Administrative handbook

Small business owners

Aetna.com

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aetna™

We're committed to the health of your business

Welcome!

Thank you for choosing us for your company's health plan — you've made a great choice. Investing in your employees' health care will pay off today and tomorrow. We've designed this handbook so you can get back to doing what's most important to you — running your business. The information you'll need to administer your Aetna® group plan is summarized here. If you have questions, reach out — the Customer Service section is on page 4.

This handbook is easy to scan quickly for what you need

That's important. You'll need to understand the provisions of your plan, particularly the need to submit timely and accurate data. All of this is described in this handbook. At times, you may notice terms or references that do not apply to your plan. No worries. The actual terms of your plan are spelled out in your plan documents.

These include:

- Group Policy
- Schedule of Benefits
- Certificate of Coverage
- Evidence of Coverage
- Group Agreement
- Group Insurance Certificate Booklet
- Booklet-Certificate

We are working hard to simplify health insurance decision making and administration. We are here to make it easy for you to manage and grow your business.

We look forward to serving you.

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Customer service

Have a question or a problem with your group plan? Need to order forms? We're here to help.

When you contact us, have your group plan's control, suffix and account number handy. We'll probably ask for them.

Calling about an employee? You'll need the employee's Social Security number (SSN), too.

Contact us

You, your employees and their families can call Member Services with questions. **Just use the number on the Aetna® member ID card.**

Our state-of-the-art voice recognition telephone service offers a choice of self-service options for simple and everyday questions. In seconds, it will get you and your employees to the right customer service professional.

Our phone service can help with:

- Checking eligibility and benefits coverage
- Checking the status of a claim
- Requesting a replacement member ID card, physician directory or claims form
- Reviewing activity on flexible spending accounts
- Obtaining contact information

HMO and HNO plans

Member Services phone number:
1-866-529-2517 (TTY: 711)

Member Services fax:
1-866-474-4040

Claims mailing addresses:

If your claims mailing address is located in the following states: AL, AK, AR, AZ, CA, FL, GA, HI, ID, LA, MS, NC, NM, NV, OR, SC, UT, TN or WA, please use the address below.

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

- If your claims mailing address is located in these states: 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 or WY, please use the address below.

  Attn: Claims Reimbursement
  Aetna
  PO Box 981106
  El Paso, TX 79998-1106*

PPO and indemnity plans

Member Services:
1-888-80-Aetna (1-888-802-3862) (TTY: 711)

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

Forms and supplies

On **Aetna.com**, you can get the forms you need to administer your plan.

For forms GR-50000 through GR-59999 and GR-60000 through GR-69000, contact your service representative.

For forms that begin with the letters "GC," contact your service representative or your claims office.

We're here when you need us

If you have any questions, call us and we will help you.

State	Toll-free number	Hours of operation
Northeast CT, DE, MA, ME, NH, NJ, PA, RI or VT	**1-800-297-7145 (TTY: 711)**	8 AM–5 PM ET
Southwest AL, AR, DC, FL, GA, MD, MS, NC, SC, TN, VA or WV	**1-855-319-7290 (TTY: 711)**	8 AM–5 PM ET
Midwest IA, IL, IN, KS, KY, MI, MN, MO, MT, ND, NE, OH, OK, SD, TX, WI or WY	**1-877-232-1621 (TTY: 711)**	8 AM–5 PM CT
West AK, AZ, CA, CO, HI, ID, NM, NV, OR, UT or WA	**1-800-343-6101 (TTY: 711)**	8 AM–5 PM MT

*This might not match what is on the employee's member ID card.

The Affordable Care Act (ACA)

What you need to know as an employer

As an employer, you need to know how the health care reform law is impacting the health care landscape.

The ACA is the driving force in health care today. We remain focused on implementing provisions of the ACA, fostering and sustaining compliance with the law, and helping our customers achieve the same.

Visit our health care reform website at **HealthReformConnection.com** to find what you need to know about health care reform.

The informational resources available on our **Health Reform Connection website** can help you learn more about how the health care landscape is changing because of the law and what health care system challenges remain.

Find tools and resources like:

- A health care reform timeline
- Explanations of laws and regulations
- A weekly health reform newsletter
- Questions and answers
- Tools for you, like the Small Group Tax Credit Calculator
- Tools for your employees, like the Member Payment Estimator and the Aetna Health℠ mobile app
- Audio updates

Visit **HealthReformConnection.com** to learn more.

Online benefits tool

Your business and your Aetna plan were made for each other.

Health insurance doesn't need to be complicated. With just three simple steps for you and your employees, you can get back to what really matters to you — running your business.

For your business

Ready, set up, go
One site gives you access to all of your benefits online. eBusiness is your gateway to hassle-free, online maintenance of your Aetna plan.

1. Tell your account manager to register you for eBusiness.
2. Enroll your employees with the online enrollment tool.
3. Set up online billing, and start viewing and paying your Aetna bills right online.

For your employees

Life with an Aetna plan
Our member website has all the tools, programs and perks that are included in your health plan.

1. Ask your employees to sign up at **Aetna.com** to get access to the member website.
2. Have your employees complete their online health assessments.
3. Tell your employees about their ability to turn off paper and start viewing all their Aetna communications online.

Enrollment — explained

Getting employees and dependents covered

We help make things easy for you. Here, learn about how to determine eligibility and how enrollment works.

Eligibility

Participation guidelines vary by state.

General requirements:

- 60% of your eligible employees, except for those with valid waivers, must take part in the plan.
- 50% of the total number of eligible employees, regardless of valid waivers, must take part in our plan.
- At least two eligible employees must take part, unless state laws require just one.
- There must be 100% participation for noncontributory plans, excluding valid waivers. By noncontributory plan, we mean the whole premium is paid by you, the employer, or by the union.

Valid waivers differ by state. Your broker can provide you with a list of valid waivers.

Eligible employees waiving coverage must complete a waiver. By "waiving coverage," your employees choose not to take part.

Your group plan can be terminated if not enough employees take part.

Dependents do not have to take part in the plan. By dependent, we mean a spouse or domestic partner, or a married or an unmarried child up to age 26.

Eligible members of the family

When an employee joins an Aetna benefits plan, their spouse and dependent children are eligible to join the plan. If eligible dependents are not signed up at open enrollment or when they become eligible, they must wait until the next open enrollment period. Newborns and minor children who are placed in physical custody of a member for adoption are automatically covered for 31 days after birth or placement for adoption. A change form will need to be completed and returned within the 60-day enrollment period. If the child is not enrolled within the first 60 days, that child may not be added until the next enrollment period. Employees or their dependents may be able to enroll in the plan as late enrollees. (See HIPAA Special Enrollment Rules on page 9.)

Note: The addition of newborn coverage for 31 days after birth or placement for adoption may also result in a premium increase for the employee unless they are located in one of the following states: Colorado, Florida, Kentucky, New Jersey, Ohio or Texas.

Note: To be eligible for enrollment under a parent's policy, dependent children must be under 26 years of age and reside in the Aetna service area. These guidelines apply unless your company has requested a special dependent age extension or other contract change, or unless state law mandates otherwise.

Dependents who are disabled

Dependent children over the limiting age who cannot support themselves because of a disability typically may continue to be covered as a dependent as long as:

- The condition existed before the child reached the limiting age.
- The child is currently covered as your dependent.
- The child's condition is documented by a doctor.
- An Aetna medical director has approved the exception.

Grandchildren

Grandchildren are generally not eligible unless there is a state mandate or court order that requires coverage. If there is such a court order, provide a copy of it. To learn more, consult your broker or Aetna service representative.

Please do not mail enrollment or change forms with your monthly payment

Since we receive payments at a bank lockbox, not at an Aetna office, including forms will delay the processing of those forms. Instead, submit enrollment changes via the online enrollment tool.

Changes to effective and employment dates

An incorrectly reported employment date can affect the original effective date and your premium statement.

That's why we require payroll records and a written confirmation signed by you and the employee to change an employment or effective date.

We honor retroactive effective or employment date changes only if there's been a clerical error on your company's part. We limit them to two months' premium adjustment from the original process date.

Probation period

You choose the probation period when you first enroll your group. By probation period, we mean the period of time before a new employee can join the group plan. This period cannot be changed until the plan's next renewal date.

- **Eligibility date:** By "eligibility date," we mean the date your employees can first use their group plan benefits.
- **What to do:** To be eligible for coverage, the employee must sign and return the enrollment form within 31 days of their eligibility date. **We suggest you enroll employees as soon as they are hired to avoid being late.**
- **Late enrollee:** This means someone who does not enroll within 31 days of the eligibility date. Look at the late enrollees section that follows. It will tell you how coverage may be affected.
- **Part time to full time:** Do you employ part-time employees but only offer coverage to full-time employees? If an employee goes from part time to full time, that person does not have to serve any additional probationary period — as long as the employee has already been working for the length of the probation period. Employees who go from part time to full time should be enrolled the day they become full time, once the probation period has been met.
- **Terminated and rehired:** Employees who leave the company and are then rehired within one year do not have to serve a new probation period before they become eligible for benefits. They are eligible on the day they are rehired.
- **Employee out of work because of illness or injury:** 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, coverage does not start until the employee returns to work for one full day.

If an employee has signed up for dependent coverage, this coverage usually begins when the employee's coverage begins. New dependents not enrolled within 31 days of their birth or adoption may be subject to late-enrollee requirements. (You can read about those in the Late Applicants section on page 10.)

Let's look at some examples*

Here are some profiles based on common information we see from members.

Jim Smith

- Jim Smith has a 60-day probation period.
- Jim is hired on January 1 and enrolls in your group plan immediately.
- Since Jim must first serve his probation period, his coverage is effective March 1, the first of the month after his probationary period.

Sally Johnson

- Sally Johnson has a 90-day probation period.
- Sally is hired on January 1, making her eligibility date March 31, the 91st day.
- On April 24, she gives her signed enrollment form to you.
- Sally 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 March 31.

Richard Jones

- Richard Jones has a 90-day probation period.
- Richard is hired on January 1, making his eligibility date March 31, the 91st day.
- On May 19, he gives his signed enrollment form to you.
- Since Richard 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. (See HIPAA Qualifying Events on page 9.)

*These are not real members.

Enrollment summary

Here, learn about the most common events that affect benefits changes and what you need to do. We show, for example, how to add new dependents or end coverage when employment ends.

Most of your administrative work for your group plan is likely to be enrollment and benefits changes. That's why it's so important to get to know this section. Pay particular attention to what needs to be included on an enrollment or change form. You'll avoid problems caused by delayed enrollment or missing information.

Standard enrollment period

The employee should return the dated and signed enrollment application to you within 31 days of the eligibility date of the employee or dependent.

Special enrollment periods

An employee or dependent may be eligible for enrollment under what we call a "special enrollment period." This can happen if an employee did not choose our coverage because they were already covered under another group plan and then lost that coverage because of one of the HIPAA (Health Insurance Portability and Accountability Act, a federal act that ensures the privacy and security of health information) qualifying events listed in the next section.

Your employees and/or their dependent(s) will generally be allowed to enroll in your group plan without delay as long as they elect coverage within 31 days of the date they lose coverage.

You can find other limitations and exceptions to your plan's late-enrollee rules in your plan documents. An applicant who experiences a "qualifying life status change" may also be able to enroll outside the open enrollment period. Qualifying life status changes include events such as births, adoptions, marriage and divorce.

HIPAA special enrollment rules

Under HIPAA special enrollment rules, employees and their dependents can enroll in the plan as late enrollees when a HIPPA-qualifying event occurs.

HIPAA qualifying events

- A company ends combined medical and dental coverage
- A company ends the medical plan
- An employee's status changes from full time to part time
- COBRA or state-mandated continuation ends (18/29/36 months must be exhausted) (See the COBRA section on page 22.)
- Coverage ends for children who are disabled (handicap coverage)
- Death
- Dependent moves out of an HMO service area with no other option available under the plan
- Dependent status is lost
- Divorce or legal separation
- Ending-of-benefits package options, unless a substitute is offered
- Layoffs
- Loss of Medicaid
- Plan stops offering dependent coverage
- Retirement of spouse
- Termination of employment
- The spouse's or dependent's coverage is lost because a company goes out of business

Employees may be allowed to enroll for other coverage, such as life insurance and accidental death and dismemberment plans, before the annual open enrollment. They may be able to do so only if they satisfy our requirements for what we call "evidence of insurability." Evidence of insurability means the employee must complete an individual health statement and may have to submit medical evidence, via medical records, at their expense.

For questions on late enrollment or HIPAA, contact us by calling the toll-free phone number on your monthly statement.

Late applicants

Employees who ask to enroll more than 31 days from the date they were first eligible must wait for the group's next open enrollment period. When such employees are enrolled, they are referred to as "late enrollees" because they enrolled more than 31 days after the original eligibility date or the date of the HIPAA qualifying event. (See HIPAA Qualifying Events on page 9.)

Late enrollees can also be those who ask to enroll more than 31 days after open enrollment ends due to having been affected by a state legislative mandate.

Late enrollees must reapply for coverage 30 days before the plan's anniversary date. By anniversary date, we mean 365 days after coverage first began.

Exceptions include but are not limited to:

- 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. For more information about special rules that apply to New Jersey late enrollees, contact your broker or call us. (For contact information, see the Customer Service section on page 4.)

Please contact us for other exceptions that may apply.

Duplicate coverage

Your group plan may not allow individuals to be covered both as an employee and as a dependent. In addition, no one may be covered as a dependent of more than one employee, unless state law requires it. Your Aetna representative can give you more information on what your plan requires.

Member ID cards

Member ID cards are issued for medical coverage so that physicians, hospitals and other health care professionals can verify coverage and bill us for services rendered. Member ID cards vary according to the plan selected and state legislation. The cards may contain the following information:

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

Prescription coverage

Many pharmacies will not accept insurance unless the member presents their member ID card.

Members who have not yet received their ID cards may still get their prescriptions filled at a participating pharmacy. Employees can also visit **Aetna.com** to print their member ID cards.

Once they get their member ID card, they can then send us a copy of the prescription receipt with their member ID number marked on it. We will then reimburse them for the cost, less their copayment. (**Copayment** is the fixed dollar amount an employee pays when they visit the pharmacy or doctor.)

The pharmacy directory contains a list of local participating pharmacies. You can also visit **Aetna.com** for our online directory.

*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.

New employees

You can help make new employees feel welcome by making benefits enrollment a part of the hiring process. By giving your new hires our enrollment materials and benefits literature, you'll help them make informed decisions. Down the road, you'll also help to avoid claims problems caused by delayed enrollment or missing information.

Here is some Aetna information you may wish to share:

- Links to enrollment forms, along with instructions
- A copy of your plan's Booklet-Certificate (or Summary Plan Description**)
- A privacy notice

Enrollment form

Many states restrict the information you may collect on an enrollment form. This means that you may need to use more than one form for your workforce. You can visit **Aetna.com/employers-organizations.html** to find enrollment forms for your state. You can also contact your broker or Aetna service representative.

Booklet-Certificate

Your plan's Booklet-Certificate describes your plan's benefits and limitations. If you offer your employees more than one benefits plan (for example, a PPO and a Managed Choice® plan), you should give employees a copy of each Booklet-Certificate.

Privacy Notice

The Privacy Notice describes our privacy policy. This applies to the employee as a covered person in a plan of group insurance. This notice is not required if your group plan is an administrative services contract.

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 want to produce your own Summary Plan Description, we are happy to provide you with our privacy policy. It's a convenient way for you to furnish notice to your employees.

The Gramm-Leach-Bliley Act (GLBA) regulates the disclosure of a patient's nonpublic 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 Aetna members and are included in standard enrollment packages.

How we guard privacy

Our Privacy Practices Notice describes our privacy policy. We distribute this to members as the law requires. The notice is required by the federal HIPAA Privacy Rule and also by individual state Gramm-Leach-Bliley privacy regulations.

The notice may vary depending on the insured product. Visit **Aetna.com/legal-notices/privacy/information-practices.html** for product-specific versions of the notice.

**If you elect to produce your own Summary Plan Description (SPD) in lieu of using a Booklet-Certificate produced by us, please remember that 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.

Confidentiality Notice

This Confidentiality Notice, in compliance with state requirements, is included along with your employee Booklet-Certificate:

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.

We use personal information for:

- 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 proceeding
- Transfer of policies or contracts to and from other insurers, HMOs and third-party administrators; underwriting activities; and 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. We use and disclose personal information listed above without member consent to the extent the law allows. You can get a copy of our Notice of Privacy Practices from us. The notice describes in greater detail our practices on the use and disclosure of personal information. Visit **Aetna.com/legal-notices/privacy/information-practices.html** or call the toll-free Member Services number on your member ID card.

Right of access and correction

Members have a right to learn the nature and substance of any information Aetna has in its files about members. Members 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 a member asks for any health information, Aetna may disclose details of the information the member asks for to their doctor. If members wish to exercise this right or if members wish to have more detail on our information practices, they may contact:

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

Enrollment — what you need

You can find the enrollment forms online at **Aetna.com** for initial enrollment of your employees.

Log in to eBusiness at **Aetna.com/employers-organizations.html** to make other enrollment changes and manage your benefits plan.

We do not accept custom enrollment forms from full-risk or self-insured businesses. That is because these forms need advance approval by us and need to be filed with the appropriate regulatory authority in the state the business is written.

New or rehired employees

Group information

- **Your company's name.**
- **Your company's address:** This is your primary business location.
- **Control or customer account numbers.**
- **Plan description:** The plan identifies the benefits you have selected.

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 starts. For example, if an employee starts work on February 1 and has to serve a two-month probation period, you should show April 1 as the effective date.

Employee information

- **Employee's Social Security number:** Provide the employee's SSN so we can create their Aetna ID number.
- **Employee's name:** The employee should list their full name (last name, first name and middle initial). Do not use nicknames.
- **Employee's address:** Street number and name, city, state and ZIP code.
- **Employee's status:** Indicate whether the employee is active, on COBRA or on state continuation.
- **Employee's sex:** "M" for male and "F" for female.
- **Phone numbers:** The employee's home and work phone numbers.
- **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:** Show "S" for spouse, common law spouse, civil union partner, or domestic partner.
- **Relation code:** Children
  - D = Biological daughter, adopted daughter, stepdaughter or any other unmarried female child the employee supports who is under the plan's limiting age and who lives with the employee in a parent-child relationship (that is, granddaughter, domestic partner's daughter, niece, female foster child, etc.).
  - S = Biological son, adopted son, stepson or any other unmarried male child the employee supports who is under the plan's limiting age and who lives with the employee in a parent-child relationship (that is, grandson, domestic partner's son, nephew, male foster child, etc.).
- **Name:** The employee should list their dependents' full names (last name, first name and middle initial). Do not use nicknames.
- **Social Security numbers:** List the SSNs of any dependents being covered. If a dependent does not have an SSN, indicate "none."
- **Birth date:** The employee must list their birth date and the birth dates for all dependents.
- **Dependent addresses:** List if different from the employee's. For example, list the address of a boarding school that the dependent children are attending.
- **Prior insurance plan:** Check "yes" if the employee and/or dependents had prior health coverage, and list the information in the space provided.
- **Other health coverage:** Check "yes" if the employee and/or dependents have other health coverage, and list the information in the space provided.

- **Currently covered by Medicare:** Check "yes" if the employee or dependent is eligible for Medicare coverage.
- **Children who are disabled:** Check "yes" if the employee is enrolling a child who is disabled.
- **Primary medical office ID number:** Provide this if your group plan requires the selection of a primary care physician (PCP). List the Aetna provider's primary office ID number for the employee and each dependent.
  Generally, employees will want to choose a PCP for themselves and any eligible dependents when they enroll. Some states, however, require that managed care organizations assign a PCP to members who do not select one at enrollment. To allow members access to the plan's full range of covered benefits, we randomly assign them a PCP based on where they live. They can change this assignment at any time.
- **Previously seen:** Check "yes" if the employee or dependent has seen the PCP before.

Signatures needed

- **Employee's signature:** The employee must sign and date the form. Electronic signatures are allowable as long as they are present on the standard Aetna enrollment application.
- **Employee's email address:** Optional.
- **Your signature:** You, as the employer, must sign and date the form.

Online benefits tool

You can save time by completing the following enrollment tasks using our online benefits tools. Visit us at **Aetna.com/employers-organizations.html** to log in to eBusiness.

Then use eEnrollment to do the following:

- Add, change or delete dependents
- Remove coverage for dependents
- Terminate or cancel coverage
- Change an employee's name or address
- Change an employee's SSN
- Change a plan number
- Change earnings and/or insurance amounts
- Change control, suffix or account numbers
- Remove multiple employees and dependents from coverage due to termination, reduced hours, death, divorce, legal separation, entitlement for Medicare coverage, age or other reason

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 indicate. Before making this change, please see the Managing the Transition to Medicare section on page 28.

Employer information

- **Your company's name:** If not already preprinted, please add.
- **Control, suffix and account number:** Fill in the prior control, suffix and account number.

Employee information

- **Employee's Social Security number:** List employee's Aetna ID number.
- **Employee's name:** The employee should fill in their full name (last name, first name and 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
- **Covered by Medicare:** Check "yes" if the employee or spouse is eligible for Medicare coverage.

Signatures needed

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

Termination and continuation of coverage

You might be able to complete these transactions online. Please log in to eBusiness at **Aetna.com/employers-organizations.html** and check your account to see if the plan is listed. If your plan is not listed, then follow the steps below on the enrollment or change form.

Activity information

- **Effective date of activity:** This is the date the employee and/or dependent of the employee is eligible to elect continuation (COBRA, for example).
- **Termination section:** Check the "terminating employment" box AND check either or both continuation boxes. If the COBRA box is checked, we will move the member to your COBRA plan and they will continue to bill on your Aetna invoice.

Terminations are limited to 60 days from the date we are notified or 2 billing cycles. We process all terminations using the last day of the billing cycle month. If your bill cycle runs the 1st–31st, your termination date will be processed using the last day of the month. If your bill cycle runs the 15th–14th, your termination date will be processed on the last day of the billing cycle, the 14th.

Please note: We do not prorate premium for terminations. Unless state regulations require a carrier to prorate, all terminations will be processed the last day of the billing cycle.

Examples

Termination request received December 3 for an October 31 termination date:

- We will process the termination as requested, effective October 31.
- The request is considered timely.

Termination request received December 3 for a September 30 termination date:

- We will not process the requested effective date of September 30.
- The termination will be processed using an October 31 effective date.

Employer information

- **Your company's 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 their full name (last name, first name and middle initial).
  - Do not use nicknames.
  - Signatures are needed.
- **Employee's signature:** The employee must sign and date the form.

Conversion

If conversion policies are available in your state, members who are no longer eligible for group plan benefits may be able to convert to an individual plan. They must continue to live within the Aetna HMO service area, however. These individual plans are known as conversion plans.

If your employee qualifies, an application for a conversion plan must be submitted to us within the specified number of days in your Group Agreement after:

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

To get forms and information about conversion plans, your employees can contact Member Services.

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

New service area out-of-state (OOS)

New hires living in a new service area may need a new OOS PPO service area and plan to be set up. Rates vary by area. Your sales support team can advise you.

Annual renewal plan changes

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

The timing of the annual renewal greatly affects the service your members receive. We will provide the renewal 30–60 days in advance of your renewal date, based on the state's renewal notification lead time. Plan changes must be submitted to us within the specified time frame on your renewal proposal. We cannot accept plan changes submitted after the date listed in the letter.

Plan changes

Plan sponsors who choose an alternate plan at renewal must have all completed paperwork into Aetna Underwriting 10 business days prior to the renewal date. If final benefits selections are not submitted within 10 days of the effective date, plan sponsors may be subject to material modification guidelines.

Billing

eBilling

If you are eligible for eBilling, you can save time by using our online tools to complete your billing tasks. Visit **Aetna.com/employers-organizations.html** and log in to eBusiness.

Invoices

Here are key things to know about our invoices:

- Bills are generated each month around two to three weeks prior to the billing due date.
- Check your invoice carefully. Make sure all eligible employees are included on the statement and that premiums are correct. Notice a mistake? Call the phone number on your invoice.
- It is important to "pay as billed" within the 31-day grace period to avoid a possible lapse of coverage.
- "**Paying as billed**" means paying the total amount due, which is shown on the billing summary, and then waiting for adjustments you've submitted to appear on a later billing invoice.
- If you have an automatic bank draft service set up, then the draft amount will equal the Total Net Charges amount.
- Premiums for new employees who are enrolled off-cycle of the policy month will not be charged until the first full policy month of enrollment. We do not prorate premiums.
- If your policy lapses for nonpayment 3 times within a 12-month period, you will not be eligible for reinstatement.

The invoice includes:

1. **Prepared date:** The date the statement was prepared.
2. **Invoice number:** Unique to every bill.
3. **Triad number:** The number for the service center assigned to your account.
4. **Your account number:** Don't forget to put this on all correspondence and forms.
5. **Bill package:** The 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.
8. **Payment due date:** Date that payment is due.

Reminders:

- Do not send any other request or correspondence with premium payments.
- If you pay by check, make the check payable to Aetna.

Consolidated billing

A consolidated bill statement has these seven sections:

1. Invoice information
2. Summary of account
3. Payment stub and remittance
4. Plan key
5. Current in-force charges
6. Retroactivity and other adjustments
7. Benefits snapshot

Summary of account

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

The summary shows:

1. **Opening balance:** The balance due from earlier 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 before or adjustments to amounts from prior invoices.
4. **Net charges:** The total of current in-force charges plus retroactivity and any other adjustments.
5. **Paid date:** The deposit date of payment(s) received. The number of entries displayed in this section may vary. That's because 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.
9. **Current admin/other adjustment charges:** Any manual or systematic adjustments that are processed to the account.

Message section

This section of your statement has any messages that would apply to your account. It may include important information about your agreement and payment terms.

Important remittance information

The payment stub summarizes your invoice information and the total amount due. If you pay by check, please return this portion with your payment.

To be sure that claims payments are not interrupted, mail your payment by the due date listed on your payment stub.

Please pay the total amount due listed on your invoice each month.

It is your responsibility to:

- Verify and check each monthly statement for accuracy.
- Submit any eligibility transactions, if needed, to accurately reflect on the next premium statement.

Make your checks payable to Aetna. Include the remittance stub, and use the mailing envelope provided.

Plan key

The plan key, on the back of the invoice summary page, lists the products and plan types that your membership is enrolled in. 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.).

1. **Current in-force charges:** The current in-force charges section of your statement reflects all subscribers insured for that billing month.
2. **Name and subscriber ID:** which indicates the name and SSN of each subscriber. The SSN is presented in a masked format (XXX-XX-6789) to protect the privacy of each enrollee.
3. **Product type and premium:** The product and total premium charged per subscriber.
4. **Total current employee charges:** The total amount by product and the total current charges.

Retroactivity and other adjustments

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

1. **Name and subscriber ID:** Lists the name and SSN 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 affected by the transaction.
5. **Product type and premium:** The product and total premium charged per subscriber.

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.

6. **Total retroactivity:** The total of all subscriber retroactive changes.
7. **Other adjustments:** A list of other adjustments made at an account level. Debit and credit adjustments will be displayed separately by date.
8. **Total retroactivity and any other adjustments:** The total net amount of the retroactivity and any 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. **Tier code:** This section will break out each tier billed to the customer (for example, EE, EE + spouse, EE + child[ren], EE + family).
4. **Our recorded empl/volume:** Volume of each tier billed and total premium for each tier billed.
5. **Singles — sub only:** The number of single-only subscribers enrolled in the plan.
6. **Premium:** The total premium for single subscribers enrolled in the plan.
7. **Couples — sub + spouse:** The number of couples enrolled in the plan.
8. **Premium:** The total premium for couples enrolled in the plan.
9. **Parent/child(ren) — sub + 1 or more children:** The number of parent(s) and children enrolled in the plan.
10. **Premium:** The total premium for parent(s) and children enrolled in the plan.
11. **Families — sub + spouse + 1 or more children:** The number of families enrolled in the plan.
12. **Premium:** The total premium for families enrolled in the plan.

Ending your contract

To end your contract, you must give us written notice at least 30 days before the date you want the contract to end. (You can only choose the last day of a month as a termination date.) You must pay total premiums each month, as they are due, until the termination date.

Continuing coverage

In some instances, employees can be given the chance to keep their group coverage for a limited period of time after certain qualifying events. We call this "continuation."

Some of the group plan provisions that allow for continuation are required by the federal government. For example, there's the Family and Medical Leave Act (FMLA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Others are standard features of your Aetna group plan. Continuation because of a disease or injury, for instance.

We'll explain the various continuation options that may be available to your employees and their dependents. We'll also list instructions for completing any forms we may require for continued coverage.

Disease or injury

If an employee is absent from work because of an extended disease or injury, coverage may be continued for a limited time. For example, coverage may continue for 3, 12 or 30 months, depending on what your plan documents say.

If the employee does not return to work when this continuation period ends, the employee, along with any covered dependents, may be eligible for other continuation provisions of your group plan for terminated employees, such as COBRA.

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

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

As the employer, you can 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 rely on you to notify us when you terminate an employee.

Please refer to the enrollment section of this handbook for instructions for terminating coverage.

Layoff or leave of absence

If an employee stops working because of a temporary layoff or leave of absence, you may choose to continue their coverage until the end of the month after the month in which the layoff or leave began.

Say, for instance, the employee takes a short-term leave of absence beginning on February 10. You may continue coverage until March 31. Whether you do this is up to you. Of course, this applies only if you keep making premium payments to Aetna on behalf of the employee.

What if the group plan ends while the employee's coverage is being continued? Then the continuation coverage will end on the date the plan ends. For example, if the employee takes a short-term leave of absence beginning on February 10 and the group plan ends on February 28, the employee's coverage will end on February 28.

If you decide not to allow the employee to continue coverage, or if the employee decides they do not want to pay for continued coverage, the employee's coverage will end immediately.

Please refer to the enrollment section of this handbook for instructions on terminating coverage.

A dependent child who is disabled

If an employee has a child who is fully disabled or who becomes fully disabled before reaching the limiting age for dependent children, as outlined in your group plan (the terms vary by state), the child's life insurance and health coverage may be continued beyond the limiting age of 26, if the child has not been issued an individual insurance policy.

To have coverage continued beyond your plan's limiting age, the child must be fully disabled because of a behavioral illness or physical disability. The following forms must be completed and sent to us for review and approval: "Request for Continuation of Medical Coverage for Handicapped Child" and "Handicapped Child Attending Physician Statement." Visit **Aetna.com** to find the forms you need.

When is a child considered fully disabled?

The following two conditions must be met and are subject to applicable laws and your plan documents:

- The child is not able to earn their own living because of behavioral illness or physical disability.
- The child must depend chiefly on the employee for support and maintenance.

If the child meets this definition, we may require proof of the child's disability. We may also require examination of the child as often as needed to determine continued eligibility.

Coverage for a dependent child who is fully disabled will end on the first of these dates to occur:

- The date dependent coverage ends under your group plan (except for reaching the limiting age)
- The date the child fails to have a required exam
- The date the employee or child fails to provide proof, when requested, that the disability continues
- The date the disability ends
- The date we do not receive any required premiums

The Consolidated Omnibus Budget Reconciliation Act (COBRA)

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 toward employers rather than toward insurance carriers, employers have to abide by its mandates and consult their own legal counsel.

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 you COBRA direct billing services. It's an efficient way to manage and bill your COBRA continuations. These can include retirees, surviving spouses, employees on leave or medical continuation — in fact, any off-payroll employee who receives benefits from your group plan.

IBA offers:

- Billing and collection of individual premiums
- Maintenance of member eligibility data
- Distribution of funds to customers

Call your local Aetna service representative for more details.

Continuation of coverage for other reasons

Sometimes you may need to continue coverage for reasons unrelated to COBRA. These reasons can include:

- A retirement agreement
- Collective bargaining
- Industry practice
- Plan procedure
- Severance
- State or local law

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is also considered "alternative coverage."

This coverage does not extend the maximum coverage period under COBRA. That is measured solely from the date of the qualifying event or, if the plan provides for it, from the date of the loss of coverage. Several states have requirements for continuation of coverage that does not begin until COBRA coverage ends.

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. Coverage must start for the employee and/or eligible dependents on the day of the qualifying event (there cannot be any gap in coverage). The coverage under COBRA must be offered to the employee and/or eligible dependents as and when indicated in these guidelines. Evidence of insurability for continuation of coverage cannot be required.

How COBRA affects you

COBRA and later laws require certain employers that provide group health coverage to allow certain individuals to continue coverage when coverage ends because of a specified qualifying event. The employer may choose to make coverage under COBRA available at the individual's expense

You are exempt from COBRA if you:

- Are considered a small employer 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
- 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 IRC

When it comes to defining "small employer," both full-time and part-time common-law employees are counted. Self-employed individuals, independent contractors and directors are not counted.

It is important to understand that the same rules of the IRC for controlling employers 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 events

COBRA coverage is only available when coverage is lost because of certain specific events. These include:

- A company files for bankruptcy under Chapter 11, but only as it affects retirees, their spouses and dependents who lose coverage (For more information about this qualifying event, contact your legal counsel.)
- Death of a covered employee
- Dependent children become ineligible for coverage under a provision of the employer's group health plan (For example, when a covered dependent surpasses the maximum coverage age.)
- Divorce or legal separation of a covered employee from the employee's spouse or a spouse's divorce or legal separation from the covered employee
- Employee's enrollment in the Medicare program, leaving spouse or dependent children without coverage
- Termination of employment (which includes strikes, layoffs and walkouts), either voluntarily or involuntarily, for reasons other than gross misconduct
- Voluntary or involuntary reduction in hours of a covered employee's employment that results in the loss of coverage (This might happen when an employee goes from full time to part time or when an increase in premium costs results in a loss of coverage.)

Depending on the circumstances, COBRA coverage may be kept for up to:

- 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 they 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, they must also notify the plan administrator that they are 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 the 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 months from the initial qualifying event.

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 their COBRA election.
- A qualified beneficiary becomes covered after the date of their 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 stops providing any group health plan coverage to any employees (including successor plans).
- When a disabled qualified beneficiary recovers from the disability before the end of the 29-month period, coverage may be ended. It may be ended 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.

Requirements for 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 quickly decide on COBRA continuation, you'll 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 after their termination. The enrollment section of this manual has details on terminating coverage.

If a terminated person later 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 if the employee and/or dependent does not choose COBRA continuation.

Note: If you are being direct billed by us, make sure premiums are being collected. In this case, the employee and/or dependents will send 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. This can include immediately discontinuing payment for the qualified beneficiary already paying directly to our COBRA Direct Bill unit.

If you are not using our direct-bill feature, you are responsible for monitoring the continuation and cancellation of coverage.

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 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 it is later than the date of the qualifying event.

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. We do 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, the beneficiary's estate or the spouse of the qualified beneficiary.

Premium requirements

The qualified beneficiary is responsible for paying for continuation coverage. Coverage may end if premium payments are not made in a timely manner. (While you, as the employer, may pay for part or all of the premiums, COBRA does not require you 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% of the cost for other similarly situated active employees. However, in the case of a qualified beneficiary 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% of the group rate.

If nondisabled 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% of the applicable premium, depending on how the plan determines the cost of the coverage. The employer may retain the additional premium (above 100%) to cover administrative expenses.

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

Completing the employer section of the Right of Continuation Notice

Before giving notice to the qualified beneficiary, you as the employer must complete this section of the Right of Continuation Notice. List or check off:

1. The beneficiary's name and address
2. 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. The beneficiary's name in the salutation (that is, the name that comes after the word "Dear")
4. The date the qualified beneficiary's group coverage will end
5. The box that describes the qualifying event making the beneficiary eligible for COBRA
6. The number of months COBRA is available to the qualified beneficiary(ies) based on the qualifying event
7. The box or boxes showing who is eligible for COBRA.
8. The effective date of COBRA
9. The date COBRA will be exhausted (Calculate the 18, 29 or 36 months.)
10. 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 before the qualifying even.)
11. The telephone number of the person who is administering the COBRA continuation (This is for the member's benefit, for questions.)
12. The address to which the qualified beneficiary must return the application and premium payment
13. 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.)

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 they were covered on the day before the start of the FMLA leave.

At your discretion, you may allow the employee to continue benefits the FMLA does not require (for example, supplemental life insurance, accidental death coverage 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 an 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 end
- Coverage ends for the employee's eligible class
- You determine their approved FMLA leave has ended*

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 they had continued in active employment, provided they ask for such coverage within 31 days of their 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 we give 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 whom employment is terminated.

*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 us which will have sole discretion to continue or discontinue the coverage for that extended leave period.

Other legal considerations

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.

In addition, insurance law(s) of the noncontract state(s) may 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.

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 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 gives 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 to include:

- After COBRA ends
- Divorce or separation
- Employee's death
- Employee's retirement
- Employment cessation
- Labor disputes
- Medicare eligibility
- Plant closings
- Total disability

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 (be it administrative, state or COBRA), they may be eligible to have health benefits extended, without payment of premium, for a limited period of time after they leave 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, check your plan documents for the specific terms that apply to your group plan.

What "totally disabled" means

A covered employee is considered "totally disabled" if they are not able to engage in their customary occupation and is not working for pay or profit.

A covered dependent will be deemed "totally disabled" if they are 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 must ask their attending physician to provide evidence of the disability to the claims office that processes your company's medical claims. The 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, ends. An employee or dependent cannot retroactively elect a continuation provision, such as a state or COBRA continuation, while they have an extension of benefits.

Important: If a person is eligible to convert their coverage to an individual insurance policy from their group health plan, they must do so when applying for any extension of benefits. Failure to do so may prohibit them from being issued an individual policy later.

Managing the transition to Medicare

Medicare is a federal health insurance program for people age 65 and older and for some disabled individuals.

The Age Discrimination in Employment Act (ADEA) requires that you counsel employees or dependent spouses nearing age 65 about Medicare benefits.

You must counsel them on:

- Eligibility requirements
- How to apply
- Medicare's relation to your group health plan

Your company's legal counsel can advise you on your Medicare responsibilities.

Your plan documents tell you 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. At least one of the following conditions must apply:

- 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

Secondary health insurance is an insurance plan that pays for some of the costs that the primary health insurance does not pay.

As an employee and/or the employee's dependent spouse approaches age 65, their primary and secondary health insurers need to be determined. It is also possible that they will remain enrolled under your Aetna group plan. (A member already on COBRA when they become entitled to Medicare will lose COBRA coverage, and certain retired members may also lose coverage.)

Coverage is determined in part by the employee's employment status (active or retired) and whether you are subject to:

- The Age Discrimination in Employment Act (ADEA)
- Amendments enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
- The Deficit Reduction Act of 1984 (DEFRA)
- The Consolidated Omnibus Budget Reconciliation Act (COBRA)
- The Omnibus Budget Reconciliation Act of 1986 (OMBRA)
- The Omnibus Budget Reconciliation Act of 1993 (OBRA)

Your company's legal counsel can help you determine which laws apply.

The information on this page will help you determine when someone is eligible for Medicare primary health coverage. The guidelines will also tell you what administrative changes, if any, need to be made to coverage for the employee and/or the employee's dependent spouse.

The Tax Equity and Fiscal Responsibility Act (TEFRA)

If your group plan IS subject to TEFRA, the following rules apply to employers with more than 20 eligible employees:

- **We are primary** for the employee if the employee is active or if they are 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, their spouse is covering them as a dependent.
- **We are primary** for the dependent if the employee is active or if they are retired and the dependent is under age 65.
- **Medicare is primary** for the dependent if Medicare End Stage Renal Disease (ESRD) Coordination of Benefits (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 less:

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

If the member is entitled to Medicare because of disability, various factors are used to determine the primary payer. These include:

- Age
- Retirement status
- Type of disability

Sometimes when a person is on Medicare because of a disability, we are primary and Medicare is secondary. So don't make this change without first contacting us.

Questions? Call Member Services using the toll-free phone number on your Aetna member ID card.

If the member has end-stage renal disease, different laws govern who the primary payer is. Member Services can answer your questions.

Reporting the change. If the employee and/or spouse is now eligible for Medicare as primary coverage, refer to the enrollment section of this handbook. It'll give you the information you must send us when changing from Aetna primary to Medicare primary.

Visit **Aetna.com** to find out more about our products and programs.

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, 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.

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 a member's medical needs, the member may request to have services provided by nonsystem or nongroup providers. The member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Informed Health® Line and Banner Health® Nurse on Call nurses cannot diagnose, prescribe or give medical advice. Specific questions should be addressed to your doctor. Alternative health care and discount programs 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 nonemergency 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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