2006 Underwriting Guidelines

Health, Dental, Vision, Pharmacy, Life and Disability

California

FOR BUSINESSES WITH
2 TO 50 ELIGIBLE EMPLOYEES
PLANS EFFECTIVE APRIL 1, 2006

A broker guide to Small Business Solutions

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We want you to know™

Aetna®

Underwriting Guidelines (Effective 4-1-06)

This list is meant to be informative 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 Regional Underwriting Director, except where Head Underwriter approval is indicated.

ALL PRODUCTS (EXCEPT THE AETNA INDIVIDUAL MEDICARE SUPPLEMENT PLAN AND AETNA GOLDEN MEDICARE PLAN)	
Census Data	Census data must be provided on eligible (and COBRA/CAL-COBRA eligible) employees and must include the following details: ■ Name ■ Age or date of birth ■ Gender ■ Dependent status ■ Residence zip code ■ Enrollment by product
Employee Eligibility	"Eligible employee" means either of the following: ■ Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of at least 30 hours, in the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply: > The employee otherwise meets the definition of an eligible employee except for the number of hours worked. > The employer offers the employee health coverage under a health benefit plan. > All similarly situated individuals are offered coverage under the health benefit plan. > The employee must have worked at least 20 hours per normal work week for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings. COBRA/CAL-COBRA ■ COBRA/CAL-COBRA eligible enrollees are required to be included on the census. ■ Health questions must be answered. ■ COBRA/CAL-COBRA qualifying reason, length, start and end date must be provided.
Dependent Eligibility	■ Eligible dependents include an employee's spouse/domestic partner and unmarried children up to the limiting age of the plan. The limiting age for Medical and Dental is to age 19 standard, to age 24 for full-time students. For Life, eligible dependents are covered from live birth to age 21 as standard, to age 23 for full-time students. ■ If both husband and wife work for the same company, they may enroll together on one single application. ■ Dependents must enroll in the same Medical and Dental benefits as the employee. ■ Dependents are not eligible for AD&D coverage.

Small Employer

"Small employer" means either of the following:

- Any person, proprietary or nonprofit firm, corporation, partnership, public agency or association that is actively engaged in business or service, that, on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, whichever is more favorable for eligibility, employed at least 2 but no more than 50 eligible employees, the majority of whom were employed within the state, that was not formed primarily for the purposes of buying health insurance and in which a bona-fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. For the purposes of determining eligibility the size of a small employer shall be determined annually.
- Any guaranteed association that purchases health coverage for members of the association.

Employer Eligibility

- All Aetna plans can be offered to sole proprietorships, partnerships or corporations.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Nonguaranteed Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms, closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible for Small Group coverage.
- Dental has ineligible industries that are listed on page 35. The Dental list does not apply when Dental is sold in combination with Medical.
- When a company is Doing Business As (DBA), a copy of the certificate of fictitious name should be provided.
- Must submit a copy of the most recent DE-6 Quarterly Wage and Tax Statement (Unemployment Compensation Tax Form), which must contain the names, salaries, etc., of all employees of the employer group.
  - > Employees who have terminated or work part time should be noted accordingly on the DE-6.
  - > For any employee who is not listed on the DE-6 because he/she is a sole proprietor, partner or corporate officer, the Aetna Proof of Eligibility Form is required to verify his/her eligibility. This employee must be identified in the required documents below:

    Sole Proprietor
    Latest filed Schedule C (IRS Form 1040 C, 1040F, 1040 SE or 1040 ES (estimated tax). State Business License or Fictitious Business name Filing is acceptable if group has not yet filed a Schedule C)

    Partner
    Latest filed Schedule K-1 (IRS Form 1065 K-1), 1040SE, 1040 ES (estimated tax). Partnership Agreement is acceptable if group has not been in business long enough to have filed a Schedule K-1

    Corporate Officer
    IRS Forms 1120, 1120 A or 1120 W (C-Corp & Personal Service Corp)
    IRS Form 1120 S Schedule K-1 or 1040 ES (estimated tax) (S-Corp)
    IRS Form 8832 (Entity Classification; for LLC's treated as a corporation)
    If the group is incorporated in a different state submit a copy of the Certificate of Qualification

    Limited Liability Company (LLC) Member
    Articles of Organization along with the Operating Agreement
  - > Employees not listed on the DE-6 and are not Sole Proprietors, Partners or Corporate Officers must provide a copy of a latest payroll stub (which documents hours worked and wages earned) or if not yet available a letter from the employer verifying hours worked and wages earned.
- Other documentation may be requested by Underwriting upon receipt and review of sold case documents for final underwriting approval and installation.
- Altered legal documentation will not be accepted.

Newly Formed Business

Employers must provide the following documentation for consideration:

- At least two weeks worth of payroll (which includes hours worked and wages earned) or a letter from an attorney or certified public accountant (CPA) listing the names of all employees and number of hours worked each week.
- The following documents are also required:

  If Sole Proprietor: State Business License or Fictitious Business Name Filing

  If Partnership or Limited Liability Partnership: Partnership Agreement

  If Limited Liability Corporation: Articles of Organization

  If Corporation: Articles of Incorporation (must be followed with a copy of the Statement of Information within 30 days of filing with the state)

Effective Date	The effective date must be the 1st or the 15th day of the month.
Group Submission Deadline	In order for Aetna to honor the requested effective date, all completed paperwork must be received by Aetna Small Group Underwriting no later than the 5th business day after the requested effective date.
Signature Dates	Aetna group application and all employee enrollment applications must be signed and dated prior to and within sixty days of the requested effective date, and must include spousal/domestic partner signatures if enrolling. All employee applications must be completed by the employee himself/herself.
Initial Premium Check	■ The initial premium check is not binding. Final premium amount due may vary after Underwriting review. ■ If the request for coverage is denied due to business ineligibility, participation and/or contribution requirements not being met, the original check will be returned or a refund check will be sent. ■ The initial premium check should be in the amount of the first month's premium and drawn on a company check made payable to Aetna. ■ Separate check(s) needs to be submitted for all Cal-Cobra enrollees made payable to Aetna. This premium check may come from either the employer or the Cal-COBRA enrollee.
Affiliated, Associated or Multiple Companies May Be Written as One Group if:	■ One Owner has controlling interest of all businesses to be included or ■ The Owner files or is eligible to file an Affiliation Schedule, Form 851, a combined tax return for all companies to be included ■ If they have completed the Common Ownership Form
Replacing Other Group Coverage	■ A copy of the most recent prior carrier bill must be provided. ■ The employer should not cancel any existing coverage until they have been notified in writing of final approval from the Aetna New Business Underwriting unit.
Mid-Policy Benefit Changes*	■ New groups may request a change of benefits after 6 months on their existing plan. ■ Upgrades are only allowed once in a twelve-month rolling period and are subject to Underwriting approval. ■ The request for changes must be submitted to Aetna Small Group Underwriting thirty days prior to the requested effective date. Late requests will be moved to the next applicable effective date pending underwriting approval.
Renewal Benefit Changes	Request for changes on renewal must be submitted prior to the renewal date. Requests for changes made after the renewal date will be moved to the next applicable effective date pending underwriting approval.
Benefit Waiting Periods	■ Benefit waiting periods must be consistently applied for all employees, including newly hired key employees. ■ At initial Underwriting, the benefit waiting period may be waived upon the employer's request. ■ Employer may select a benefit waiting period of: first day of the billing cycle following 0, 30, 60, 90, 120, 150 or 180 days. ■ A change to the benefit waiting period may be requested after six months from the original effective date and may only be requested once in a 12-month rolling period. No retroactive changes will be allowed. ■ Refer to Dental only section on page 35 for Dental Coverage Waiting Period guidelines.
Ancillary Plan Additions	■ Can be requested up to the renewal date for changes to take effect on the renewal date. ■ Must be requested 30 days prior to the desired effective date, for changes requested off of the renewal date. ■ Future renewal dates of the ancillary products will be the same as the Medical plan renewal date.
Rate Guarantee	Rates are guaranteed for one year, except for Life Insurance, which is two years.

*During the first 30 days of coverage, the small employer shall have the option of changing coverage to a different benefit plan design offered by the same carrier. If a small employer notifies the carrier of the change within the first 15 days of a month, coverage under the new benefit plan design shall become effective no later than the first day of the following month. If a small employer notifies the carrier of the change after the 15th day of a month, coverage under the new benefit plan design shall become effective no later than the first day of the second month following notification.

SPECIFIC TO PRODUCTS

	Medical	Dental	Basic Term Life and Packaged Life & Disability
Late Applicants	■ An employee or dependent who enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee. ■ Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as follows:		
	■ Late applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll.	■ An employee or dependent may enroll at any time; however, coverage is limited to Preventive & Diagnostic Services for the first 12 months. No coverage for most Basic and Major Services for the first 12 months (24 months for Orthodontics) ■ Late Entrant provision does not apply to enrollees less than age 5.	■ Late applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and must wait for the group's next renewal date to enroll.
Employer Contributions	■ The employer must contribute at least 50% of employee rate.	■ The employer must contribute at least 50% of the employee-only cost or 25% of the total cost of the plan. ■ Coverage can be denied based on inadequate contributions.	■ Groups with less than 10 eligible lives: The employer must contribute 100% of the cost of the plan. ■ Groups with 10-50 eligible lives: The employer must contribute at least 50% of the cost of the plan (excluding Optional Dependent Life).
Pick-A-Plan	■ For Pick-A-Plan product bundling, employer must contribute 50% toward the employee rate of whichever plan the employee selects. ■ For Pick-A-Plan product bundling, the employer may choose to offer a Defined Contribution of at least $80 or the actual cost of the plans picked, whichever is less.	■ Not applicable	■ Not applicable

SPECIFIC TO PRODUCTS

	Medical	Dental	Basic Term Life and Packaged Life & Disability
Participation Medical Note: If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement.	■ **For noncontributory plans, 100% participation is required.** All employees, excluding those with coverage through another employer's plan, must enroll. ■ **Groups with 2-3 eligible employees:** 100% of eligible, excluding those with coverage through another employer's plan, must participate. ■ **Groups with 4-50 eligible employees:** 75% of eligible (rounded), excluding those with coverage through another employer's plan, must participate. Employees waiving due to individual, governmental (Medicare, Champus, Medi-Cal) or spousal coverage may be required to provide proof of their other coverage by providing a copy of their insurance card if the group does not appear to be meeting our standard participation guidelines (75%). All employees waiving coverage must complete the Section B and the waiver section of the application.	■ **Groups with 2-3 eligible employees:** 100% participation is required, excluding those with other qualifying existing Dental coverage. ■ **Groups with 4-50 eligible employees:** 75% participation is required, excluding those with other qualifying existing Dental coverage. A minimum of 50% of total eligible employees must enroll in the Dental plan. ■ 100% participation is required for noncontributory plans. All employees, excluding those with other qualifying existing Dental coverage, must enroll. ■ Employees may select coverage for eligible dependents under the Dental plan, even if they selected single coverage on the Medical plan or vice-versa.	■ **Groups with less than 10 eligible lives:** 100% participation is required. ■ **Groups with 10-50 eligible lives:** 75% participation is required if the plans are at least partially contributory. For noncontributory plans, 100% participation is required.
Option Sales Alongside Other Carriers	Standard participation of 75% must be met in order for a group to qualify for coverage.	Option sales alongside another Dental carrier are not allowed. All Dental plans must be sold on a full-replacement basis.	■ Option sales alongside another Life/AD&D/Packaged Life & Disability carrier are not allowed. ■ All Life/AD&D/Packaged Life & Disability plans must be sold on a full-replacement basis.
Product Availability	**Pick-A-Plan** ■ Pick-A-Plan is a special product bundling feature that allows the employees to choose their Medical product from a wide selection of product offerings selected by the employer. ■ Employer must select products to offer to all employees on the Employer Application. Products not selected on the Employer Application will not be available to enrolling employees (neither existing nor future employees). ■ Requests to add more products to the group's Pick-A-Plan offerings are subject to underwriting approval. ■ Only available to groups enrolling at least four eligible employees. (For groups enrolling less than 4 eligible employees only one plan may be selected.) **Aetna Value Network** ■ May not be sold alongside the Standard Small Group HMO products	■ For groups of 2 or less than 3 eligible employees, Dental must be sold with Medical and cannot be sold on a standalone basis. Dental may be installed on an unbundled basis with the Medical offering (i.e., an eligible employee may enroll in Dental and not Medical and vice-versa), but Medical and Dental must be offered to all employees. ■ For groups of 3 or more eligible, Dental may be sold on a standalone basis or along with Medical on a bundled or unbundled basis. ■ Orthodontic coverage is available to groups with 10 or more eligible employees. Orthodontic coverage on all plans is for both adults and dependent children.	■ For groups of 2-9 eligible employees, Life/Packaged Life & Disability must be sold with Medical and cannot be sold on a standalone basis. ■ For groups of 10-25 eligibles, Life/Packaged Life & Disability may be sold packaged with either Medical or Dental. ■ For groups with 26 or more eligibles, Life/Packaged Life & Disability plans are available either packaged with Medical or Dental or on a standalone basis. ■ The above are all group-level requirements, meaning that employees will be able to individually elect Life/Packaged Life & Disability coverage even if they do not elect Medical coverage. For groups with less than 10 eligible employees, certain plan differences apply.

	Medical	Dental	Basic Term Life and Packaged Life & Disability
Product Availability (continued)	**Aetna Value Network (cont.)** ■ Can be sold as part of the Pick-A-Plan alongside PPO, MC and EPO plans **Carve Outs** ■ California Branch Location, Management/Non-Management, Salary/Hourly and Union vs. Non-Union are the general types of carve outs that could be considered by Aetna. ■ Aetna must enroll and maintain a minimum of 10 eligible employees who reside within Aetna's California Network Service Area unless standard participation is met. ■ All requests to Carve Out a specific class of employees for coverage are subject to Underwriting approval and could be declined, unless standard participation requirement is met. ■ Employer must provide all employee class definitions in writing on company letterhead prior to final approval. **Out-of-Area within California (Employees residing out of any Aetna network service area within California)** ■ Must enroll in the Aetna Indemnity plan. ■ Aetna Indemnity plan is only available if the employee resides outside of both the Aetna PPO network service areas and the Aetna HMO network service areas. **Out-of-State (Employees residing outside of California)** ■ Must enroll in an out-of-state PPO plan if PPO network and product is available where the out-of-state employee resides, otherwise Indemnity is only product available. ■ Out-of-state employees can be offered only one of the specific Out-of-State Medical Plans. **Indemnity Only States** ■ No PPO is available in the following states: AL, ID, MN, MT, ND, NM, RI, UT, WI, WY. ■ No Indemnity or PPO available in HI or VT.	**Out-of-Area within California (Employees residing out of any Aetna network service area within California)** ■ Employees who still reside within California but outside of a DMO service area may be offered an In-State PPO plan. **Out-of-State (Employees residing outside of California)** ■ Out-of-state employees may only be offered one of the specific Out-of-State Dental plans; 3 PPO and 3 Indemnity plan designs. ■ Maximum out-of-state employee percentage (and/or number of employees) will agree with the Medical guidelines for each state. ■ Orthodontic coverage is included for groups with 10 eligible employees. Out-of-State plans offer orthodontic coverage to dependent children only. **Indemnity-Only States** ■ No PPO is available in the following states: AR, AK, HI, ID, ME, MT, ND, NH, NM, SD, WY.	■ Life and AD&D is a bundled product and must be sold together. ■ Carve outs are not allowed. ■ Dual options are not allowed. **Out-of-State (Employees residing outside of California)** ■ Out-of-state employees are eligible for the Basic Term Life or Packaged Life & Disability Plan, depending on the option selected by the home office.

SPECIFIC TO ONE PRODUCT ONLY

Medical Only

- A California small employer subject to Guaranteed Issue cannot be declined based on medical conditions or claims experience; however, rates may be adjusted for known medical conditions (.90 RAF to 1.10 RAF).
- All eligible employees and COBRA/CAL-COBRA enrollees applying for Medical coverage are required to complete the individual health questionnaire section of the Employee Enrollment/Change Form. Failure to do so may result in a maximum 1.10 RAF determination.
- Groups enrolling 2-4 employees will receive an automatic RAF of 1.10.
- Groups enrolling 5-50 employees may qualify for a RAF of .90.
- Please check with your Aetna Sales Manager for information on Aetna's latest RAF promotion.

Dental Only

Open enrollments are prohibited.

Coverage Waiting Period

- For Major and Orthodontic services, employees must be enrolled members of the plan for one year (not applicable to DMO). Waiting Period is waived separately for Major and Ortho for employees who were covered by the group's immediately preceding dental plan. To waive Waiting Period for Orthodontic services, the group's immediately preceding group plan must have covered Orthodontic services. To waive Waiting Period for Major services, the group's immediately preceding group plan must have covered Major services.

  Example: Prior Major coverage but no Ortho coverage. New plan has both Major and Ortho coverage. The Waiting Period is waived for Major services but not for Ortho services.

Product Packaging

- DMO can be either sold standalone or packaged with any PPO Option as a Dual Option.
- PPO can be sold standalone or packaged with the DMO as a Dual Option.
- Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold.

Ineligible Industries

Applies when Dental is sold standalone or packaged only with Group insurance. This list does not apply if sold in combination with Medical.

SIC Range	SIC Description	SIC Range	SIC Description
0761-0783	Seasonal Employees	7631	Watch, Clock & Jewelry Repair
3911-3915	Jewelry Manufacturing	7692-7699	Miscellaneous Repair
4111-4121	Passenger Trans.	7800-7999	Amusement, Rec. & Enter.
5271	Mobile Home Dealers	8000-8059	Medical Groups
5511-5599	Auto Dealerships	8071-8099	Medical Groups
5800-5899	Restaurants	8100-8199	Legal
6500-6799	Real Estate	8211-8299	Schools, Libraries, Education
7000-7099	Hotels	8300-8399	Social Service
7221	Photo Studios	8400-8499	Museums, Art Galleries, Botanical Gardens
7231-7241	Beauty & Barber Shops		
7251-7299	Repairs, Cleaning, Personal Services	8600-8699	Associations & Trusts
7319	Advertising, Misc.	8700-8799	Engineering & Management Services
7331-7338	Direct Mailing, Secretarial Services		
7361-7363	Employment Agencies	8800-8899	Service - Private Households
7379	Miscellaneous Computer Services	8999	Miscellaneous Services
7381-7382	Security Systems, Armored Cars	9721	International Affairs
7384	Photofinishing Labs		
7389	Miscellaneous Business Services		

Basic Term Life and Packaged Life & Disability Only

Job Classification (Position) Schedules

Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up to three separate classes are allowed (with a minimum requirement of 3 employees in each class). Items such as probationary periods must be applied consistently within a class of employee. The benefit for the class with the richest benefit must not be greater than five times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows:

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

Guaranteed Issue Coverage

Aetna provides certain amounts of life insurance without requiring an employee to answer any medical questions. These insurance amounts are called "Guaranteed Issue." 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 submit to a medical exam. Depending on a customer's size, life insurance amounts are Guaranteed Issue up to the maximums listed below:

Case Size	Basic Term Life Amount
2-9 Eligible Lives	$20,000
10-25 Eligible Lives	$75,000
26-50 Eligible Lives	$100,000

Evidence of Insurability (EOI)

EOI is required when one or more of the following conditions exist:

1) Life insurance coverage amounts requested are above the Guaranteed Standard Issue Limit.
2) New coverage is requested during the renewal period.
3) Coverage is requested outside of the employer's renewal period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.)

Actively at Work

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.

Continuity of Coverage

(No Loss/No Gain)

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. 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.

Ineligible Industries

Life/AD&D—All industries are eligible

Packaged Life/Disability—The following industries are not eligible:

SIC Range	SIC Description	SIC Range	SIC Description
1000-1499	Mining	7381	Service – Detective
2892-2899	Explosives, Bombs & Pyrotechnics	7500-7599	Auto Repair & Service
3291-3292	Asbestos Products	7800-7999	Motion Picture, Amusement/ Recreation
3310-3329	Primary Metal Industries		
3480-3489	Fire Arms/Ammunition	8010-8043	Medical Doctors/Clinics
5921	Liquor Stores	8600-8699	Membership Assoc
6211	Security Brokers	8800-8899	Service – Private Household
6531	Real Estate – Agents	9999	Nonclassified Estab

SMALL GROUP BENEFIT CHANGES REQUIRMENTS — CALIFORNIA

Benefit Changes	When Eligible	Request Must Be Received	Required Documentation
UPGRADE MEDICAL BENEFITS**** (To include adding Medical Plans to existing Medical Plans)	**New Business** During the initial plan year a group may only change plans 6 months post sale/6 months prior to the renewal date.** **Example:** A group with a 12-1 effective date can only upgrade benefits 6-1 **Existing Business** Upgrades are allowed once*** in a twelve month rolling period, limited to the 6 month period following the renewal date. **Example:** A 1-1 renewal may request a plan change through 6-1.	**On Renewal** - request must be submitted prior to the effective date of the renewal **Off Renewal** - request must be submitted thirty days prior to the requested effective date	1. A letter from the group requesting the change 2. A new employer application 3. New employee enrollment forms with appropriate medical questionnaires* completed for employees requesting to change to the new plan 4. A copy of the most recent filed DE-6 5. A Joinder Agreement when appropriate
DOWNGRADE MEDICAL BENEFITS	**New Business** During the initial plan year a group may only change plans 6 months post sale/6 months prior to the renewal date.** **Example:** A group with a 12-1 effective date can only downgrade benefits 6-1 **Existing Business** Downgrades are allowed twice*** in a twelve month rolling period, limited to the 6 month period following the renewal date. **Example:** A 1-1 renewal may request a plan change through 6-1.	**On Renewal** - request must be submitted prior to the effective date of the renewal **Off Renewal** - request must be submitted thirty days prior to the requested effective date	1. A letter from the group requesting the change 2. A new employer application 3. New employee enrollment forms for employees requesting to change to the new plan 4. A Joinder Agreement when appropriate
ADD DENTAL TO EXISTING MEDICAL PLANS (refer to Dental Guidelines)	Anytime	**On Renewal** - request must be submitted prior to the effective date of the renewal **Off Renewal** - request must be submitted thirty days prior to the requested effective date	1. A letter from the group requesting the change 2. A new employer application 3. New employee enrollment forms for all employees enrolling in or declining the dental benefits.
ADD LIFE TO EXISTING MEDICAL PLANS (refer to Life Underwriting Guidelines)	Anytime	**On Renewal** - request must be submitted prior to the effective date of the renewal **Off Renewal** - request must be submitted thirty days prior to the requested effective date	1. A letter from the group requesting the change 2. A new employer application 3. New employee enrollment forms for all employees enrolling in or declining the life benefits.
ADD PART-TIME COVERAGE	Renewal date only	Request must be submitted prior to the effective date of the renewal	1. A letter from the group requesting the change 2. A new employer application 3. New employee enrollment forms for all eligible part-time employees who are enrolling or declining the coverage 4. A copy of the most recent filed DE-6

CHANGES TO THE RENEWAL DATE ARE NOT ALLOWED

* Groups with 2-10 eligible employees enrolling must complete the long health questionnaire
Groups with 11-50 eligible employees enrolling may complete the short health questionnaire
** California law requires six month rate guarantees
*** Renewal plan changes are counted towards the maximum number of allowable changes
**** Buy Ups are subject to Medical Underwriting and may be declined

Existing California Groups Buy Up/Buy Down Guide
Effective 4/1/06

PLAN DESIGN NAME	HMO $10/$20	HMO $10/$30	HMO $20/$40	HMO $30/$40	EPO 80	EPO 90	MC $250 90/70	MC $0 90/60	MC $250 80/60	MC $500 80/60	MC $500 80/50	MC $1000 80/50	MC $2000 80/50	MC Basic	PPO $500 90/70	MC HDHP $2100 80/50	MC HDHP $3000 80/50	INDEM	AVN $10/$20	AVN $15/$30	AVN $25/$40
PLAN ID																					
HMO 10/10	D	D	D	D	D	D	U	U	U	D	D	D	D	D	U	D	D		D	D	D
HMO 15/15	U	D	D	D	D	D	U	U	U	U	D	D	D	D	U	D	D		D	D	D
HMO 10/30	U		D	D	D	D	U	U	U	U	D	D	D	D	U	D	D		D	D	D
HMO 20/40	U	U		D	D	U	U	U	U	U	D	D	D	D	U	D	D		U	D	D
HMO 30/40	U	U	U		D	U	U	U	U	U	U	D	D	D	U	D	D		U	D	D
EPO	U	U	D	D	D	U	U	U	U	U	D	D	D	D	U	D	D		D	D	D
MC $0 90/70	U	D	D	D	D	D		D	D	D	D	D	D	D	U	D	D		D	D	D
MC $0 90/60	U	D	D	D	D	D	U		D	D	D	D	D	D	U	D	D		D	D	D
MC $250 80/60	U	D	D	D	U	U	U	U		D	D	D	D	D	U	D	D		D	D	D
MC $500 80/60	U	D	D	D	U	U	U	U	U		D	D	D	D	U	D	D		D	D	D
MC $500 70/50	U	U	D	D	U	U	U	U	U	U		D	U	D	U	D	D		U	D	D
MC $1000 80/50	U	U	U	U	U	U	U	U	U	U	U		D	D	U	D	D		U	U	U
MC $2000 80/50/50	U	U	U	U	U	U	U	U	U	U	U	U		D	U	D	D		U	U	U
HDHP $2100 100/50	U	U	U	U	U	U	U	U	U	U	U	U	U	D	U		D		U	U	U
HDHP $3000 90/50	U	U	U	U	U	U	U	U	U	U	U	U	U	D	U	U			U	U	U
HDHP $5000 100/50	U	U	U	U	U	U	U	U	U	U	U	U	U	D	U	U	U		U	U	U
MC BASIC	U	U	U	U	U	U	U	U	U	U	U	U	U		U	U	U		U	U	U
PPO $250 90/70	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	D	D		U	U	U
PPO $500 80/60	U	U	U	U	U	U	U	U	U	U	U	U	U	U		D	D		U	U	U
INDEMNITY	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N		N	N	N

D=BUY DOWN (NO MEDICAL UNDERWRITING REQUIRED)
U=BUY UP (MEDICAL UNDERWRITING REQUIRED AND MAY BE DECLINED)
N=NO ALTERNATES AVAILABLE

Eligibility Guidelines for the Aetna Golden Medicare Plan® (Effective 1/1/06)

Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules and Eligibility Rules (for Aetna's Medicare Advantage Plans).

ELIGIBLE CASES	
Participation	▪ 2-19 Eligible Employees: a minimum of two Medicare-eligible retirees, employees or dependents must enroll. ▪ 20-50 Eligible Employees: a minimum of two Medicare eligible retirees must enroll. Active employees are not eligible to enroll.
Employer Contributions	There are no employer contribution requirements.
Employer Eligibility	▪ Retiree medical plans can be offered to sole proprietorships, partnerships or corporations. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage. ▪ Taft Hartley, Professional Employers Organizations (PEO)/employee leasing firms and unions require underwriting approval. ▪ If the Medicare Group plan is offered to 2 or more enrollees, the Medicare plan can be offered on a standalone basis.
Member Eligibility	▪ Members and dependents are individually eligible if they are entitled to Medicare Part A and enrolled in Medicare Part B. Medicare eligible active employees are not eligible to enroll if the group has 20+ eligible employees. ▪ Eligible dependents include an employee's Medicare-eligible spouse and Medicare-eligible unmarried children. ▪ Members must be eligible for retiree coverage under the employer group. ▪ Members and dependents must reside in Aetna's approved Medicare service area (county based). ▪ If a member or dependent resides outside of Aetna's approved service area (county based) for more than six months, they will be disenrolled from the plan pursuant to federal regulations. ▪ No individual medical underwriting. ▪ No pre-existing condition limitations.
Option Sales	Aetna's Medicare product must be the sole Medicare Advantage carrier within covered service areas. (Exceptions permitted when union contracts stipulate different carrier/product).
Dual Product Option	Groups with 2 to 50 eligibles may offer only one Aetna Medicare product.
CASE SUBMISSION	
Verification of Employee/ Retiree Status	Groups may be asked to submit evidence of employment status for Medicare-eligible employees and retirees. Evidence may include Unemployment Tax Forms, Prior Carrier Bill, Notarized Letter from Company President verifying retiree name, position, employment dates.
Effective Dates/ Rate Change Dates	▪ A group can only be effective on the first day of the month. ▪ Due to the annual nature of the Centers for Medicare and Medicaid Services (CMS) payment increases, Aetna standard requires customer to renew on January 1.
Licensed, Registered Producers	▪ Only appropriately licensed Agents/Producers registered by Aetna may market, present, sell and be paid commission on the sale of Aetna Products. ▪ All quotes are subject to change based upon additional information that becomes available in the quoting process and during case submission/installation including any change in census.
Initial Premium Check	▪ An initial premium check equal to one month's plan premium must accompany the Medicare application. The initial check is not a binder check. ▪ Enrolled dependents are considered to be individual subscribers. All subscribers are rated with single tier coverage. ▪ If the request for coverage is denied due to business ineligibility, the initial plan premium check will be returned to the employer.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include Aetna Health of California Inc., Aetna Dental of California Inc. and/or Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of healthcare/dental services. However, Aetna itself is not a provider of healthcare/dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither employees nor agents of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations) and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Information supplied by Aetna InteliHealth® is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. While only your doctor can diagnose, prescribe or give medical advice, the Informed Health nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs. Alternative health care programs, Vision One® and the fitness program are rate-access programs and may be in addition to any plan benefits. Program providers are solely responsible for the products and services provided thereunder. Aetna does not endorse any vendor, product or service associated with these programs. Discounts offered hereunder are not insurance.

Health benefit and insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. If your plan covers outpatient prescription drugs, your plan may include a Preferred Drug List (formulary). A preferred drug list is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the Preferred Drug List. The medications listed on the Preferred Drug List are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the Preferred Drug List, and information about other pharmacy programs such as precertification and step therapy, please refer to Aetna's website at www.aetna.com, or the Preferred Drug List. Many drugs, including many of those listed on the Preferred Drug List are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, your costs may be higher for a "preferred drug" than they would be for a "nonpreferred drug." You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services.

Aetna Health Savings Accounts (HSA) are administered by Aetna Life Insurance Company. HSA fees, interest rates and investment options are subject to change without notice. Investment options are not insured by Aetna or the FDIC and may result in loss of principal. This document is not intended to provide tax or investment advice. Please consult your independent financial advisor before opening an HSA or making an investment selection.

While this material is believed to be accurate as of the print date, it is subject to change.

For more information about Aetna's Small Business Solutions, please contact your local Aetna Sales Manager or the Small Group Service Center from 8 a.m. to 5 p.m. (PST).

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