Member Services toll-free number on their ID cards **1-888-80-AETNA (1-888-802-3862)**.

HMO claims and reimbursements

If a member receives a bill for covered services from an HMO or wishes to submit a reimbursement for eyeglasses/contacts or prescriptions, she or he should send the itemized bill for payment, with his or her member ID number clearly marked, to Claims Reimbursements as indicated on the employee's ID card:

Attn: Claims Reimbursement
Aetna Health Inc.
P.O. Box 14079
Lexington, KY 40512-4079***

For questions about claims, members are asked to call the Member Services toll-free number on their ID cards **1-888-70-AETNA (1-888-702-3862)**. When submitting a claim for an out-of-network provider, members in the Quality Point-of-Service® (QPOS®) program are asked to use the special claims envelope for this program.

*Contact your Aetna service representative when you have a question regarding renewing your group plan. Otherwise, direct all calls, except for claims or benefits questions, to the Customer Service Unit at the toll-free number listed on your Billing Statement.

**Please note that this number is for your group benefits administrator or an individual who has the authority to act on behalf of your company. The number is not to be released to employees. Employee claims and benefits questions should be directed to the toll-free number shown on the employee's ID card.

***This may or may not match what is on the employee's ID card.

Aetna — Plan Sponsor Services

Mailing Address

Enrollment/Changes Phone

(____) _____

Fax

(____) _____

Control

(____) _____

Suffix

Account

Aetna — Marketing

Marketing Office

Service Representative

Phone

(____) _____

Fax

(____) _____

Claims office information

The claims office that is nearest your primary place of business typically will process your claims. The address and toll-free phone number are shown on your employee's ID card.

Forms and supplies

Your Aetna service representative will provide the forms necessary for the administration of your plan, including additional enrollment forms; please call your service office representative.

All forms, other than enrollment:

If the form number is GR-50000 through GR-59999 or GR-60000 through GR-69000, you may order additional copies from your Aetna service representative. If the form number begins with the letters "GC," you may order additional copies and envelopes through the claims office or your Aetna service representative.

Customer service — here to help (*continued*)

Emergency services — what you need to know

Emergency care is provided 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 these guidelines for 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 first call his or her primary care physician (PCP). If a call is not made beforehand, 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 so the PCP can 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 if there are any time limits for notification.
3. If a member is admitted to an inpatient facility, the member, or a family member or friend, should notify the member’s PCP as soon as possible on his or her behalf.
4. The PCP should coordinate all follow-up care.

What to do outside Aetna’s 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. Urgent care may be obtained 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’s service areas.

If, after reviewing information submitted to us by the attending health care professional, we judge that the situation does not qualify for urgent or emergency coverage, we may need additional information from the member. A Member Services representative can take this information by phone, or we will send the member an Emergency Room Notification Report to complete.

Follow-up care after emergencies:

The member’s PCP should coordinate all follow-up care. 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, she or he must obtain a referral before any follow-up care can be covered. Examples of follow-up care include suture removal, cast removal, X-rays, and clinic and emergency room revisits.

Enrollment — getting your people covered

The Enrollment section of the manual is divided into two parts. The first deals with employee eligibility and how they enroll. If your group plan includes health coverage, this section, for example, explains how an employee's late enrollment may affect the coverage start date.

The second part provides guidance for enrollment. It also provides several examples of the most common events that affect benefit changes and instructions for processing those changes. It shows, for example, how to add new dependents or terminate coverage when employment terminates.

For most companies, enrollment and benefit changes represent the greatest share of the administrative process. As such, we recommend that you familiarize yourself with this section and pay particular attention to the information that must be included on an enrollment or change form. This will prevent potential claims problems that arise caused by delayed enrollment or missing information.

For your convenience, an “Enrollment Checklist”

For your convenience, we recommend that you refer to this checklist whenever you process a request for enrollment or benefits change.

The first part of this section covers:

- Open enrollment
- Internet-based eligibility solutions
- Contributory coverage/noncontributory coverage
- Probationary period/waiting period
- Duplicate coverage
- Identification cards (ID cards)
- Aetna Navigator®
- Aetna Voice Advantage®

The second part of this section covers:

- New employee, first steps
- Privacy notice
- Completing an Enrollment/Change Request Form

Open enrollment — the time for your people to choose

The open enrollment period is the time of year during which you and your employees can reevaluate your benefits needs and select the plan(s) that best meet those needs for the following year. The actual open enrollment process generally involves four steps:

1. Announcement — 1st week
2. Distribution of information — 2nd week
3. Employee meetings — 3rd week
4. Enrollment activities — 4th week

The timing of open enrollment greatly affects the service your members receive. By conducting the enrollment at least two months prior to your effective date, ID cards will likely be received prior to the effective date, and your bill should be accurate.* In addition, your employees can make informed decisions by having sufficient time to learn about all their benefits options.

Here is the optimal time frame for running your open enrollment for a January 1 effective date:

November 1: Begin open enrollment

December 1: Applications due

January 1: Benefits effective

*Note: New Hampshire mandates an open enrollment period of 60 days for small employers (100 employees and under).

Enrollment — getting your people covered (*continued*)

Electronic enrollment and other Internet-based solutions

Through the use of secure, web-based tools and applications, we have improved our customer service and administration. Plan sponsors can now conduct several different functions at one site, rather than having to go through several separate logins and applications.

Guidelines for participation and contribution — contributory and noncontributory coverage

Note: Small group contribution guidelines can vary by state.

Standard Participant Guidelines for groups with 2 to 50 eligible employees*

Groups with 2 to 9 eligible employees: 100 percent of eligible employees, excluding those waived by spousal coverage, must participate in Aetna's plan.

Groups with 10 or more eligible employees:

- 75 percent of eligibles, excluding spousal waivers, must participate in Aetna's plan. In addition, 50 percent of total eligibles, regardless of spousal coverage, must participate in Aetna's plan.
- Minimum of 2 eligibles, unless state regulations require 1 eligible.
- 100 percent participation is required for non-contributory plans.
- Eligibles waiving coverage must complete a waiver and provide proof of enrollment in a spouse's plan by submitting a copy of the ID card for that plan.
- Coverage can be denied based on inadequate participation.
- Dependent participation is not required.
- When determining the number of employees that must enroll, round to the nearest whole number unless state legislation specifies otherwise. Less than .5, round down. For .5 or higher, round up.

Standard Employer Contribution Guidelines for groups with 2 to 50 eligible employees*

Groups with 2 to 9 eligible employees: Employer must contribute 100 percent of the employee-only plan cost or 50 percent of the total plan cost.

Groups with 10 to 50 eligible employees:

- Employer must contribute at least 50 percent of the total plan cost or 75 percent of the employee-only cost of coverage.
- In option situations, the employer-contribution strategy must place Aetna on at least a level playing field with any competitive offering.
- Coverage can be denied based on inadequate contributions.
- Different employer contribution levels may not be offered within the same group.

How the probationary or waiting period may affect your people

Existing employees (those already working on your plan's effective date) generally will not have to serve a probationary or waiting period in order to be eligible for benefits on your plan's effective date. New employees, however, generally will be required to serve a probationary period before their benefits take effect. As the employer, you have the discretion to decide whether or how long new employees (or, if you choose, existing employees) must wait to be eligible for coverage. If employees are required to serve a probationary period, it must apply equally to all employees in that class (for example, full-time or part-time).

If you select a probationary period, the employee's eligibility date is the day after she or he finishes serving the probationary period. In order to be eligible for coverage, the employee must sign and return the enrollment form within 31 days of his or her eligibility date. Otherwise, the employee will be treated as a "late enrollee," whose coverage may be subject to the requirements outlined in the Late Enrollees section that follows.

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 provide coverage only 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. In addition, employees who terminate employment and who are then rehired within one year do not have to serve a new probationary period.

Examples:

1. Jim Smith has a three-month probationary period. Jim is hired on January 1 and enrolls in your group plan immediately. Since Jim must first serve his probationary period, his coverage will not become effective until April 1.

2. June Smith has a three-month probationary period. June is hired on January 1, making her eligibility date April 1. On April 24, she gives her signed enrollment form to you. June can be covered, since she signed and returned her enrollment form to you within 31 days of her eligibility date. Her coverage becomes effective on April 24.

3. Jon Smith has a three-month probationary period. Jon is hired on January 1, making his eligibility date April 1. On May 19, he gives his signed enrollment form to you. Since Jon did not enroll within 31 days of his eligibility date, he must wait until the next annual open enrollment period, or HIPAA qualifying event, to enroll for health coverage.

Note: If an employee is away from work because of illness or injury on the date any coverage other than health coverage would have taken effect, such coverage does not take effect until the employee returns to work for one full day. If an employee has enrolled for dependent coverage, dependent coverage usually takes effect when the employee's coverage takes effect. New dependents not enrolled within 31 days may be subject to late-enrollee requirements. See the following section for details.

Enrollment — getting your people covered (*continued*)

How to handle late applicants

Employees requesting enrollment more than 31 days from the date first eligible, must wait for the group's next renewal date, open enrollment or late entrant period. Late applicants (those requesting enrollment more than 31 days following the date of the HIPAA qualifying event or state legislative mandate) must wait for the group's next renewal date, open enrollment or late entrant period to enroll. Enroll the employee in a "Not Insured" status and understand that the employee is not insured and must enroll at the next open enrollment or late entrant period. The applicant must reapply for coverage 30 days prior to the plan anniversary date.

Exceptions:

- Colorado (applies to small group only): Late entrants are deferred for 12 months.
- California (applies to groups of all sizes): Special rules apply to California applicants.
- New Jersey (applies to small group only): New Jersey late entrants cannot be postponed. See special rules that apply to New Jersey late enrollees.

Enrollment period

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

HIPAA special enrollment periods

An employee or dependent may be eligible for enrollment under a special enrollment period if she or he did not elect coverage because she or he was already covered under another group plan and then lost coverage because of one of the HIPAA qualifying events listed at right. The employee and/or dependent(s) will generally be 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 covered in your plan documents.

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

Special enrollment through HIPAA qualifying events:

- Cessation of COBRA or state-mandated continuation (18/29/36 months must be exhausted)
- Cessation coverage for incapacitated children (handicap coverage)
- Change from full-time to part-time status
- Loss of spouse/dependent coverage because a company is out of business
- 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

The following additional HIPAA qualifying events are effective as of 7/1/2005:

- Dependent moving out of an HMO service area and no other option available under the plan
- Plan ceases to offer dependent coverage
- Loss of dependent status, per the terms of the plan
- Termination of benefit-package options, unless a substitute is offered

Employees may be allowed to enroll for nonmedical coverages (for example, life insurance and accidental death and dismemberment coverage) prior to the annual open enrollment if they are able to satisfy our requirements for evidence of insurability. Please refer to the Life Insurance section of this manual for information on requirements for evidence of insurability.

If you have any questions about late enrollment or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contact the person whose name appears on your billing statement. If your billing statement does not include a name, call the toll-free number shown on your statement. Please refer to the Customer Service Information section of this manual for additional information.

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, except where required by state law. Please contact your Aetna service representative for information on your group plan.

ID cards

ID cards are issued for medical coverage so that physicians, hospitals and other health care professionals can verify coverage and bill Aetna for services rendered. ID cards vary according to the plan selected and state legislation. 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 (PCP) telephone number (if applicable)*
- Copay amounts (if applicable)
- Claims office address and phone number
- Member Services toll-free number

The ID cards are mailed directly to employee homes or to the plan sponsor, depending on the plan selected.

Additional or replacement ID cards may be obtained by calling the person or the customer service number listed on your billing statement or by calling the Member Services phone number on the ID card. Members may also visit our website **www.aetna.com** to make this request.

Members usually receive their ID cards within 30 days of our receipt of their enrollment. When you return a copy of the Aetna enrollment form to your employee after you have signed the employer authorization with the effective date, it may be used for 30 days from the effective date for PCP office visits only. Members can also print a temporary ID from Aetna Navigator.

*In some states, HMOs are required to designate a PCP for members who do not select one at the time of enrollment. The selection is a random process based on proximity to the member's residence. Members are free to change this selection at any time.

Enrollment — getting your people covered (*continued*)

If you provide prescription coverage, please note that many pharmacies will not dispense medications without payment unless the member presents the ID card. Members who have not yet received their ID card may still have their prescriptions filled at a participating pharmacy. Once they have received their card, they can send us a copy of the prescription receipt with their member ID clearly marked on it, and we will reimburse them for the cost, less their copayment. The pharmacy directory contains a list of local participating pharmacies, as does DocFind® (see next section for more information).

Physician listing and changes: Members may also change their PCP selections, update their home address and request extra ID cards by visiting our website at www.aetna.com. Members may also locate a participating physician, dentist or other health care professional simply by linking to DocFind, our extensive online directory. In addition, members may change their PCP and dentist selections by calling Members 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. New ID cards are also automatically generated when there is a copayment change to the Aetna benefits plan, changes to the plan type, or an addition/deletion of prescription drug benefits.

Aetna Navigator: A better way to manage health and financial information

Aetna Navigator, www.aetna.com, is our secure website that subscribers and their covered family members can use to manage their health and financial information — 24 hours a day, 7 days a week. Once registered, here's what subscribers can do:

Review plan information

- Who is covered, claims status and EOB statements
- Selections for primary care physician (PCP) or primary care dentist (PCD)
- Aetna's pharmacy information, including the Medication Formulary Guide, participating pharmacies and Aetna's mail-order drug program
- Status of health care account(s), account balance(s) and tools

Access helpful resources to manage health care

- Personalized health history report that 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
- Estimate the Cost of Care tool, which compares the estimated costs for health care services; review costs for medical procedures, office visits, medical diseases and conditions, prescription drugs and dental procedures
- Price transparency tool, which allows members to compare providers' actual prices to his or her peers and view quality and efficiency ratings (available in certain markets)
- The Aetna Navigator Hospital Comparison Tool, to help members review hospitals based on selected criteria
- An online survey for members to rate their health care professional

Perform transactions

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

Gain access to sources of health information

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

When registered, dependents, depending on their plan, can:

- Access Simple Steps To A Healthier Life®, their online wellness program (dependents 18 years and older)
- Refill mail-order prescriptions and check on the status of orders (when available, for dependents 13 years and older)

The advantage of Aetna Voice Advantage

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

- Fewer questions to get information, to minimize steps and increase satisfaction
- A choice of self-service options, for simple and everyday inquiries
- Seamless routing, to provide direct access to the most appropriate customer service professional
- Member information 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 speech-recognition technology that recognizes what callers say and responds in a conversational manner. It has been proven to help members 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. The service allows members to:

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

Making new employees feel welcome

We can help you make new employees feel welcome by making benefits enrollment an integral part of the hiring process. We provide enrollment material and benefits literature to your new employees so that they can make informed decisions and prevent potential problems with claims caused by delayed enrollment or missing information.

If you choose to make benefits enrollment part of your hiring process, you may want to provide the following to new hires:

- An enrollment form with instructions
- A copy of your plan's Booklet/Certificate (or Summary Plan Description*)
- A Privacy Notice

*If you elect to produce your own Summary Plan Description (SPD) in lieu of using a Booklet/Certificate produced by Aetna, please remember you are responsible for providing the employee with a statement of their rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), if you have established an ERISA plan. We can assume no responsibility for providing this statement.

Enrollment — getting your people covered (*continued*)

Enrollment form. Many states have laws governing the information that may be collected on an enrollment form, so you may need to use more than one form for your workforce. Web links to enrollment forms are located at the end of this section, or your Aetna service representative can get you the right ones.

Booklet/Certificate. Your plan's Booklet/Certificate contains a detailed description of your plan's benefits and limitations. If you offer your employees a choice of more than one plan of benefits (for example, PPO or Managed Choice®), employees should be given a copy of each Booklet/Certificate.

Privacy Notice. The Privacy Notice describes certain aspects of our privacy policy, which applies to the employee as a covered person in a plan of group insurance insured by Aetna. This notice is not required if your group plan is an administrative services contract (ASC).

As a general standard, the Privacy Notice is not part of either the group agreement or the employee's Booklet/Certificate. To help employees keep their health benefits-related material organized, however, we bind it into the Booklet/Certificate. If your plan includes insured coverages and you have elected to produce your own SPD, we are happy to provide you our privacy policy as a convenient way for you to furnish notice to your employees.

The Gramm-Leach-Bliley Act (GLBA) regulates the disclosure of a patient's non-public personal information by financial and insurance institutions. It requires us to distribute a Notice of Privacy Practices to plan sponsors and subscribers of our fully insured benefits plans. Notices are mailed to existing Aetna members and are included in standard enrollment packages.

If you have employees who are enrolled in a self-funded benefits plan, we encourage you to inform them of our policy by providing them with a copy of our Notice. Product-specific versions of the Notice are available on our website at www.aetna.com/about/privacy.html.

How we protect privacy

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

Since privacy notices are not applicable to employees in self-funded benefits plans, plan sponsors may be obligated to develop a privacy notice and provide it to these employees. Please be sure to consult your counsel and/or consultants about developing any such required privacy notice.

Confidentiality Notice. While not a formal part of the employee booklet or certificate, the following Confidentiality Notice, in compliance with state requirements, is included along with employee Booklets/ Certificates:

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 Internet site 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

Traditional enrollment

Completing an Enrollment/Change Request form. The Enrollment/Change form is used to enroll new subscribers, to process changes in family status, such as the birth of a child or marriage, or to change plan coverage.

Enrollment/change forms vary by state and according to the plan selected. Your service representative can provide you with these correct forms. A sample of a medical Enrollment/Change form is included later in this section.

Upon completion, please make a copy for your records. Members can use this as a temporary ID card until they receive a permanent one.

For each of the transactions described on the following pages, if any of the pertinent information is missing, it could delay enrollment or pose problems with claims.

Enrollment — getting your people covered (*continued*)

As the employer, you are responsible for making sure that your employees have properly completed all enrollment or change request forms before you call or mail or fax them to us. If you have any questions, call Aetna Plan Sponsor Services at the number shown in the Customer Service Information section of this manual.

Custom enrollment forms

Since custom enrollment forms for full-risk and self-insured business require advanced approval by Aetna and, when required by the state in which the business is written, filing with the appropriate regulatory authority, we cannot always accept them. Regardless of the enrollment or change form you are using, however, the following information must be provided for each respective situation:

1. Enrolling a new or rehired employee

Employer group information

Employer name: If not preprinted, please add.

Employer address: The employer's primary business location.

Control, suffix and account numbers: If not preprinted, please add.

Plan number: The plan number identifies the combination of benefits offered under your group plan. It details the employees eligible for a particular plan, the particular benefits covered under each plan, the plan numbers and basic administrative instructions. If your group plan offers more than one combination of benefits, please refer to your plan summary sheet for the appropriate plan number. We either have included the plan summary sheet in the front pocket of this manual, or your Aetna service representative will provide it to you.

Servicing field office: This information will be preprinted on your Enrollment/Change Request form.

Activity information

Type of activity: New enrollee or rehire (check one) and include the employee's date of hire.

Effective date of activity: This is the date the employee's coverage takes effect. For example, if an employee starts work on February 1 and has to serve a two-month probationary period, you should show April 1 as the effective date.

Employee information

Employee's Social Security number:

Necessary for the employee's Aetna ID number.

Employee's name: The employee should list his or her full name (last, first, middle initial). Do not use nicknames.

Employee's address:

Street, city, state, zip code.

Employee status: Indicate whether the employee is active or retired.

Employee's sex: Show "M" for male and "F" for female.

Phone numbers: Fill in the employee's home and work phone numbers.

Beneficiary designation: If your group plan includes life insurance, this information is necessary to determine who receives benefits in case of death. If additional space is needed, use the space for Special Remarks.

Beneficiary's Social Security number:

Needed for paying claims, if available.

Relationship to employee:

The relationship of the beneficiary to the employee.

Earnings: If benefits (for example, life insurance or disability coverage) are based on earnings, indicate the employee's weekly, monthly or annual salary in whole dollars.

Individuals covered

Transaction type: Show "A" for adding new coverage.

Relation code:

Spouse

- "H" — Husband, Common Law Spouse or Civil Union Partner
- "W" — Wife, Common Law Spouse or Civil Union Partner
- "Y" — Sponsored Male (Domestic Partner)
- "X" — Sponsored Female (Domestic Partner)

Children

- "S" — Biological, adopted, stepson, or any other unmarried child the employee supports under the plan's limiting age who lives with the employee in a parent-child relationship (i.e., grandson, domestic partner's son, nephew, foster child, etc.).*
- "D" — Biological, adopted, stepdaughter, or any other unmarried child the employee supports under the plan's limiting age who lives with the employee in a parent-child relationship (i.e., granddaughter, domestic partner's daughter, niece, foster child, etc.).*

Name: While it is not necessary to repeat the employee's name, the employee should list his or her dependents' full names (last, first, middle initial). Do not use nicknames.

Social Security numbers: While it is not necessary to repeat the employee's Social Security number, the employee should list the Social Security numbers of any dependents being covered. If a dependent does not have a Social Security number, indicate "none."

Birth date: The employee must list his or her birth date and the birth dates for all dependents.

Dependent addresses: List if different from the employee's — for example, dependent children attending school. Note: This information is required only for IMO customers.

Prior insurance plan: Indicate "yes" if the employee and/or dependents had prior health coverage, and list the information in the space provided.

Other health coverage: Indicate "yes" if the employee and/or dependents have other health coverage, and list the information in the space provided.

Currently covered by Medicare: Indicate "yes" if the employee or dependent is eligible for Medicare coverage.

Handicapped children: Indicate "yes" if the employee is enrolling a handicapped child.

Students age 19 or older: Indicate "yes" if the employee is enrolling a child over the age of 19. Dependent children over age 19 who are not attending school generally are not eligible for coverage.

Primary medical office ID number: If your group plan requires the selection of a primary care physician (PCP), list the physician's name and Aetna ID number for the employee and each dependent.

Previously seen: Check "yes" if the employee or dependent has seen the PCP previously.

Acknowledgments:

Employee's signature: The employee must sign and date the form.

Employee's e-mail address: Optional

Employer's Signature: The employer must sign and date the form.

*If your group plan permits employees to cover dependent children who are not their own biological, adopted or stepchildren — such as a niece, nephew or grandchild — the employee needs to complete a Special Dependent form to determine if the child is eligible for coverage. If the Special Dependent form is not submitted with the enrollment form, we will send you a copy for completion by the employee. A sample of the form is included later in this section.

Enrollment — getting your people covered (*continued*)

2. Adding or changing dependents

Activity information

Effective date of activity: This is the effective date the dependent's coverage should be added or changed.

Employer group information

Employer name: If not preprinted, please add.

Control, suffix and account numbers: If not preprinted, please add.

Employee information

Employee's Social Security number: List employee's Aetna ID number.

Employee's name: The employee should list his or her full name (last, first, middle initial). Do not use nicknames.

Individuals covered

Transaction type: Show "A" for adding new coverage or show "C" for changing coverage.

Relation code:

Spouse

- "H" — Husband, Common Law Spouse or Civil Union Partner
- "W" — Wife, Common Law Spouse or Civil Union Partner
- "Y" — Sponsored Male (Domestic Partner)
- "X" — Sponsored Female (Domestic Partner)

Children

- "S" — Biological, adopted, stepson, or any other unmarried child the employee supports under the plan's limiting age who lives with the employee in a parent-child relationship. (i.e., grandson, domestic partner's son, nephew, foster child, etc.)*
- "D" — Biological, adopted, stepdaughter, or any other unmarried child the employee supports under the plan's limiting age who lives with the employee in a parent-child relationship. (i.e., granddaughter, domestic partner's daughter, niece, foster child, etc.)*

Newborn children of an employee or an employee's dependent are automatically covered for 31 days after birth. To continue coverage of a newborn child beyond 31 days, the employee must apply to Aetna by submitting the change to you within the 31-day period. The change can be made on the appropriate enrollment/change form. This 31-day grace period varies by state. Please consult your Group Agreement for details.

Name: List the dependent's full name (last, first, middle initial). Do not use nicknames.

Social Security numbers: List the Social Security numbers of any dependents being added or changed. If a dependent does not have a Social Security number, indicate "none."

Birth date: Indicate the date of birth for the dependent.

Dependent address: List if different from the employee's — for example, dependent children attending school. Note: This information is required only for IMO customers.

Prior insurance plan: Indicate "yes" if the dependent had prior coverage and list information in the space provided.

Other health coverage: Indicate "yes" if the dependent has other health coverage and list information in the space provided.

Currently covered by Medicare: Indicate "yes" if the dependent is eligible for Medicare coverage.

*If your group plan permits employees to cover dependent children who are not their own biological, adopted or stepchildren — such as a niece, nephew or grandchild — the employee needs to complete a Special Dependent form to determine if the child is eligible for coverage. If the Special Dependent form is not submitted with the enrollment form, we will send you a copy for completion by the employee. A sample of the form is included later in this section.

Handicapped children: Indicate “yes” if the child is handicapped. If the child is over the limiting age of a group plan (for example, age 19 or age 23 if attending school) please provide the member with the following forms:

- Request for Continuation of Medical Coverage for Handicapped Child
- Handicapped Child Attending Physician Statement

For further information on handicapped children and to locate sample forms, please refer to the Handicapped Dependent Children section under the Continuation bookmark.

Students age 19 or older: Indicate “yes” if the employee is adding a dependent child over age 19 and the child is attending college.

Individuals covered

Primary medical office ID number:

If your group plan requires the selection of a primary care physician, list the physician’s name and ID number.

Previously seen: Check “yes” if the dependent has seen the PCP previously.

Acknowledgments

Employee’s signature: The employee must sign and date the form.

Employer’s signature: The employer must sign and date the form.

3. Removing dependents from coverage

Activity information

Effective date of activity: This is the effective date you wish to remove the dependent’s coverage.

Employer group information

Employer name: If not preprinted, please add.

Control, suffix and account number:

If not preprinted, please add.

Employee information

Employee’s Social Security number:

List employee’s Aetna ID number.

Employee’s name: The employee should list his or her full name (last, first, middle initial). Do not use nicknames.

Individuals covered

Activity type: Fill in “R” next to the name of each dependent being removed.

Dependent’s name: The employee should list dependent’s full name (last, first, middle initial).

Dependent’s Social Security number:

List the Social Security numbers of any dependents being removed.

Acknowledgments

Employee’s signature: The employee must sign and date the form.

Employer’s signature: The employer must sign and date the form.

4. Termination or cancellation of coverage

Activity information

Effective date of transaction: This is the date the employee’s employment terminates or the date the employee cancels his or her coverage. For credit transactions, the effective date will be limited to three months from the date we receive your request. The date the employee terminates or cancels coverage can be either:

- The date the employee ceases active work, is no longer in an eligible class or cancels coverage.
- The last day of the billing cycle during which the employee ceases active work, is no longer in an eligible class or cancels coverage. For example, if your next billing due date is November 1 and an employee’s last day of work is October 23, you have the option of extending that employee’s benefits through October 31, the end of the current billing cycle.

Note: Any continuation (e.g., COBRA) will begin on the day following the date of termination or cancellation of coverage, regardless of which option is elected. All terminations or cancellations under your plan must be reported in the same manner. We will process the termination or cancellation as of the date you specify.

Enrollment — getting your people covered (*continued*)

Termination section: Check the appropriate box and provide the reason for terminating or canceling coverage. (If the employee and/or dependent elects continuation, follow the instructions for item #12 on the following pages.)

Note: There is an important distinction between canceling an employee's coverage and terminating an employee's coverage. The cancellation box should be checked only when the employee cancels his or her coverage but remains active at work. This applies, for example, to an employee who remains in your employment but cancels his coverage because he has opted to become covered under his wife's group plan. The termination box should be checked only when the employee ceases employment or becomes a member of a class of employees not eligible for coverage. This distinction is important because an employee who terminates employment and is rehired or who rejoins an eligible class within one year of termination will typically not be required to serve another probationary period.

Employer group information

Employer name: If not preprinted, please add.

Control, suffix and account numbers: If not preprinted, please add.

Employee information

Employee's Social Security number: List employee's Aetna ID number.

Employee's name: The employee should list his or her full name (last, first, middle initial). Do not use nicknames.

Acknowledgments

Employer's signature: The employer must sign and date the form. When any member is no longer eligible to collect benefits, please request their ID card and destroy it. Do not return it to Aetna.

Note: The effective date for credit transactions may be limited from the date we receive your request.

Note: Some states prohibit retroactive terminations. Contact your Aetna service representative with questions.

5. Changing an employee's name or address

Activity information

Effective date of activity: This is the date the employee's name changed or the date the employee's address changed.

Change section: Check the "other" box and fill in the new name or new address. If both apply, fill in both.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: If not already preprinted, please add.

Employee information

Employee's Social Security number: List employee's Aetna ID number.

Employee's name: The employee should list his or her "new" name (last, first, middle initial). Do not use nicknames.

Employee information

Employee's address: The employee should list his or her new address (street, city, state and zip code).

Acknowledgments

Employee's signature: The employee must sign and date the form.

Employer's signature: The employer must sign and date the form.

6. Changing an employee's Social Security number

Activity information

Effective date of activity: Use a current effective date.

Change section: Check the Social Security number box and fill in the old and the new Social Security numbers.

Employer information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: If not already preprinted, please add.

Employee information

Employee's name: The employee should fill in his or her full name (last, first, middle initial). Do not use nicknames.

Acknowledgments

Employee's signature: The employee must sign and date the form.

Employer's signature: The employer must sign and date the form.

7. Changing a plan number

Activity information

Effective date of activity: This is the date the employee's plan number has changed.

Change section: Check the "other" box and fill in plan number change.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: If not already preprinted, please add.

Plan number: Fill in the new plan number, which you can find on your Plan Summary sheet.

Employee information

Employee's Social Security number: List employee's Aetna ID number.

Employee's name: The employee should fill in his or her name (last, first, middle initial). Do not use nicknames.

Acknowledgments

Employee's signature: The employee must sign and date the form.

Employer's signature: The employer must sign and date the form.

8. Changing earnings and/or insurance amounts

Activity information

Effective date of activity: This is the date the employee's earnings and/or insurance amount change becomes effective.

Change section: Check the "other" box and fill in whether it is a change of earnings or insurance amount.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: If not already preprinted, please add.

Employee information

Employee's Social Security number: List employee's Aetna ID number.

Employee's name: The employee should fill in his or her full name (last, first, middle initial). Do not use nicknames.

Earnings: Fill in the employee's new earnings and/or insurance amount.

Acknowledgments

Employer's signature: The employer must sign and date the form.

Enrollment — getting your people covered (*continued*)

9. Changing control, suffix and account numbers

Activity information

Effective date of activity: This is the date the control, suffix and account numbers change.

Change section: Check the “Control/Suffix/Acct” box and fill in the old and new numbers.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: Fill in the prior control, suffix and account numbers.

Plan number: If the plan number is changing, fill in the new number. Refer to your Plan Summary sheet for the new plan number.

Employee information

Employee’s Social Security number: List employee’s Aetna ID number.

Employee’s name: The employee should fill in his or her full name (last, first, middle initial). Do not use nicknames.

Acknowledgments

Employer’s signature: The employer must sign and date the form.

10. Medicare primary

Activity information

Effective date of activity: This is the date the employee and/or dependent spouse becomes eligible for Medicare.

Change section: Check the “other” box and fill in Medicare primary. If the employee or spouse is eligible for Medicare because of disability, use the “Special Remarks” section to so. Before making this change, please see the Medicare section of this manual for guidance.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: Fill in the prior control, suffix and account numbers.

Employee information

Employee’s Social Security Number: List employee’s Aetna ID number.

Employee’s name: The employee should fill in his or her full name (last, first, middle initial). Do not use nicknames.

Individuals covered

Transaction type: Fill in “C” for changing coverage.

Relation code: Use the following abbreviations to indicate the relationship of the dependent to the employee:

W = Wife

H = Husband

Currently covered by Medicare: Indicate “yes” if the employee or spouse is eligible for Medicare coverage.

Acknowledgments

Employee’s signature: The employee must sign and date the form.

Employer’s signature: The employer must sign and date the form.

11. Termination and continuation of coverage

Activity information

Effective date of activity: This is the date the employee and/or dependent of the employee is eligible to elect continuation (for example, COBRA).

Termination section: Check the “terminating employment” box AND check either or both continuation boxes as necessary.

Employer group information

Employer name: If not already preprinted, please add.

Control, suffix and account numbers: If not already preprinted, please add.

Employee information

Employee’s Social Security number: List employee’s Aetna ID number.

Employee’s name: The employee should fill in his or her full name (last, first, middle initial). Do not use nicknames.

Acknowledgments

Employee’s signature: The employee must sign and date the form.

Employer’s signature: The employer must sign and date the form.

HMO enrollment — what you need to know

Eligible members of the family. When an employee joins an Aetna benefits plan, his or her spouse and dependent children are eligible to join the plan. If eligible dependents do not sign up at open enrollment or when they become eligible, they must wait until the next open enrollment period.

Note: To be eligible for enrollment under a parent's policy, dependent children (non-students) must be unmarried, under 19 years of age* and reside in the Aetna service area unless your company has requested a special dependent age extension or other contract change, or unless state law mandates otherwise.

Full-time college students

Unless otherwise specified by your plan, dependents may be covered until age 23 (or older where required by law). Proof or verification of full-time student status may be required each year by attaching a current course schedule or letter from the school confirming full-time student status (12 or more credits per semester). Students attending college in an Aetna HMO service area receive all the benefits of the plan by selecting a primary care physician (PCP) near their school. Unless they are enrolled as out-of-area PPO plan members, students who attend school outside an Aetna HMO service area are covered for emergency care only, including follow-up of emergencies, and specialty care when medically necessary.

*The age through which student dependents are covered varies by state regulation and the plan design you have purchased. Please consult your Group Agreement for details.

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. An Aetna medical director must approve all exceptions. (These requirements do not pertain to Colorado, where there is no limiting age.)

Grandchildren

Eligibility of dependent grandchildren varies by state regulation and by employer choice. For more information, please contact your Aetna service representative.

How to complete HMO enrollment forms

Review all completed enrollment/change forms. To ensure proper processing and timely issuing of ID cards, confirm that the form includes the following required information:

- Type of activity
- Plan option (if applicable)
- Name(s)
- Address
- Birth date(s)
- Social Security number(s)
- Employer name
- Date of hire
- Employee and applicable dependent information

- Primary care physician (PCP)
- Explanation (if applicable) for dependents having a different last name
- Employee signature
- Employer signature
- Effective date

NOTE: When enrolling new hires or submitting a change for an existing subscriber or member, always include your group number, which is a numeric code for your company, and the subgroup number, which indicates the specific benefits level or company classification. These numbers can be found on the last page of your invoice.

Please do not mail enrollment/change forms with your monthly payment. Since we receive payments at a bank lockbox, not at an Aetna office, doing so would delay the processing of any enrollment changes.

Enrollment — getting your people covered (*continued*)

While it is most convenient for employees to select a primary care physician (PCP) for themselves and any eligible dependents when they enroll, some states require that managed care organizations assign a PCP to members who do not select one at enrollment. To allow members immediate access to the full range of covered benefits under the plan, we randomly assign them a PCP based on their area of residence, although they can change this assignment at any time.

Changes to effective and employment date

Since an employment date incorrectly reported can affect the original effective date, we require payroll records and a written confirmation signed by the employer and employee in order to change an employment or effective date. We honor retroactive effective or employment date changes only in the event of an employer's clerical errors, and we limit them to two months' premium adjustment from the original process date.

When to use Group Termination forms

With the Group Termination form you can remove multiple employees and their dependents when group plan coverage ends because of termination, reduced hours, death, divorce, legal separation, entitlement for Medicare coverage or loss of dependent coverage because of age or another reason. You must state the reason for termination on the Group Termination form using one of the appropriate codes, which can be found at the bottom of the form. This form has a carbon copy, and we ask you to retain the copy for your records. Contact your Aetna service representative for additional forms when needed. Changes may also be submitted to your Plan Sponsor Services unit via the phone or fax.

Please do not include the Group Termination form with your payment. Since we receive payments at a bank lockbox, not at an Aetna office, doing so would delay the processing of any group terminations.

How to add or delete dependents

To ensure seamless coverage, it is important that you notify us of any changes in an employee's family status. Newly married employees may wish to change from single to couple or family membership. A member may wish to add a newborn child or other new dependent or convert a dependent who is no longer eligible for group coverage to individual membership. Newborn children of the subscriber or the subscriber's dependent are automatically covered for 31 days after birth.

To continue coverage of a newborn child beyond 31 days, the subscriber must apply to Aetna by submitting the change to you within the 31-day period.* The change can be made on the appropriate enrollment/change form by marking the appropriate box.

*The length of the grace period varies by state regulation. Please consult your Group Agreement for details.

Whenever your employees have a change in dependent status, we must receive the enrollment/change form within 31 days. Otherwise, they must wait until your next open enrollment period to add the dependent. Since additions and deletions of dependents may affect your bill, you must authorize any changes to your employees' family status before you submit the change to Aetna. Feel free to call your service representative for the appropriate form or if you have questions.

Hardship clause

The hardship clause permits a subscriber to add dependents midyear when the subscriber's spouse loses coverage because of a layoff or termination. The effective date is the day the spouse's insurance coverage is terminated.

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

Termination of coverage

Employee and dependent coverage under an Aetna HMO, QPOS®, USAccess® or Open Access® HMO plan may be terminated for the following reasons:

- 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 moves out of and no longer works in their Aetna service area.
- The member fails to make any required copayments.
- The member fraudulently uses his or her Aetna ID card or misrepresents himself or herself during enrollment.

Dependents may lose coverage because of divorce, death of the subscriber, reaching the maximum age for dependent coverage or marriage of the child.

The effective date and reason for termination should be indicated on the Group Control form and mailed to the address at the top of the form. You may also submit the information to your Plan Sponsor Services unit by mail, phone or fax. Your Aetna service representative may be able to provide additional coverage options that might be available after termination. Requests to advance a termination date require payroll records and a confirmation letter signed by the employer and employee. All termination date changes are limited to a maximum of two months' premium adjustment from the original process date. When a member is no longer eligible to collect benefits, please request his or her ID card and destroy it. Please do not return it to Aetna.

Note: Some states prohibit retroactive terminations. Contact your Aetna service representative about eligibility in your state or with any questions.

Enrollment — getting your people covered (*continued*)

Converting from group membership to individual membership

Most group members who terminate employment or otherwise cease to be eligible for benefits may be eligible to convert to an individual conversion plan, where available, if they continue to live within the Aetna HMO service area. Conversion plans and rates differ from the group plan. If your employee qualifies, an application for conversion membership must be submitted to Aetna within the specified number of days in your Group Agreement after:

- Termination of employment
- Loss of group membership
- Loss of dependent status
- Termination of any continuation coverage required under federal or state law (see the section on COBRA for more details)

For necessary forms and information about conversion plans, please have your employees contact Member Services.

Note: Prescription, dental and certain other plans and benefits cannot be converted. New Jersey, Massachusetts, New York and Pennsylvania residents will be offered an Aetna Individual Advantage PlanSM product as their conversion option.

Enrollment checklist

Has the employee included his or her:

- Benefits selection?
- Full name and address?
- Social Security number?
- Date of birth?
- Dependent's name(s), relationship code(s) and date(s) of birth?
- PCP selection and network ID (if applicable)?
- 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 plan number or plan name (HMO)?
- The name and address of your company?
- Your signature and date?
VERY IMPORTANT!

Eligibility and enrollment forms

To gain access to eligibility and enrollment forms, please visit: http://www.aetna.com/employer/smallgroup/resource_small/forms_small/smallgroup.html

Consolidated billing — where it's all in one place

Under our Consolidated Bill process, we produce statements based on the benefits, the rate for each benefit, and the number of employees and dependent lives that our administrative system indicates are enrolled in your group plan as of a given date. Our Consolidated Bill process also maintains a list of your members for claims verification. If your group plan is Consolidated Billed, you will be billed in advance of the statement due date. Your Aetna service representative can answer any questions you may have regarding the information shown on your statement.

A Consolidated Bill statement consists of these following seven sections:

- Invoice information
- Summary of account
- Payment stub and remittance
- Plan key
- Current in-force charges
- Retroactivity/other adjustments
- Benefit snapshot

Important remittance information:

To be sure that claims payments are not interrupted, please be sure to mail the total amount due on your payment stub by the due date. Make your checks payable to Aetna, and please include your invoice and/or account numbers.

Invoice information

1. **Prepared date:** The date the statement was prepared.
2. **Invoice number:** A unique bill identifier.
3. **Triad number:** The number representing the service center assigned to your account.
4. **Account number:** A unique plan sponsor identifier that you should include on all correspondence and forms.
5. **Bill package:** The account number assigned at plan setup.
6. **Coverage period:** The time period for which you are being billed for coverage.
7. **Customer name and address:** The name and address of the customer to which the invoice will be sent.

Summary of account

The summary of account is a summary of all due and paid activity that occurs on your account.

1. **Opening balance:** The balance due from prior months.
2. **Current in-force charges:** The current charges based on active membership as of the prepared date.
3. **Retroactivity and other adjustments:** Charges for activity that has not been billed previously, or adjustments to amounts billed previously.
4. **Net charges:** The total of current in-force charges plus retroactivity and other adjustments.
5. **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.
6. **Payment ID:** The identifier associated with the payment(s) received. This is usually a check or wire transfer number.
7. **Total payments received since last invoice:** The total of payments received since the last invoice.
8. **Amount due:** The total amount due on the account as a result of the cumulative balance.

Consolidated billing — where it's all in one place (*continued*)

Message section

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

Payment stub and remittance

The payment stub summarizes the invoice information and the total amount due. Please return this portion with your payment.

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. We use a three-digit plan type code to refer to individual members throughout the remainder of the invoice. For retroactive membership transactions, the plan key also lists the transaction category (new, term, change, etc.).

Current in-force charges

The current in-force charges section of your statement reflects all subscribers insured for that billing month. It includes:

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. **Product type and premium:** The product and total premium charged per subscriber.
3. **Total sub:** The total amount of premium per subscriber for all products.
4. **Total current charges:** The total amount by product and the total current charges.

Retroactivity and other adjustments

The retroactivity/other adjustment portion of the statement displays enrollments, changes and terminations that have been processed during the current billing period. It includes:

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 (N = 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, we 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. Debits or credits will be given for no more than three months.
8. **Total retroactivity/other adjustments:** The total net amount of the retroactivity and other adjustments to transactions.

Benefits snapshot

The benefits and service analysis section of your statement displays a summary of benefits for active subscribers and dependents on your account. It includes:

1. **Product:** Displays only those products with active membership.
2. ***Plan type:** The unique identifier code for those products with active membership.
3. **Singles — sub 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 — sub + spouse:** The number of couples enrolled in the plan.
6. **Premium:** The total premium for couples enrolled in the plan.
7. **Parent/Child(ren) — sub + 1 or more children:** The number of parent(s) and children enrolled in the plan.
8. **Premium:** The total premium for parent(s) and children enrolled in the plan.
9. **Families — sub + spouse + 1 or more children:** The number of families enrolled in the plan.
10. **Premium:** The total premium for families enrolled in the plan.

Continuing coverage — peace of mind through seamless protection

In some instances, employees have the 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 give details of 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 we may require for continued coverage.

This section provides an overview of continuation of group coverage as it applies to:

- Disease or injury
- Layoff or leave of absence
- Handicapped dependent children
- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- The Family and Medical Leave Act (FMLA)
- Other situations
- Extension of benefits

Disease or injury

If an employee is absent from work because of an extended disease or injury, coverage may be continued for a limited period of time (for example, 3, 12 or 30 months) as stated in your plan documents. 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 terminated employees (COBRA, for example).

If your group plan includes a separate disability feature applicable to 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 discontinues while the employee’s (and any dependents’) coverage is being administratively continued, coverage will end on the date your group plan discontinues.

Note: As the employer, you have the discretion to decide whether you will allow coverage to continue up to the limits stated in your plan documents or whether you will continue coverage at all. We 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 (see item #4).

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 sole discretion of the employer until the end of the month following the month in which the layoff or leave began, as long as you continue to make premium payments to Aetna on behalf of the employee. If the employee, for example, takes a short-term leave of absence beginning on February 10, coverage may 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. For 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 she or he does not want to pay for continued coverage, the employee’s coverage will be discontinued immediately. Please refer to the Enrollment section of this manual for instructions on terminating coverage (see item #4).

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 (e.g. age 19 or age 23 if attending school), provided the child has not been issued a policy of individual insurance.

To be eligible for coverage to be continued beyond your plan's limiting age, the child must be fully handicapped due to mental illness or physical handicap. A child is considered fully handicapped if she or he is not able to earn his or her own living because of mental illness or physical handicap and must depend chiefly on the employee for support and maintenance.

If the child meets the definition of a fully handicapped child, we will have the right to require proof of such handicap condition. We also reserve the right to examine or 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 date on which:

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

The above terms vary from state to state. In addition, if your group plan is an administrative services contract (ASC), the terms of your group plan may not require that a provision for a handicapped dependent child be included. Please refer to the "General Information About Your Coverage" section of your plan documents for the specific terms that apply to your group plan.

If the handicapped child is eligible, the forms "Request for Continuation of Medical Coverage for Handicapped Child" and "Handicapped Child Attending Physician's Statement" must be completed (see samples that follow).

COBRA — The Consolidated Omnibus Budget Reconciliation Act of 1985

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

Because COBRA is directed to employers rather than to carriers, employers have the responsibility to abide by its mandates and obligations and to consult their own legal counsel regarding compliance and any other circumstances that are directly or indirectly related. 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 noncompliance.

For a fee through our Individual Billing Administration (IBA), we offer plan sponsors COBRA direct billing services as an efficient way to manage and bill COBRA continuations. These can include retirees, surviving spouses, employees on leave or medical continuation — in fact, 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 related services for both customers and members. For more information, please call your local Aetna service representative.

Continuing coverage — peace of mind through seamless protection (continued)

Continuation of coverage for other reasons

In some circumstances, you may need to continue coverage for reasons unrelated to COBRA — as a result, for example, of state or local law, industry practice, severance, collective bargaining, a retirement agreement or plan procedure. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is also considered “alternative coverage.”

While this coverage does not extend the maximum coverage period under COBRA (which is measured solely from the date of the qualifying event or, if the plan provides, from the date of the loss of coverage), several states have requirements for continuation of coverage that does not begin until COBRA coverage terminates.

Continuing coverage needs to be identical

Coverage under COBRA must generally be the coverage provided to similarly situated non-COBRA beneficiaries under the group plan and provided to the employee and/or eligible dependents on the day before the qualifying event. Evidence of insurability for continuation of coverage cannot be required.

Employers affected 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. At the employer’s discretion, the coverage under COBRA may be at the individual’s expense.

The following employers are exempt from the provisions of COBRA. Those that:

- 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)).
- Are 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. For making this determination under COBRA, employees working for employers under common control must all be aggregated.

Note: Many states also have mandated continuation provisions that apply to all groups, including those of fewer than 20 employees. Refer to your Group Agreement for state-specific continuation options.

Qualifying event. COBRA provides that continuation of coverage be made available to covered employees, their spouses and dependent children, and anyone else who performs services for the employer and is covered by the group health plan (and 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 a 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.
- Entitled employee’s 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 as it affects retirees, their spouses and dependents who lose coverage. If you want more information about this qualifying event, which is not discussed in detail in this manual, please contact your legal counsel.

Duration of continued coverage

(Length of COBRA). Continuation of group coverage begins on the date of the qualifying event 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:

- 18 months for loss of coverage from termination of employment or reduction in hours.
- 29 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. This requires that she or he submit 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. Within 30 days of the final determination, she or he must also notify the plan administrator that he/she is no longer disabled.

- 36 months for loss of coverage because of any other qualifying event such as an employee's death, divorce or legal separation, an entitled employee's enrollment in Medicare or children reaching limiting age.

Under this last provision, if a second qualifying event occurs within the original 18-month period following termination of employment or reduction in hours, the qualified beneficiaries who are spouses and/or children may be entitled to continuation of coverage for a total of 36 months from the initial qualifying event. If the second qualifying event is the covered employee's enrollment in the Medicare program, the period of coverage for qualified beneficiaries would be 36 from the initial qualifying event.

Termination of COBRA coverage.

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 an exclusion for a pre-existing condition.
- 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 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.

Continuing coverage — peace of mind through seamless protection (continued)

Requirements for Right of Continuation Notice, premium and COBRA election. When a qualifying event occurs, we recommend that you notify us promptly of all terminated employees and/or dependents. If they elect continuation under COBRA quickly, you will be able to process only one change. You will also have to notify us a second time, however, if the employees and/or dependents elect COBRA continuation subsequent to their termination. 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 being paid during the election period, should the employee and/or dependent not elect COBRA continuation.

Note: If you are being direct-billed by Aetna, 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. Your use of direct billing does not exempt you as the employer from your obligation under COBRA, which can include immediately discontinuing payment for the qualified beneficiary already paying directly to Aetna's COBRA Direct Bill unit.

If you are not using Aetna's direct-bill feature, you are responsible for monitoring the continuation and cancellation of 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 the employer) has 14 days after being informed of a qualifying event to send a Right of Continuation Notice to all qualified beneficiaries. We recommend that you provide this notice to the qualified beneficiaries immediately, since the 60-day COBRA election period does not begin until the date the qualified beneficiary is notified if later than the date of the qualifying event. An example of our Right of Continuation Notices for both HMO and Traditional customers appears on the following pages.

The employee and/or dependents 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, please retain the original copy of the election form on file. Aetna does not require a copy of the Right of Continuation Notice.

When a covered employee or spouse elects to cover any other qualified beneficiary, the other qualified beneficiary is bound by that election. But since each qualified beneficiary is entitled to elect continuation coverage, the covered employee or spouse may not decline coverage on behalf of another qualified beneficiary. An election on behalf of a minor child may be made by the child's parent or legal guardian. Also, an election on behalf of a qualified beneficiary who is incapacitated may be made by the legal representative of the qualified beneficiary or the beneficiary's estate or the spouse of the qualified beneficiary.

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. (While employers may pay for part or all of the premiums, COBRA does not require them to contribute to the cost of the coverage.) Employees and dependents must be given 45 days after their election to pay the initial premium that covers the period from the qualifying event or loss of coverage (if later than the qualifying event) through the month during which the initial retroactive premium payment comes due. Your company should receive subsequent payments within 31 days of their due date.

Premiums may not exceed 102 percent of the cost for other similarly situated active employees. In the case of a qualified beneficiary, however, who is entitled, because of disability, to the 11-month extension of continuing coverage, 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.

Completing the employer section of the Right of Continuation Notice.

Before giving notice to the qualified beneficiary, you as the employer complete this section.

1. Enter the beneficiary's name and address.
2. Enter the "date of this notice." This is the date that will be used to determine timely filing of the application and the due date of the first premium payment.
3. Enter the beneficiary's name in the salutation (i.e., "Dear:").
4. Enter the date that the qualified beneficiary's group coverage will terminate.
5. Check the appropriate box that describes the qualifying event making the beneficiary eligible for COBRA.
6. Enter the number of months COBRA is available to the qualified beneficiary(ies) based on the qualifying event.
7. Check the appropriate box or boxes showing who is eligible for COBRA.
8. Enter the effective date of COBRA.

9. Enter the date COBRA will be exhausted. (Calculate the 18, 29 or 36 months.)
10. Provide the total cost of the premium that will be charged to the member(s) for COBRA. Complete this section based on the coverage the member(s) had immediately prior to the qualifying event.
11. Enter the telephone number of the person who is administering the COBRA continuation. (This is for the member's benefit, for questions.)
12. Enter the address to which the qualified beneficiary must return the application and premium payments.
13. Indicate the date by which the qualified beneficiary must return the application. This is the date that is 60 days from the "date of this notice," in item #2 above.
14. Indicate the date the qualified beneficiary's application must be returned or postmarked. This is the date that is 60 days from the "date of this notice," in item #2 above.

Continuing coverage — peace of mind through seamless protection (continued)

Understanding the Family and Medical Leave Act (FMLA)

This section is not intended as, nor should it be interpreted as, legal advice as to an employer's legal obligations under the Family and Medical Leave Act. If you, as an employer, however, determine that you will offer an employee the option to continue basic term life insurance benefits during the terms of a FMLA leave of absence, the following information describes how this will affect your Aetna group life insurance coverage.

If you grant an employee a leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), the employee may be allowed to continue the basic term life insurance benefits for which she or he was covered on the day before the start of the FMLA leave. At your discretion, you may allow the employee to continue additional benefits the FMLA does not require (for example, supplemental life insurance and accidental death and personal loss coverage). This also includes coverage for the employee's eligible dependents. If the employee acquires a new dependent while coverage is being continued under the FMLA, the new dependent may also be eligible for coverage.

At the time the employee requests a leave, it is your responsibility to make arrangements with the employee to collect any contributions you may require for the continued coverage.

If your group has any benefits that are affected by an age or retirement reduction, the employee's coverage will be subject to those rules while on a FMLA leave.

Coverage for an employee or an eligible dependent may not be continued beyond the first date on which any of the following occurs:

- Any required contributions cease.
- You determine their approved FMLA leave has ended.*
- Coverage ceases for the employee's eligible class.

Any coverage for a dependent will not be continued beyond the date it otherwise would have terminated.

When an employee returns from an approved FMLA leave, coverage under your group plan may continue as though she or he had continued in active employment, provided the she or he makes a request for such coverage within 31 days of his or her return to work. If the employee does not make such a request within 31 days, coverage may again be effective under your group plan only if Aetna gives its written consent.

If your group plan provides any other continuation of coverage (for example, upon termination of employment) the employee (or eligible dependents) may be eligible for such continuation on the date their approved FMLA leave has ended. Any continuation will be available on the same terms as those for which employment is terminated.

Other legal considerations to consider

If your group plan is full-risk or split-funded, the insurance laws of the state in which your group plan is issued (the contract state) may mandate that you offer continuation of coverage to employees and/or covered dependents in certain situations (as shown later in this section).

In addition, insurance law(s) of the non-contract state(s) may also apply to your group plan if the law(s) are written to apply to residents of that state, regardless of the state in which the contract is issued. These are known as "extraterritorial" laws, and if they apply, employees may be eligible for continuation as prescribed. Many of the state laws that require you to offer continuation, however, also provide that if the qualifying event would qualify the employee and/or dependent for COBRA continuation, you need not offer the state-mandated continuation. We urge you to consult your legal counsel about your responsibilities for continuation under state laws.

*If you grant an approved FMLA leave for longer than the period required by the FMLA, any extended continuation of coverage during that period will be subject to approval by Aetna, which will have sole discretion to continue or discontinue the coverage for that extended leave period.

If your group plan is required to offer continuation due to a mandated insurance law, the "General Information About Your Coverage" section of your plan documents will give details of the continuation provisions and whether eligibility for COBRA continuation has any impact on the state mandated continuation provision.

Note: If the employee and/or dependent elects to be covered by a state-mandated continuation that provides coverage for a qualifying event also addressed by COBRA, the period of time the person is covered under the state-mandated continuation provision will count toward the federal COBRA law's 36-month maximum duration.

Here are some of the continuation provisions state law may require your group plan may to include:

- Total disability
- Labor disputes
- Ceasing employment
- Employee's death
- Plant closings
- Divorce or separation
- Employee's retirement
- Medicare eligibility
- After COBRA ceases

If you are required to offer continuation for one or more of the provisions above, you will receive a supply of the necessary continuation election forms that you should give to employees when they become eligible.

How to extend an employee's benefits

If a covered person is "totally disabled" when all medical health coverage ends (administrative, state or COBRA), she or he may be eligible to have health benefits extended, without payment of premium, for a limited period of time after she or he terminates from your group plan or you discontinue your plan.

Generally, a person who is totally disabled will be covered for up to 12 months, but only for expenses related to the injury or disease that caused the total disability. But since some group plans cover all injuries or diseases, we ask you to check your plan documents for the specific terms that apply to your group plan.

What "totally disabled" means

A covered employee will be deemed "totally disabled" if she or he is not able to engage in his or her customary occupation and is not working for pay or profit.

A covered dependent will be deemed "totally disabled" if she or he is not able to engage in most of the normal activities of a person of like age and sex who is 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 only after any other continuation of coverage period, if elected, ceases. An employee or dependent cannot retroactively elect a continuation provision, such as a state or COBRA continuation, while they are extension of benefits.

Important: If a person is eligible to convert his or her coverage to an individual insurance policy from his or her group health plan, she or he 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 — managing the transition with skill and sensitivity

Medicare is a federal health insurance program established for people age 65 and over and for disabled individuals who meet certain eligibility requirements. The Age Discrimination and Employment Act (ADEA) requires that an employer counsel employees or dependent spouses approaching age 65 about Medicare benefits. You as an employer should inform them of eligibility requirements, how to apply for Medicare and how Medicare coverage operates in relation to your group health plan. Please consult your legal counsel regarding your Medicare responsibilities.

Aetna considers a person to be eligible for Medicare if they are covered by Medicare or if they have elected not to be covered, have dropped it or have failed to properly request 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 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 or spouse has not already changed to Medicare for their primary coverage.
- The employee is retired but has not already changed to Medicare for their primary coverage.

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

Choosing the primary or secondary health insurer

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

Coverage is determined in part by the employee's employment status (active or retired) and 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, need to be made to 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 or if she or he is retired and under age 65.

Medicare is primary for the *employee* if the employee is retired and is age 65 or older, unless the retiree has coverage under an active group plan — that is, his or her spouse is covering her or him as a dependent.

Aetna is primary for the *dependent* if the employee is active or if she or he is retired and the dependent is under age 65.

Medicare is primary for the *dependent* if Medicare ESRD COB rules are affected by the ESRD "coordination period," and the employee is retired and the dependent is 65 years of age or older.

If your group plan is not subject to TEFRA:
The following rules apply to employers with
20 eligible employees or fewer.

Aetna is primary for the *employee*
if the employee is under age 65.

Medicare is primary for the *employee*
if the employee is age 65 or older.

Aetna is primary for the *dependent*
if the dependent is under age 65.

Medicare is primary for the *dependent*
if the dependent is age 65 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. Because there are circumstances
that would require Aetna to be primary to
Medicare, even if the person is on Medicare
because of disability, please do not make
this change without first contacting us.
To request help, contact Member Services
using the toll-free number on your Aetna
ID card.

If the member has end-stage renal disease,
different laws govern the determination
of primary payer. For assistance, please
contact the Member Services office using
the toll-free number on your Aetna ID card.

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

Small Group sales support

Member Services (Claim Forms)

HMO Claim Form:

http://www.aetna.com/employer/forms/HMO_Medical_Reimbursement_form.PDF

HMO Member Service Phone Number:

1-888-70-AETNA (888-702-3862)

HMO Member Service Fax Number:

1-866-474-4040

HMO Claims Mailing Addresses:

Claim Mailing Address Locations AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, UT, TN, WA:

Attn: Claims Reimbursement
Aetna
PO Box 14079
Lexington, KY 40512-4079*

Claim Mailing Address Locations CO, CT, DC, DE, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MT, NE, ND, NH, NJ, NY, OH, OK, PA, RI, SD, TX, VA, VT, WI, WV, WY:

Aetna
PO Box 981106
El Paso, TX 79998-1106

PPO/Indemnity Claims Mailing Address:

Attn: Claims Reimbursement
Aetna Health Inc.
PO Box 14079
Lexington, KY 40512-4079*

PPO/Indemnity Claim Form (Address on Form)

http://www.aetna.com/employer/forms/Traditional_Medical_form.PDF

PPO/Indemnity Member Service Phone Number:

1-888-80-AETNA (888-802-3862)

PPO/Indemnity Member Service
Fax Number:

1-866-474-4040

Pharmacy Claim Form

http://www.aetna.com/data/forms_library/gc-1360.pdf

Pharmacy Member Service Phone Number:

See above

Claim Address:

Aetna Pharmacy Management
Attn: Claim Processing
PO Box 14024
Lexington, KY 40512-4024

Dental, Life, Disability

http://aetnet.aetna.com/nco/department/claim_call/pps/plan_setup/marketing/sbm_sfocclaim.html

Plans and Products

<http://www.aetna.com/plansandproductshe or healthplans/index.html>

Contributory Mandates by State

http://aetnet.aetna.com/Small_Group_UW/Tools/Participation_Contribution_Grid.doc

PSS Contacts

http://aetnet.aetna.com/rbco/pss/rbco_pss_main.htm

ISO Contacts

<http://aetnet.aetna.com/rbco/iso/iso.html>

Claim/Call Contacts

http://www.aetna.com/employers/smallgroup/resource_small/forms_small/smallgroup.html

Enrollment Forms

http://www.aetna.com/employer/smallgroup/plan_small/elig_small/smallgroup.html

*This may or may not match what is on the employee's ID card.

Health Savings Account (HSA) services are independently offered and administered by HSA custodians or vendors selected by employers or members. HMO and QPOS® medical plans are provided by Aetna Health of California Inc. PPO and Indemnity medical plans are provided or administered by Aetna Life Insurance Company. The Dental Maintenance Organization (DMO®) plans are provided or administered by Aetna Dental of California Inc.; PPO and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.

This material is for informational purposes only and contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Aetna arranges for the provision of health care services. However, Aetna itself is not a provider of health care services, and therefore, cannot guarantee any results or outcomes.

Consult the plan documents (e.g., Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

The availability of a plan or program may vary by geographic service area and by plan design.

With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC., is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by nonsystem or nongroup providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Aetna assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied by Aetna IntelliHealth®. Information supplied by Aetna IntelliHealth is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Informed Health® Line nurses cannot diagnose, prescribe or give medical advice. Specific questions should be addressed to your doctor. Alternative health care programs, Aetna VisionSM Discounts and the Fitness Program are rate-access programs and may be in addition to any plan benefits. Program providers are solely responsible for the products and services provided thereunder. Aetna does not endorse any vendor, product or service associated with these programs. Discounts offered hereunder are not insurance. Some benefits are subject to limitations or visit maximums. Members or providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available at the highest copay under plans with an open formulary, or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after enrollment) are not covered, and medical exceptions are not available for them.

Securities (including mutual funds and variable annuities) and investment advisory services are offered through Chase Investment Services Corp. (CISC) or affiliated broker/dealers. Annuities and insurance products are provided by various insurance companies and offered through Chase Insurance Agency, Inc. (CIA), a licensed insurance agency doing business as Chase Insurance Agency Services, Inc. in Florida. CISC, a member of NASD/SIPC, and CIA are affiliates of JPMorgan Chase Bank, N.A. Products not available in all states. JPMorgan Chase Bank, N.A., and its affiliates do not offer legal or accounting advice to their clients. Clients are urged to consult with their own legal, accounting and tax advisors with respect to their specific situations. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC.

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