

Aetna Avenue

# SMALL GROUP UNDERWRITING GUIDELINES

**For Businesses with 50 or Fewer Eligible Employees**

This material is for informational purposes only and is not intended to be all inclusive. Other policies and guidelines may apply.

Note: State and federal legislation/regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of the Regional Underwriting Manager except where Head Underwriter approval is indicated. This information is the property of Aetna and its affiliates (“Aetna”), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing.

<p><b>Case Submission Dates</b></p>	<ul style="list-style-type: none"> <li>▪ Groups with 2-50 eligible employees must have all completed paperwork into Aetna Small Group Underwriting 1 business day prior to the requested effective date.</li> <li>▪ Any cases received after the cut-off date will be considered on an exception basis only, as approved by the Underwriting Unit Manager.</li> <li>▪ If not approved, the effective date will be moved to the next available effective date.</li> </ul>
<p><b>COBRA and/or State Continues</b></p>	<ul style="list-style-type: none"> <li>▪ COBRA coverage will be extended in accordance with the federal law.</li> <li>▪ COBRA and State Continues are not eligible for Life or Disability coverage.</li> <li>▪ COBRA and State Continues are included in the Medical underwriting of the group.</li> <li>▪ Health information must be provided on COBRA and State Continues along with the rest of the group.</li> <li>▪ COBRA/State Continues’ qualifying event, length, start and end date must be provided.</li> <li>▪ Employers with 20 or more employees (full and part time) are eligible to offer COBRA coverage.</li> <li>▪ Employers with less than 20 employees (full and part time) are eligible to offer State Continuation.</li> <li>▪ Note: COBRA/State Continues are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, COBRA/State Continues can be included for coverage subject to normal underwriting guidelines.</li> </ul>
<p><b>Deductible Credit</b></p>	<ul style="list-style-type: none"> <li>▪ Employees who are eligible and want to receive credit for deductible paid to prior Company should submit a copy of the Explanation of Benefits (EOB) to Aetna.</li> <li>▪ This may be submitted at the initial Small Group submission or with their first claim.</li> </ul>
<p><b>Dependent Eligibility</b></p>	<ul style="list-style-type: none"> <li>▪ Eligible dependents include an employee’s spouse. If both husband and wife work for the same company, they may enroll together or separately, except in two life groups, where the spouse must enroll separately. Children can only be covered under one parent’s plan.</li> <li>▪ Domestic partners may be covered as an eligible dependent if the employer elects this designation at contract effective or renewal date.</li> <li>▪ Dependent children, as defined in plan documents in accordance with state and federal law, are eligible for medical and dental coverage up to age 26.</li> <li>▪ At the request of the employer, medical coverage for dependent children may be extended to age 30 and must meet all of the following:                         <ul style="list-style-type: none"> <li>– Need not be a full-time student.</li> <li>– Is not married.</li> <li>– Has no dependents.</li> <li>– Is a resident of this Commonwealth or is enrolled as a full-time student at an institution of higher education.</li> <li>– Is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program.</li> </ul> </li> <li>▪ Grandchildren are eligible if court ordered.</li> <li>▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan.</li> <li>▪ Dependents must enroll in the same benefit option as the employee.</li> <li>▪ Dependents are not eligible for AD&amp;D Ultra® or Disability.</li> <li>▪ Life — Children are eligible to age 19 or 23 if attending school on a regular basis and dependent solely on the employee for support.</li> </ul>

<b>Effective Date</b>	<ul style="list-style-type: none"> <li>The effective date must be the 1st or the 15th of the month.</li> <li>The effective date requested by the employer may be up to 60 days in advance.</li> </ul>
<b>Electronic Funds Transfer</b>	<ul style="list-style-type: none"> <li>Once the group is issued customers can pay their monthly premiums online or by calling an automated phone number, 1-866-350-7644, with no extra charge. This eliminates the need for checks, envelopes and postage while also supplying peace of mind that payments have been received.</li> </ul>
<b>Employee Eligibility</b>	<ul style="list-style-type: none"> <li>Eligible employees are those employees and active owners who are permanent and work on a full-time basis, as defined by the employer, and who meet any authorized waiting period requirements. Aetna's minimum acceptable hours per week is 25.</li> <li>This includes a sole proprietor or partner of a partnership, if included as an employee in the health benefits plan of employer.</li> <li>Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement.</li> <li>Employees/Individuals not eligible for coverage include 1099 contractors, temporary, seasonal, substitute, uncompensated employee, volunteer, early retiree (&lt;65 years of age), inactive owner, shareholder only, officer who is not active, managing member who is not active, investor only or a silent partner.</li> </ul> <p><b>Retirees</b></p> <ul style="list-style-type: none"> <li>Early Retiree coverage is not available.</li> <li>Coverage is available for Medicare-eligible retirees and/or active Medicare-eligibles in accordance with the Small Group Medicare Underwriting Guidelines.</li> <li>Medicare eligible retirees who are enrolled in an Aetna Medicare Plan are eligible to enroll in Standard Dental Plans in accordance with these Dental Underwriting Guidelines.</li> <li>Retirees are not eligible for Life, Disability or Voluntary Dental coverage.</li> </ul>
<b>Employer Definition</b>	<ul style="list-style-type: none"> <li>An employer who employed at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code, shall be treated as one employer.</li> </ul>
<b>Employer Eligibility</b>	<ul style="list-style-type: none"> <li>Group applicants that do not meet the above definition of a small employer are not eligible for coverage.</li> <li>Medical plans can be offered to sole proprietorships, partnerships or corporations.</li> <li>Organizations must not be formed solely for the purpose of obtaining health coverage.</li> <li>Taft Hartley groups and closed groups are not eligible.</li> <li>Dental and Disability have ineligible industries which are listed separately under Product Specifications.</li> <li>The Dental ineligible industry list does not apply when Dental is sold in combination with Medical.</li> </ul>
<b>Initial Premium Check</b>	<ul style="list-style-type: none"> <li>The initial premium check should be in the amount of the first month's premium and drawn on a company check.</li> <li>The initial premium check is not a binder check and does not bind Aetna to provide coverage.</li> <li>If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium will be returned to the employer.</li> <li>If the initial premium check is returned for non-sufficient funds, coverage will be terminated retroactive to the effective date.</li> </ul>
<b>Licensed, Appointed Producers</b>	<ul style="list-style-type: none"> <li>Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna products.</li> <li>License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted.</li> </ul>
<b>Multi-Option Plans</b>	<ul style="list-style-type: none"> <li>A minimum of 1 person must enroll in each plan when a dual option is offered.</li> <li>Groups can offer 2 medical plans, provided the 2 plans offered have different medical features. The same medical plan with different prescription drug plans cannot be offered.</li> <li>Groups with 20-50 enrolling employees can offer 3 medical plans. If 3 plans are offered, they must have different medical features. The same medical plan with different prescription drug plans cannot be offered.</li> </ul>
<b>Municipalities and Townships</b>	<ul style="list-style-type: none"> <li>A township is generally a small unit that has the status and powers of local government.</li> <li>A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town or village. A municipality is typically governed by a mayor and city council, or municipal council. In most countries, a municipality is the smallest administrative subdivision to have its own democratically elected officials.</li> <li>Underwriting Requirements <ul style="list-style-type: none"> <li>Quarterly Wage and Tax Statement (QWTS)</li> <li>W2 – Elected or appointed officials and Trustees “may” be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS; rather, they may be paid via W2 and must provide a copy of their W2.</li> <li>If elected officials are to be covered, provide a copy of the charter or contract indicating which classes or employees are to be covered, the minimum hours required to work per week to be eligible for coverage, and confirmation that coverage will be offered to all employees meeting the minimum number and participation will be maintained.</li> </ul> </li> </ul>

**PENNSYLVANIA PLAN GUIDE**

<p><b>Newly Formed Business</b> (in operation less than 3 months)</p>	<p>The following documentation must be provided for consideration:</p> <ul style="list-style-type: none"> <li>▪ Business License (not a professional license). If not available, provide a copy of the Partnership Agreement, Articles of Organization, or Articles of Incorporation; and</li> <li>▪ Employer identification number/federal tax ID number; and</li> <li>▪ Quarterly Wage and Tax Statement. If not available, when will one be filed? and</li> <li>▪ The most recent two consecutive pay periods, which include hours worked, taxes withheld, check number and wages earned; or</li> <li>▪ A letter from Certified Public Accountant listing the names of all employees (full and part-time), the number of hours worked each week, dates of hire, and weekly salary. Have payroll records been established? If not, when? Will a Quarterly Wage and Tax Statement be filed? If so, when?</li> </ul>
<p><b>PEO</b> (Professional Employer Organization)</p>	<ul style="list-style-type: none"> <li>▪ As long as the PEO provides payroll specific for the small group and we can determine it is a small group, even though the small group may be reported under the PEO tax ID number, the group may be considered, subject to underwriting approval.</li> </ul>
<p><b>Prior Aetna Coverage</b></p>	<ul style="list-style-type: none"> <li>▪ Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until: (1) 12 months after the termination date; and (2) payment of 2 months of premium in advance of issuance of the health benefits plan. Additionally, all premiums still owed on the prior Aetna plan must be paid in full.</li> <li>▪ Medical claims will be reviewed along with the health information provided on the employee application and included in the overall medical assessment of the group.</li> </ul>
<p><b>Rating Information</b></p>	<ul style="list-style-type: none"> <li>▪ Rates are based on final enrollment and require that: <ul style="list-style-type: none"> <li>– No portion of the member’s cost sharing, including, but not limited to, copayments, deductibles and/or coinsurance balances will be subsidized or funded by the employer, with the exception of a federally-qualified Health Reimbursement Arrangement (HRA), or Health Savings Account (HSA), whether insured or self-funded, including, but not limited to, a partially self-funded Section 105 wrap around, now or in the future; and</li> <li>– Employer is not funding the deductible of the quoted health plan through an HRA or HSA arrangement in excess of 50% annually.</li> </ul> </li> <li>▪ All quotes are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in census.</li> <li>▪ If both husband and wife work for the same company and apply under one contract, rates will be based on the oldest adult.</li> <li>▪ All rates will be quoted on a 4-tier structure: single, couple, employee plus child(ren), family.</li> </ul>
<p><b>Replacing Other Group Coverage</b></p>	<ul style="list-style-type: none"> <li>▪ Current carrier bill with billing summary and employee roster is required.</li> <li>▪ The employer should be told not to cancel any existing medical coverage until it has been notified of approval from the Aetna Underwriting unit.</li> </ul>
<p><b>Signature Dates</b></p>	<ul style="list-style-type: none"> <li>▪ The Aetna Employer Application and all employee applications must be signed and dated prior to and within 60 days of the requested effective date.</li> <li>▪ All employee applications must be completed by the employee himself/herself.</li> </ul>
<p><b>Spin-Off Groups</b> (current Aetna customers leaving an Aetna group only)</p>	<p>Aetna will consider the group with the following:</p> <ul style="list-style-type: none"> <li>▪ A letter from the group or broker indicating the group is enrolling as a spin off. Letter needs to include the name of the group from which it is spinning off.</li> <li>▪ Ownership documents showing that the spin-off company is a newly formed separate entity.</li> <li>▪ A minimum of 2 weeks’ payroll. If the group that is spinning off has been in business longer than 2 weeks, payroll will be required for the amount of time in business up to a maximum of 6 consecutive weeks.</li> <li>▪ Current Aetna customers leaving an Aetna group will have medical claims reviewed along with the health information provided on the employee application and included in the overall medical assessment of the group.</li> </ul>

<p><b>Tax Information / Documents</b></p>	<ul style="list-style-type: none"> <li>▪ Must submit a copy of the most recent UC-2/Quarterly Wage and Tax Statement (Unemployment Compensation Tax Form).</li> <li>▪ The QWTS must contain the names and wages of all employees of the employer group.</li> <li>▪ Employees who have terminated, work part time or are newly hired should be noted accordingly on the QWTS.</li> <li>▪ Any handwritten comments added to the QWTS must be signed and dated by the employer. The underwriter may request payroll in questionable situations.</li> <li>▪ Newly hired employees should be written in on the QWTS and signed by the employer. The underwriter may request payroll in questionable situations.</li> <li>▪ Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours which must match the totals on Form 941.</li> <li>▪ Proprietors, partners or officers of the business who do not appear on the QWTS need to complete Aetna’s Small Group Proof of Eligibility Form (<a href="https://www.aetna.com/producer/SmallGroup/forms/pennsylvania.html">https://www.aetna.com/producer/SmallGroup/forms/pennsylvania.html</a>) and submit one of the following. This list is not all inclusive. The employer may provide any other documentation to establish eligibility.</li> </ul> <table border="1" data-bbox="328 478 1474 1171"> <tr> <td data-bbox="328 478 711 682"> <p><b>Sole Proprietor</b></p> <ul style="list-style-type: none"> <li>▪ Franchise</li> <li>▪ Limited Liability Company (operating as a Sole Proprietor)</li> </ul> </td> <td data-bbox="711 478 1474 682"> <ul style="list-style-type: none"> <li>▪ IRS Form 1040 along with Schedule C (Form 1040)</li> <li>▪ IRS Form 1040 along with Schedule SE (Form 1040)</li> <li>▪ IRS Form 1040 along with Schedule F (Form 1040)</li> <li>▪ IRS 1040 along with Schedule K1 (Form 1065)</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul> </td> </tr> <tr> <td data-bbox="328 682 711 877"> <p><b>Partner</b></p> <ul style="list-style-type: none"> <li>▪ Partnership</li> <li>▪ Limited Liability Partnership</li> </ul> </td> <td data-bbox="711 682 1474 877"> <ul style="list-style-type: none"> <li>▪ IRS Form 1065 Schedule K-1</li> <li>▪ IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</li> <li>▪ Partnership agreement if established within 2 years - Eligible partners must be listed on agreement</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul> </td> </tr> <tr> <td data-bbox="328 877 711 1171"> <p><b>Corporate Officer</b></p> <ul style="list-style-type: none"> <li>▪ Limited Liability Company (operating as C Corp)</li> <li>▪ C-Corporation</li> <li>▪ Personal Service Corporation</li> <li>▪ S-Corporation</li> </ul> </td> <td data-bbox="711 877 1474 1171"> <ul style="list-style-type: none"> <li>▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040)</li> <li>▪ IRS Form 1120 W (C-Corp &amp; Personal Service Corp)</li> <li>▪ 1040 ES (Estimated Tax) (S-Corp)</li> <li>▪ IRS Form 8832 (Entity classification as a corporation)</li> <li>▪ W2</li> <li>▪ Articles of Incorporation if established within 2 years - Corporate officers must be listed</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul> </td> </tr> </table>	<p><b>Sole Proprietor</b></p> <ul style="list-style-type: none"> <li>▪ Franchise</li> <li>▪ Limited Liability Company (operating as a Sole Proprietor)</li> </ul>	<ul style="list-style-type: none"> <li>▪ IRS Form 1040 along with Schedule C (Form 1040)</li> <li>▪ IRS Form 1040 along with Schedule SE (Form 1040)</li> <li>▪ IRS Form 1040 along with Schedule F (Form 1040)</li> <li>▪ IRS 1040 along with Schedule K1 (Form 1065)</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul>	<p><b>Partner</b></p> <ul style="list-style-type: none"> <li>▪ Partnership</li> <li>▪ Limited Liability Partnership</li> </ul>	<ul style="list-style-type: none"> <li>▪ IRS Form 1065 Schedule K-1</li> <li>▪ IRS Form 1120 S Schedule K-1 along with Schedule E (Form 1040)</li> <li>▪ Partnership agreement if established within 2 years - Eligible partners must be listed on agreement</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul>	<p><b>Corporate Officer</b></p> <ul style="list-style-type: none"> <li>▪ Limited Liability Company (operating as C Corp)</li> <li>▪ C-Corporation</li> <li>▪ Personal Service Corporation</li> <li>▪ S-Corporation</li> </ul>	<ul style="list-style-type: none"> <li>▪ IRS Form 1120 S Schedule K1 along with Schedule E (Form 1040)</li> <li>▪ IRS Form 1120 W (C-Corp &amp; Personal Service Corp)</li> <li>▪ 1040 ES (Estimated Tax) (S-Corp)</li> <li>▪ IRS Form 8832 (Entity classification as a corporation)</li> <li>▪ W2</li> <li>▪ Articles of Incorporation if established within 2 years - Corporate officers must be listed</li> <li>▪ Any other documentation the owner would like to provide to determine eligibility</li> </ul>
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<p><b>Two or More Companies – Affiliated, Associated or Multiple Companies, Common Ownership</b></p>	<p>Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following are met:</p> <ul style="list-style-type: none"> <li>▪ One owner has controlling interest of all business to be included; or</li> <li>▪ The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. A copy of the latest filed tax return must be provided; and</li> <li>▪ All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only two of the three businesses to be enrolled, the group will be considered a carve out, will not be Guarantee Issue, and could be declined.</li> <li>▪ There are 50 or fewer employees in the combined employer groups.</li> <li>▪ The two or more groups may have multiple Standard Industrial Classification Codes (SIC); however, rates will be based on the SIC code for the group with the majority of employees.</li> <li>▪ Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups.</li> <li>▪ Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case underwriting exception.</li> </ul> <p>Example: One owner has controlling interest of all companies to be included:          Company 1 – Jim owns 75% and Jack owns 25%          Company 2 – Jim owns 55% and Jack owns 45%          Both companies can be written as one group since Jim has controlling interest in both.</p>						

<b>Waiting Period</b>	<ul style="list-style-type: none"> <li>▪ At initial submission of the group, the benefits waiting period may be waived upon the employer’s request. This should be checked on the Employer Application.</li> <li>▪ The benefits waiting period for future employees may be first of the month following 0, 1, 2, 3, 4, 5 or 6 months.</li> <li>▪ A change to the benefits waiting period may only be made on the plan anniversary date.</li> <li>▪ No retro active changes will be allowed.</li> <li>▪ Two benefit waiting periods may be selected and must be consistently applied within a class of employees as defined by the employer, such as management versus non-management, hourly versus salaried, etc.</li> <li>▪ Benefits waiting periods <b>must be consistently applied to all employees</b>, including newly hired key employees.</li> <li>▪ For new hires, the eligibility date will be the first day of the policy month following the waiting period. Examples:             <ul style="list-style-type: none"> <li>▪ Group A – effective date is July 1st; employees will be issued an effective date of the 1st of the month following the chosen waiting period.</li> <li>▪ Group B – effective date is July 15th, employees will be issued an effective date of the 15th of the month following the chosen waiting period.</li> </ul> </li> </ul>
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## PRODUCT SPECIFICATIONS

	<b>Medical</b>	<b>Dental</b>	<b>Basic Life/AD&amp;D, Disability, Packaged Life and Disability</b>
<b>Product Availability</b>	<ul style="list-style-type: none"> <li>▪ Groups of 2-50 eligible employees.</li> <li>▪ May be written standalone or with ancillary coverage as noted in the following columns.</li> <li>▪ Only non-occupational injuries and disease will be covered.</li> </ul>	<p><b>2 eligible employees</b></p> <ul style="list-style-type: none"> <li>▪ Standard Dental available with Medical.</li> <li>▪ Voluntary Dental not available.</li> </ul> <p><b>3 to 50 eligible employees</b></p> <ul style="list-style-type: none"> <li>▪ Standard Dental available with or without Medical.</li> <li>▪ Voluntary Dental available with or without Medical.</li> <li>▪ Standalone available. Standalone Dental has ineligible Industries which are listed separately under the SIC code section of the guidelines.</li> </ul> <p><b>Orthodontia coverage</b></p> <ul style="list-style-type: none"> <li>▪ Available with 10 or more eligible employees with a minimum of 5 enrolled employees for dependent children only.</li> </ul>	<p><b>Life and/or Disability</b></p> <ul style="list-style-type: none"> <li>▪ 2-9 eligible employees available if packaged with Medical.</li> <li>▪ 10-50 eligible employees available if packaged with Medical or Dental.</li> <li>▪ 26-50 eligible available on a standalone basis.</li> </ul> <p><b>Packaged Life and Disability</b></p> <ul style="list-style-type: none"> <li>▪ 2-50 eligible employees if packaged with Medical.</li> <li>▪ 10-50 eligible employees on a standalone basis.</li> <li>▪ A plan sponsor cannot purchase both Life and Packaged Life and Disability plans.</li> <li>▪ Product packaging rule is a group level requirement. Employees will be able to individually elect Life, Disability or Packaged Life &amp; Disability insurance even if they do not elect Medical coverage.</li> </ul> <p><b>Disability</b></p> <ul style="list-style-type: none"> <li>▪ Groups are ineligible for coverage if 60% or more of eligible employees or 60% or more of eligible payroll are for employees over 50 years old.</li> <li>▪ Conversion options are not available.</li> <li>▪ Available to employees only; dependents are not eligible.</li> <li>▪ Employees may elect Disability coverage even if they do not elect Medical coverage.</li> </ul>
<b>Excluded Class/Carve Outs</b>	<ul style="list-style-type: none"> <li>▪ Union employees are the only class of employees that may be excluded. However, union employees are included in the total count of eligible employees in determining the case size.</li> <li>▪ Management carve-outs are not permitted.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Union employees, if packaged with Medical.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Union employees, if packaged with Medical.</li> </ul>

PRODUCT SPECIFICATIONS			
	Medical	Dental	Basic Life/AD&D, Disability, Packaged Life and Disability
<b>Employer Contribution</b>	<ul style="list-style-type: none"> <li>50% of the employee-only cost or 50% of the total cost of the plan.</li> <li>Coverage can be denied based on inadequate contributions.</li> </ul>	<p><b>Standard Dental</b></p> <ul style="list-style-type: none"> <li>2-50 eligibles</li> <li>25% of the total cost of the plan or 50% of the cost of employee-only coverage.</li> </ul> <p><b>Voluntary Dental</b></p> <ul style="list-style-type: none"> <li>Employer contribution of less than 50% of the cost of the employee-only coverage.</li> <li>Employee-Pay-All plans are permitted.</li> </ul> <p><b>Standard and Voluntary</b></p> <ul style="list-style-type: none"> <li>Coverage can be denied based on inadequate contributions.</li> </ul>	<ul style="list-style-type: none"> <li>2 to 9 eligible employees - 100% of the total cost of the basic Life plan.</li> <li>10 to 50 eligible employees - At least 50% of the total cost of the plans excluding Optional Dependent Term Life.</li> </ul> <p><b>All</b></p> <ul style="list-style-type: none"> <li>Coverage can be denied based on inadequate contributions.</li> </ul>
<b>Late Applicants</b>	<ul style="list-style-type: none"> <li>An employee or dependent who enrolls for coverage more than 31 days from the date first eligible or 31 days of the qualifying event is considered a late enrollee. Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as noted below.</li> <li>Voluntary cancellation of coverage is NOT a qualifying event. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next plan anniversary date to be eligible to be added.</li> </ul>		
	<ul style="list-style-type: none"> <li>Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.</li> </ul>	<ul style="list-style-type: none"> <li>An employee or dependent may enroll at any time, however, coverage is limited to Preventive &amp; Diagnostic services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).</li> <li>Late Entrant provision does not apply to enrollees less than age 5.</li> </ul>	<ul style="list-style-type: none"> <li>Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.</li> <li>The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).</li> <li>Life late enrollee example: Group has \$50,000 life with \$20,000 guarantee issue limit. Late enrollee enrolling for \$50,000 would not automatically get the \$20,000. Since the applicant is late, he/she must medically qualify for the entire \$50,000.</li> </ul>
<b>Live/Work Situs</b>	<ul style="list-style-type: none"> <li>Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA, and VA (the Situs region) will receive the same rates and benefits as the headquarter location.</li> </ul>	<ul style="list-style-type: none"> <li>Eligible employees who live or work in CT, DC, DE, MD, NJ, NY, PA, and VA (the Situs region) will receive the same rates and benefits as the headquarter location.</li> </ul>	<ul style="list-style-type: none"> <li>Not applicable.</li> </ul>
<b>Medical Underwriting</b>	<ul style="list-style-type: none"> <li>Groups cannot be denied based on medical conditions; however, rates may be adjusted for known medical conditions.</li> <li>Medical conditions of COBRA enrollees and/or State Continues are included in this rating calculation.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<ul style="list-style-type: none"> <li>All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested.</li> <li>Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts listed below will be required to submit EOI, which means they must complete an individual health statement and may have to submit to medical evidence via medical records at their expense.</li> </ul>
<b>Out-of-Area within Pennsylvania</b>	<ul style="list-style-type: none"> <li>Out-of-Area employees must be enrolled in a PPO plan if available, otherwise an indemnity plan.</li> </ul>	<ul style="list-style-type: none"> <li>Out-of-Area employees must be enrolled in a PPO plan if available, otherwise an indemnity plan.</li> </ul>	<ul style="list-style-type: none"> <li>Not applicable.</li> </ul>

**PRODUCT SPECIFICATIONS**

	<b>Medical</b>	<b>Dental</b>	<b>Basic Life/AD&amp;D, Disability, Packaged Life and Disability</b>
<b>Out-of-State/ Situs Employees</b>	<ul style="list-style-type: none"> <li>▪ Any active employee who lives and works in a state other than those included in the defined Situs is considered an out-of-situs employee.</li> <li>▪ For groups with 50% or fewer employees that work and reside outside of CT, DE, MD, NJ, NY, PA, VA and Washington, DC, these employees can enroll in a Pennsylvania PPO plan (or indemnity plan if PPO network is not available).</li> <li>▪ If more than 50% of the group's employees work and reside outside of CT, DE, MD, NJ, NY, PA, VA and Washington, DC, Aetna will decline coverage for these employees.</li> <li>▪ PPO is not available in the following states: AL, HI, ID, MN, MT, ND, NM, RI, UT, VT, WI, WY.</li> <li>▪ Indemnity is not available in HI or VT.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Employees who live and work outside of NJ, PA, DE, MD, VA, DC, NY or CT are considered outside the situs region. Out-of-State/Situs employees will be offered one of the specific Out-of-State/Situs Dental PPO plans. Employees who fall outside a Dental PPO network area will default to a comparable indemnity plan. Maximum out-of-state/situs employee percentage (and/or number of employees) will agree with the Medical guidelines.</li> <li>▪ Out-of-State employees can only be offered one of the specific Out-of-State Dental plans; 3 PPO and 3 indemnity plan designs.</li> <li>▪ Maximum Out-of-State employee percentage (and/or number of employees) will agree with the Medical guideline for each state.</li> <li>▪ Out-of-State employees must be enrolled in a PPO Dental plan if available; otherwise, an indemnity Dental plan.</li> <li>▪ OOS PPO Dental is not available in the following states: AR, AK, HI, ID, MA, ME, MT, NC, ND, NH, NM, SD, VT, and WY.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Not applicable.</li> </ul>

PRODUCT SPECIFICATIONS			
	Medical	Dental	Basic Life/AD&D, Disability, Packaged Life and Disability
<b>Participation</b>	<p><b>Non-contributory plans</b></p> <ul style="list-style-type: none"> <li>100% participation is required for non-contributory plans. That means 100% of all employees must enroll.</li> </ul> <p><b>Contributory plans</b></p> <ul style="list-style-type: none"> <li>2-4 eligible employees - 100% of the eligibles must participate, excluding those with qualifying existing spousal, governmental (Medicare, Medicaid, Military) or union coverage.</li> <li>5-50 eligible employees - 75% of the eligibles must participate, excluding those with qualifying existing spousal, governmental (Medicare, Medicaid, Military) or union coverage Example: 22 lives, 2 covered under spouse: <math>22 - 2 = 20 \times 75\% = 15</math> (rounded down) must enroll.</li> </ul> <p><b>ALL</b></p> <ul style="list-style-type: none"> <li>Any eligible employees waiving coverage must complete the waiver section of the Employee Application.</li> <li>Coverage can be denied based on inadequate participation.</li> </ul>	<p><b>Non-contributory plans</b></p> <ul style="list-style-type: none"> <li>100% participation is required, excluding those with other qualifying dental coverage.</li> </ul> <p><b>Standard</b></p> <ul style="list-style-type: none"> <li>2-3 eligibles 100% participation is required excluding those with other qualifying dental coverage. Example: 3 eligibles, 1 spousal dental <math>3 \text{ minus } 1 = 2 \times 100\% = 2</math> must enroll.</li> <li>4-50 eligibles 75% participation is required excluding those with other qualifying dental coverage. A minimum of 50% of total eligible employees must enroll in the dental plan.</li> <li>A minimum of two (2) employees must enroll.</li> </ul> <p><b>Voluntary Dental</b></p> <ul style="list-style-type: none"> <li>3-50 eligible employees</li> <li>25% participation, excluding those with other qualifying existing dental coverage or a minimum of 3 enrollees (5 enrollees for orthodontia coverage), whichever is greater, is required.</li> </ul> <p><b>Standalone Dental</b></p> <ul style="list-style-type: none"> <li>75% participation excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan.</li> </ul> <p><b>Voluntary and Standalone</b></p> <ul style="list-style-type: none"> <li>Employees may select coverage for eligible dependents under the Dental plan, even if they elected single coverage on the Medical plan or vice versa.</li> <li>Coverage can be denied based on inadequate participation.</li> </ul>	<p><b>Non-contributory plans</b></p> <ul style="list-style-type: none"> <li>100% participation is required.</li> </ul> <p><b>Contributory plans</b></p> <ul style="list-style-type: none"> <li>2-9 eligibles - 100% participation</li> <li>10-50 eligibles - 75% participation</li> </ul> <p><b>ALL</b></p> <ul style="list-style-type: none"> <li>COBRA and State Continuees are not eligible.</li> <li>Retirees are not eligible.</li> <li>Employees may elect Life insurance even if they do not elect Medical coverage, and the group must meet the required participation percentage. If not, then Life will be declined for the group. Example: 9 employees 3 waiving medical 9 must enroll for life</li> <li>Coverage can be denied based on inadequate participation.</li> </ul>
<b>Plan Change Group Level</b>	<ul style="list-style-type: none"> <li>Plan anniversary date only.</li> </ul>	<ul style="list-style-type: none"> <li>Dental plans must be requested 5 days prior to the desired effective date.</li> <li>The future renewal date of the change will be the same as the Medical plan anniversary date.</li> </ul>	<ul style="list-style-type: none"> <li>Packaged Life/Disability must be requested 30 days prior to the desired effective date.</li> <li>Non-packaged plans are only available on the plan anniversary date.</li> </ul>
<b>Plan Change Employee Level</b>	<ul style="list-style-type: none"> <li>Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified Special Enrollment events).</li> </ul>	<ul style="list-style-type: none"> <li>May change from voluntary to standard and vice versa at anytime.</li> </ul>	<ul style="list-style-type: none"> <li>Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified Special Enrollment events).</li> </ul>

## PRODUCT SPECIFICATIONS

	Medical	Dental	Basic Life/AD&D, Disability, Packaged Life and Disability																																																										
<b>Standard Industrial Classification Code (SIC)</b>	<ul style="list-style-type: none"> <li>▪ All industries are eligible.</li> <li>▪ The employer should provide the SIC code (four-digit number) or NAIC state code six-digit code) filed with the state on the business tax return and/or the Workers' Compensation form.</li> </ul>	<ul style="list-style-type: none"> <li>▪ All industries are eligible if sold with Medical.</li> <li>▪ The following industries are not eligible when Dental is sold standalone or packaged only with Life.                             <table border="1" style="margin-left: 20px; width: 80%; border-collapse: collapse;"> <tr><td style="padding: 2px;">7933</td><td style="padding: 2px;">Bowling Centers</td></tr> <tr><td style="padding: 2px;">8611</td><td style="padding: 2px;">Business Associations</td></tr> <tr><td style="padding: 2px;">7911</td><td style="padding: 2px;">Dance Studios, Schools</td></tr> <tr><td style="padding: 2px;">7361-7363</td><td style="padding: 2px;">Employment Agencies</td></tr> <tr><td style="padding: 2px;">7999</td><td style="padding: 2px;">Misc Amusement and Recreation</td></tr> <tr><td style="padding: 2px;">8699</td><td style="padding: 2px;">Misc Membership Organizations</td></tr> <tr><td style="padding: 2px;">8999</td><td style="padding: 2px;">Misc Services</td></tr> <tr><td style="padding: 2px;">7991</td><td style="padding: 2px;">Physical Fitness Facilities</td></tr> <tr><td style="padding: 2px;">8811</td><td style="padding: 2px;">Private Households</td></tr> <tr><td style="padding: 2px;">7941-7948</td><td style="padding: 2px;">Professional Sports Clubs &amp; 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## DENTAL ONLY

<b>Coverage Waiting Period</b>	<ul style="list-style-type: none"> <li>▪ For Major and Orthodontic Services, employees must be an enrolled member of the employer's plan for 1 year before becoming eligible.</li> <li>▪ There is no waiting period for DMO.</li> <li>▪ Discount plans do not qualify as previous coverage.</li> <li>▪ Virgin group (no prior coverage) - The waiting periods apply to employees at case inception as well as to any future hires.</li> <li>▪ Takeover/Replacement cases (prior coverage) - You must provide a copy of the last billing statement and schedule of benefits in order to provide credit. If a group's prior coverage did not lapse more than 90 days prior, the waiting periods are waived. In order for the waiting period to be waived, the group must have had a Dental plan in place that covered Major (and Ortho, if applicable) immediately preceding our takeover of the business. Example: Prior Major coverage but no Ortho coverage. Aetna plan has coverage for both Major and Ortho. The Waiting Period is waived for Major services but not for Ortho services.</li> </ul>
<b>Product Packaging</b>	<p><b>Voluntary</b></p> <ul style="list-style-type: none"> <li>▪ Dental Dual Option sales are not permitted. All Voluntary plans must be a single plan sold.</li> <li>▪ All Voluntary plans require a minimum of 3 to enroll.</li> <li>▪ Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll.</li> </ul> <p><b>Standard</b></p> <ul style="list-style-type: none"> <li>▪ DMO can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled.</li> <li>▪ PPO can be sold standalone or packaged with the DMO as a Dual Option with a minimum of 2 enrolled.</li> <li>▪ Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold.</li> <li>▪ Orthodontic coverage is available with 10 or more eligibles for dependent children only. A minimum of 5 employees must enroll.</li> </ul>
<b>Open Enrollment</b>	<ul style="list-style-type: none"> <li>▪ An employee or dependent can enroll at any time, but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible, unless a qualifying life event has occurred or the enrollee is less than age 5.</li> </ul>
<b>Option Sales</b>	<ul style="list-style-type: none"> <li>▪ Option sales alongside another dental carrier are not allowed.</li> <li>▪ All dental plans must be sold on a full replacement basis.</li> </ul>
<b>Reinstatement</b> (applies to Voluntary Plans only)	<ul style="list-style-type: none"> <li>▪ Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.</li> </ul>

# LIFE AND DISABILITY ONLY

<p><b>Job Classification</b> (Position) Schedules</p>	<ul style="list-style-type: none"> <li>Varying levels of coverage based on job classifications are available for groups with 10 or more lives.</li> <li>Up to 3 separate classes are allowed (with a minimum requirement of 3 employees in each class).</li> <li>Items such as probationary periods must be applied consistently within a class of employee.</li> <li>The benefit for the class with the richest benefit must not be greater than 5 times the benefit of the class with the lowest benefit, even if only 2 classes are offered. For example, a schedule may be structured as follows:</li> </ul> <table border="1" data-bbox="324 357 1494 504"> <thead> <tr> <th>Position/Job Class</th> <th>Basic Term Life Amount</th> <th>Disability</th> <th>Packaged Life &amp; Disability</th> </tr> </thead> <tbody> <tr> <td>Executives</td> <td>\$50,000</td> <td>Flat \$500</td> <td>High Option</td> </tr> <tr> <td>Managers, Supervisors</td> <td>\$20,000</td> <td>Flat \$300</td> <td>Medium Option</td> </tr> <tr> <td>All Other Employees</td> <td>\$10,000</td> <td>Flat \$200</td> <td>Low Option</td> </tr> </tbody> </table>	Position/Job Class	Basic Term Life Amount	Disability	Packaged Life & Disability	Executives	\$50,000	Flat \$500	High Option	Managers, Supervisors	\$20,000	Flat \$300	Medium Option	All Other Employees	\$10,000	Flat \$200	Low Option
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All Other Employees	\$10,000	Flat \$200	Low Option														
<p><b>Guaranteed Issue Coverage</b></p>	<ul style="list-style-type: none"> <li>Aetna provides certain amounts of Life insurance to all timely entrants without requiring an employee to answer any Medical questions. These insurance amounts are called "Guaranteed Issue."</li> <li>Employees wishing to obtain increased insurance amounts will be required to submit Evidence of Insurability, which means they must complete a Medical questionnaire and may be required to provide Medical records.</li> <li>On-time enrollees who do not meet the requirements of Evidence of Insurability will receive the Guaranteed Issue Life amount.</li> <li>Late enrollees must qualify for the entire amount and are not guaranteed any coverage.</li> </ul>																
<p><b>Actively-at-work</b></p>	<ul style="list-style-type: none"> <li>Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work one full day.</li> </ul>																
<p><b>Continuity of Coverage</b> (no loss/no gain)</p>	<ul style="list-style-type: none"> <li>The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers.</li> <li>If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.</li> </ul>																
<p><b>Evidence of Insurability</b> (EOI)</p>	<p>EOI is required when one or more of the following conditions exist:</p> <ol style="list-style-type: none"> <li>Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit.</li> <li>Coverage is not requested within 31 days of eligibility for contributory coverage.</li> <li>New coverage is requested during the anniversary period.</li> <li>Coverage is requested outside of the employer's anniversary period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).</li> <li>Reinstatement or restoration of coverage is requested.</li> <li>Requesting Life or Disability at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the Guaranteed Issue Limit. Example: Group has \$50,000 life with \$20,000 Guaranteed Issue Limit. Late enrollee enrolling for \$50,000 would not automatically get the \$20,000. Since the applicant is late, they must medically qualify for the entire \$50,000.</li> </ol>																

## LIMITATIONS AND EXCLUSIONS

### POS/HEALTH NETWORK OPTION PLANS

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

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

## PPO PLANS

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

- All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Dental care and X-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Hearing aids
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics
- Over-the-counter medications and supplies
- Reversal of sterilization

- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Treatment of those services for or related to treatment of obesity or for diet or weight control

## PPO PRE-EXISTING CONDITIONS EXCLUSION PROVISION

These plans impose a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable. A pre-existing conditions exclusion means that if the member has a medical condition before coming to the plan, the member might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis or treatment was recommended or received or for which the individual took prescribed drugs within 90 days prior to the enrollment date.

Generally, this period ends the day before coverage becomes effective. However, if the member was in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from the first day of coverage, or, if the member was in a waiting period, from the first day of the waiting period.

If the member had prior credible coverage within 90 days immediately before the date enrolled under the plan, then the pre-existing conditions exclusion in the plan, if any, will be waived.

If the member had no prior creditable coverage within the 90 days prior to the enrollment date (either because the member had no prior coverage or because there was more than a 90-day gap from the date the prior coverage terminated to the enrollment date), we will apply the plan's pre-existing conditions exclusion.

In order to reduce or possibly eliminate the exclusion period based on creditable coverage, the member should provide Aetna with a copy of any Certificates of Creditable Coverage. Please contact Aetna Member Services at **1-888-80-AETNA (1-888-802-3862)** for assistance in obtaining a Certificate of Creditable Coverage from the prior carrier or with any questions on the information noted above.

The pre-existing conditions exclusion does not apply to pregnancy nor to a child under the age of 19.

Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

## LIMITATIONS AND EXCLUSIONS

### DENTAL

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to the plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance.
- Experimental services, supplies or procedures.
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder.
- Replacement of lost, missing or stolen appliances and certain damaged appliances.
- Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved.

#### *Specific service limitations:*

- DMO plans: Oral exams (4 per year).
- PPO plans: Oral exams (2 routine and 2 problem-focused per year).
- All plans:
  - Bitewing X-rays (1 set per year)
  - Complete series X-rays (1 set every 3 years)
  - Cleanings (2 per year)
  - Fluoride (1 per year; children under 16)
  - Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)
  - Scaling and root planing (4 quadrants every 2 years)
  - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in the plan documents.

## AD&D ULTRA

This coverage is only for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- A bodily or mental infirmity
- A disease, ptomaine or bacterial infection\*
- Medical or surgical treatment\*
- Suicide or attempted suicide (while sane or insane)
- An intentionally self-inflicted injury
- A war or any act of war (declared or not declared)
- Voluntary inhalation of poisonous gases
- Commission of or attempt to commit a criminal act
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician, and an accident in which your blood level as operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release
- Air or space travel; this does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo)

## DISABILITY

No benefits are payable if the disability:

- Is due to intentionally self-inflicted injury (while sane or insane)
- Results from your committing or attempting to commit, a criminal act.
- Is due to participation in an insurrection or rebellion
- Is due to war or any act of war (declared or not declared)
- Results from an automobile accident caused by you while you are intoxicated ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred)

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense, the person will not be deemed to be disabled and no benefits will be payable.

No benefit is payable for any disability that occurs during the first 12 months of coverage and is due to a pre-existing condition for which the member was diagnosed, treated or received services, treatment, drugs or medicines three (3) months prior to coverage effective date.

\*These do not apply if the loss is caused by an infection that results directly from the injury or surgery needed because of the injury. The injury must not be one that is excluded by the terms of the contract.





# AETNA AVE

*Aetna Avenue® — Your Destination for Small Business Solutions®*

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

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/Dental benefits, health/dental insurance, life and disability insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Investment services are independently offered through HealthEquity, Inc. Discount programs provide access to discounted prices and are NOT insured benefits. **The member is responsible for the full cost of the discounted services.** Aetna HealthFund HRAs are subject to employer-defined use and forfeiture rules, and are unfunded liabilities of your employer. Fund balances are not vested benefits. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health, dental and disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).



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