Aetna Avenue

SMALL GROUP UNDERWRITING GUIDELINES

This material is for informational purposes only. It 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.

CARVE OUTS/EXCLUDED CLASS

- Union employees, as a class, may be excluded by an employer as not being eligible for coverage.
- Management carve outs are not permitted.

CENSUS DATA

- Census data must be provided on all eligible (and COBRA/State Continuation eligible) employees and include name, age/date of birth, date of hire, gender, dependent status, employee work location zip code and residence zip code.
- Retirees are not eligible.

COBRA/STATE CONTINUATION ELIGIBILITY

- COBRA/State Continuation eligibles should be included and noted on the census.
- Family Health Statements must be provided on COBRA/State Continuation individuals along with the rest of the group.
- Date COBRA/State Continuation coverage began and the length of eligibility will be required at time of enrollment.
- Employers with 20 or more employees (full-time and part-time) are required to offer COBRA coverage.
- Employers with less than 20 employees (full-time and part-time) are required to offer State Continuation.

CASE SUBMISSION DATES

- Groups with 1 to 50 eligibles must have all completed paperwork into Aetna Underwriting 5 business days prior to the requested effective date. If not received by this date, the effective date will be moved to the next month. Specific health benefits plans are available for groups of one (1). Please contact your Aetna sales representative or Aetna Small Group Underwriting.
- Medicare Advantage sales must have all completed paperwork in to Aetna Underwriting 15 business days prior to the requested effective date. If completed paperwork is not received by this date, the effective date will be moved to the next month.

DUAL PRODUCT OPTION

- Minimum of 5 enrolled with 75% participation after spousal or Medicare waivers for all combinations of products.
- The plan selections are limited to any 2 currently marketed medical plans with the same prescription drug card.
- One person must enroll in each plan when a dual option is offered.

TRIPLE PRODUCT OPTION

- Minimum of 10 enrolled with 75% participation after spousal or Medicare waivers for all combinations of products.
- The plan selections are limited to any 3 currently marketed medical plans, 1 of which must be an HSA-compatible plan.
- One person must enroll in each plan when a triple option is offered.

EFFECTIVE DATE

- The effective date will be the 1st or the 15th of the month.
- The effective date requested by the employer may be up to 60 days in advance.
- Medicare Advantage may only be effective on the 1st of the month.
- When a Medicare Advantage plan and a commercial plan are sold to an employer, the effective dates must coincide (i.e., 1st of the month).

EMPLOYER ELIGIBILITY

- Medical plans can be offered to sole proprietorships, partnerships, corporations or self-employed individuals.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage.
- Submission of the most recent UC-5A and Employer Verification Form.
  - If there are employees who have the same last name, provide a W-2 for each employee and the UC-5A should include both individuals listed as separate employees.
  - Employees who have terminated or work part-time should be noted accordingly on the census.
  - Employees not listed on the UC-5A should have a W-4 or payroll stub sent in with the request for coverage.

Single employer groups with multiple employer tax ID numbers will be considered together as long as:

- One owner controls the majority of each separate business. For example:
  - Business 1 – John owns 75% and Mike owns 25%
  - Business 2 – John owns 55% and Mike owns 45%
  - Both businesses can be written as one group since John has controlling interest in both companies
- 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.
- A copy of current 1120 S (Schedule K-1 Form) must be provided unless owner is listed on prior carrier bill; and
- A copy of most recent Quarterly Wage and Tax Statement for all companies must be provided.
- If employee is a sole proprietor, partner or corporate officer, the Proof of Eligibility Form (see Producer World or contact Underwriting for this form) must be completed and submitted with the following:

Sole Proprietor

Must submit one of the following:
IRS Form 1040C or 1040F
IRS Form 1040SE

Submit all applicable:

Assumed Name Certificate
(Fictitious Business Names or DBA)
Filed Certificate of Organization
(Only required for LLC)

Partner

Must submit one of the following:
IRS Form 1065 (Schedule K-1)
IRS Form 1040SE

Submit all applicable:

State Filed Partnership Agreement
Assumed Name Certificate
(Fictitious Business Names or DBA)
Filed Certificate of Organization
(Only required for LLC)

Corporate Officer

Must submit one of the following:
IRS Form 1120, 1120A or 1120W
(C-Corp & Personal Service Corp)
IRS Form 1120S, K-1 or 1040 ES (S-Corp)

Submit all applicable:

Filed Certificate of Organization
(Only required for LLC)
Articles of Incorporation
(complete, including name of officers)
AND
Filed Certification of Qualification
(if incorporated in a different state)

EMPLOYER FINANCIAL CONDITIONS

- A current carrier bill with billing summary will be required; group must be no more than one month in arrears on payments (i.e., current month only may not yet be paid).
- Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until 12 months after the date of termination.

INITIAL PREMIUM CHECK

- The initial premium check is not a binder check and does not bind Aetna to provide coverage.
- If the request for coverage is denied due to business ineligibility, participation and/or contributions not met, or other permissible reasons, the check will be returned to the employer.
- An initial premium check equal to one-month premium must accompany application.
- Checks must be on company check stock (personal checks and cashier's checks are not acceptable).

FINAL RATES

Rating will be based on final enrollment.

NEWLY FORMED BUSINESS

- A company must have been in business for a minimum of 3 months to be eligible for coverage and must provide the following documentation for consideration:
  - Payroll records or letter from attorney or Certified Public Accountant listing the names of all employees and number of hours worked each week; and
  - Tax ID number.

PROBATIONARY PERIOD

- The employer decides whether or not to impose a probationary period.
- The probationary period must be consistently applied to all eligible employees.
- On-time entrant eligibility date will be the first day of the policy month (1st or 15th of the month) following the waiting period of 0, 30, 60, 90, 120, 150 or 180 days.
- Changes allowed on anniversary only.

PRODUCERS

Only appropriately licensed Agents/Producers appointed 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 the case submission/installation, including any change in census.

REPLACING OTHER GROUP COVERAGE

- A copy of the current billing statement that includes the account summary showing the plan is paid to the current premium due date.
- **The employer should be told not to cancel any existing medical coverage until they have been notified of approval.**

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/Packaged Life & Disability	Short Term Disability (STD)
Product Availability	▪ All plans are available for groups with 2 to 50 eligible employees. ▪ May be written standalone or with ancillary coverage as noted in the following columns. ▪ Sole Proprietor may only enroll in one of the following: – Connecticut Mandated CSEHRP HMO – Connecticut Mandated CSEHRP Traditional Choice	▪ 2 eligible employees – – Standard Dental available with Medical – Voluntary Dental – Not available ▪ 3 to 50 eligible employees – Standard and Voluntary Plans available with or without Medical. ▪ Orthodontic coverage is available to dependent children only for groups with 10 or more eligible employees with a minimum of five enrolled for both Standard and Voluntary plans.	▪ 2 to 9 eligible employees – available only if packaged with Medical. ▪ 10 to 25 eligible employees – Standard life available either packaged with Medical or Dental. ▪ 26 to 50 eligible employees – Standard life available either packaged with medical or dental or on a standalone basis. ▪ 10 to 50 eligible employees – Packaged Life & Disability available either packaged with Medical or Dental or on a standalone basis. ▪ Conversion options are not available.	▪ 2 to 9 eligible employees – available only if packaged with Medical. ▪ 10 to 25 eligible employees – available only if packaged with either Medical or Dental. ▪ 26 to 50 eligible employees – available only if packaged with Medical or Dental or on a standalone basis. ▪ Product packaging rule is a group level requirement. Employees will be able to individually elect STD even if they do not elect Medical coverage. ▪ Not available in New York, New Jersey, California, Rhode Island, Hawaii and Puerto Rico. ▪ Conversion options are not available. ▪ Must be written on a full or primary replacement basis.
Employer Contributions	▪ We strongly recommend in groups with less than 10 eligible lives, that the employer contribute 100% of the employee-only cost or 50% of the total cost of the plan. ▪ We strongly recommend in groups with 10 to 50 eligible lives, that the employer contribute at least 50% of employee-only cost or 50% of the total cost of the plan.	▪ For Standard plans, employers must contribute at least 25% of the total cost of the plan or 50% of the cost of employee only coverage. Coverage will be denied based on inadequate contributions. ▪ For Voluntary plans, employers must contribute less than 50% of the cost of employee-only coverage. Aetna allows zero percent contributory plans.	▪ 2 to 9 eligible employees – 100% of the total cost. ▪ 10 to 50 eligible employees – at least 50% of the total cost (excluding Optional Dependent Term).	▪ 2 to 9 eligible employees – 100% of the total cost. ▪ 10 to 50 eligible employees – at least 50% of the total cost.
Employee Eligibility	▪ Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 30 hours and who have met any authorized waiting period requirements. ▪ 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. ▪ Employees who do not meet the definition of a permanent full-time employee will not be eligible (e.g., leased, part-time, temporary, seasonal or substitute employees). ▪ Connecticut Small Group reform excludes union employees who are covered by a collective bargaining agreement.	▪ Eligible employees are those employees who are permanent and work on a full-time basis with a normal work week of at least 30 hours and who have met any authorized waiting period requirements. ▪ 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. ▪ Employees who do no meet the definition of a permanent full-time employee will not be eligible (e.g., leased, part-time, temporary, seasonal or substitute employees).	▪ Permanent full-time employees who work the minimum hours required for Medical coverage as mandated by the state are eligible for insurance on the effective date of the plan, provided they are actively at work on that date. ▪ New employees will be eligible after the completion of a period of continuous active service. ▪ 1099 contractors, stockholders, partners or other outside consultants who are not active, permanent full-time employees are not eligible. ▪ Coverage must be extended to all employees meeting the above conditions, unless they belong to a class excluded as the result of conditions pertaining to their employment (e.g., union status or job class). ▪ 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.	▪ Permanent full-time employees who work the minimum hours required for medical coverage as mandated by the state are eligible for insurance on the effective date of the plan, provided they are actively at work on that date. ▪ New employees will be eligible after the completion of a period of continuous active service. ▪ 1099 contractors, stockholders, partners or other outside consultants who are not active, permanent full-time employees are not eligible. Foreign nationals and expatriates are not eligible. ▪ Coverage must be extended to all employees meeting the above conditions, unless they belong to a class excluded as the result of conditions pertaining to their employment (e.g., union status or job class).

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/Packaged Life & Disability	Short Term Disability (STD)
Dependent Eligibility	▪ Eligible dependents include an employee's spouse, same sex civil union partners, domestic partners, and unmarried dependent children up to the limiting age of the plan (age 26). ▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. ▪ Dependents must enroll in same benefit options as the employee.	▪ Eligible dependents include an employee's spouse, same sex civil union partners, domestic partners, and unmarried dependent children up to the limiting age of the plan (ages 19 or 23 if full-time student). Student status will be verified. ▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. ▪ Dependents must enroll in same benefit options as the employee.	▪ Dependent children are covered from 14 days up to age 19, or up to 25 if in school (subject to state laws). ▪ Incapacitated children can be covered beyond the standard age limit. ▪ Eligible dependents include an employee's spouse and unmarried children up to the limiting age of the plan. ▪ Individuals cannot be covered as an employee and dependent under the same plan, nor may children eligible for coverage through both parents be covered by both under the same plan. ▪ Dependent Life Insurance is available as a separate plan design. ▪ Dependents are not eligible for AD&D Ultra®.	Available to employees only. Dependents are not eligible.
Late Applications/Entrant	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, adoption, 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 will be deferred to the next plan anniversary date of the group and must reapply for coverage 30 days prior to the group anniversary date.	▪ An employee or dependent that enrolls other than within 31 days of first becoming eligible is subject to the Late Entrant provision. ▪ Coverage limited to Preventive & Diagnostic services for first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).	An employee or dependent that enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee and may only enroll for coverage 30 days prior to the next plan anniversary date. The applicant will be required to complete an individual health statement/ questionnaire and provide Evidence of Insurability (EOI).	An employee or dependent that enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee and may only enroll for coverage 30 days prior to the next plan anniversary date. The applicant will be required to complete an individual health statement/ questionnaire and provide Evidence of Insurability (EOI).
Option Sales	▪ All medical plans must be offered on a full-replacement basis. ▪ No other employer sponsored medical plan.	▪ All dental plans must be offered on a full-replacement basis. ▪ No other employer sponsored dental plan.	Must be written on a full or primary replacement basis.	Must be written on a full or primary replacement basis.
Medical Underwriting	Not Applicable.	Not Applicable.	▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested. ▪ Employees wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit Evidence of Insurability (EOI), which means they must complete an individual health statement and may have to submit medical evidence.	▪ All timely entrants will be issued the Guaranteed Issue amount unless reinstatement or restoration of coverage is requested and/or they are late entrants.

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/Packaged Life & Disability	Short Term Disability (STD)
Participation	▪ For non-contributory plans, 100% participation is required, excluding all valid waivers.* ▪ For contributory plans: – Groups with 1 to 50 eligible employees — 75% participation excluding valid waivers* must enroll in Aetna's plan.	▪ For non-contributory plans, 100% participation is required, excluding those with other qualifying Dental coverage. ▪ Standard Dental – 2 to 3 eligibles 100% participation is required, excluding those with other qualifying existing Dental coverage. – 4 to 50 eligibles 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. ▪ Voluntary Dental – 3 to 50 eligibles 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. ▪ Standalone Dental – 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. Employees may select coverage for eligible dependents under the Dental plan even if they elected single coverage on the Medical plan or vice versa. Coverage can be denied based on inadequate participation.	▪ For non-contributory plans, 100% participation is required. ▪ Employees may elect Life or Packaged Life/Disability insurance even if they do not elect Medical coverage, and the group must meet the required participation percentage. If not, then Life or Packaged Life/Disability will be declined for the group. Example: 9 employees, 3 waiving Medical. All 9 must enroll for Life or Packaged Life/Disability. ▪ 2 to 9 eligibles 100% participation is required. ▪ 10 to 50 eligibles 75% participation is required. ▪ COBRA continuees are not eligible for Life. ▪ Coverage can be denied based on inadequate participation.	For contributory plans: ▪ 2 to 9 employees 100% participation is required. ▪ 10 to 50 employees 75% participation is required. For non-contributory plans: ▪ 100% participation is required. ▪ COBRA continuees are not eligible for Disability.
Retiree Coverage	Retiree coverage is not available for Medical coverage.	Retiree coverage is not available for Dental coverage.	Retirees are not eligible for Life or Packaged Life/Disability Insurance coverage.	Retirees are not eligible for STD coverage.

*Valid waivers include spousal/parental group coverage, Medicare, Husky, Champus/ChampVA, Military coverage, Retiree coverage or Association coverage. Individual coverage is not a valid waiver.

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/Packaged Life & Disability	Short Term Disability (STD)
Out-of-State Employees	▪ In order for Aetna to accommodate an out-of-state/situs employee, 51% or more of the employees must be employed in the domiciled state. ▪ Any employee residing in a state with an Aetna Managed Choice Network will be eligible to enroll in the Connecticut Managed Choice Health Benefit Plan. ▪ Any employee not residing in a state with an Aetna Managed Choice Network will be enrolled in the Connecticut Traditional Choice Indemnity Benefit Plan. ▪ Any employee located in Connecticut, New Jersey or New York, but not residing in a state with an Aetna Managed Choice Network will be enrolled in the Connecticut Traditional Choice Indemnity Benefit Plan. ▪ For groups with more than 50% of the group's employees working outside of Connecticut, New Jersey and New York, Aetna will decline to offer coverage to the group. ▪ Employees of Connecticut-based groups who commute to the Connecticut work location from another state may be enrolled in the Connecticut plan(s) offered under live/work rules.	Employees who reside outside of Connecticut, New Jersey and New York 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.		
Ineligible Industries	All industries are eligible for medical coverage subject to underwriting guidelines.	The ineligible industry list applies only when Dental is sold stand-alone or packaged only with Group Insurance. This list does not apply when Dental is sold in combination with Medical.	▪ Basic Term Life: all industries are eligible. ▪ Packaged Life/Disability: the following industries are not eligible:	

SIC Range	SIC Description
7933	Bowling Centers
8611	Business Associations
7911	Dance Studios, Schools
7361-7363	Employment Agencies
7999	Misc Amusement and Recreation
8699	Misc Membership Organizations
8999	Misc Services
7991	Physical Fitness Facilities
8811	Private Households
7941-7948	Professional Sports Clubs & Producers, Race Tracks
8621-8651	Professional Membership Organizations, Labor Unions, Civic Social & Fraternal Organizations, Political Organizations
7992-7997	Public Golf Courses, Amusements Membership Sports & Recreation Clubs
8661	Religious Organizations
7922-7929	Theatrical Producers, Bands, Orchestras, Actors

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

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

PRODUCT SPECIFICATIONS

	Medical	Dental	Life/Packaged Life & Disability	Short Term Disability (STD)
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.	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.	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.

DENTAL ONLY

FOR STANDALONE DENTAL SALES ONLY

- Employer Eligibility will require the completion of the Employer Verification Form.
- The Quarterly Wage & Tax for Standalone dental is not required.
- Submission of an employer roster is required.

FULL-TIME HOURS

Full-time hour guideline will agree with the Medical guidelines.

OPEN ENROLLMENT

- Open enrollments are prohibited.
- 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.

COVERAGE WAITING PERIOD

- For Major and Orthodontic Services, must be an enrolled member of plan for 1 year before becoming eligible (not applicable to DMO).
- The coverage waiting period is waived separately for Major or Orthodontic Services for employees who were covered by the group's immediately preceding Dental plan.
- To waive the waiting period for Orthodontic Services, the group's immediately preceding plan must have included orthodontic coverage.
- To waive the waiting period for Major Services, the group's immediately preceding plan must have included Major Services.

Example: Prior Major coverage but no Orthodontic coverage. Aetna plan has coverage for both Major and Orthodontics. The waiting period is waived for Major Services but not for Orthodontic Services.

REINSTATEMENT

For Voluntary plans, members who were once enrolled then 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.

PRODUCT PACKAGING

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

FORMS

The same enrollment applications are required for new business medical.

LIFE ONLY

FULL-TIME HOURS

Full-time hour guideline will agree with the Medical guidelines.

CONTRACTUAL UNDERWRITING

- Open enrollments are prohibited.
- Life is bundled with Medical at the employer level, not the employee level. Therefore, a subscriber within a given group can waive Medical Underwriting coverage and still enroll for Life/AD&D.
- Life coverage can be offered to sole proprietorships, partnerships or corporations.
- Associations, Taft-Hartley groups, employee leasing firms and closed groups are not eligible for coverage and must be written individually.
- Must meet the qualifications of a small business. The same employer eligibility guidelines that apply to medical will apply to the life coverage.

MEDICAL UNDERWRITING

New Business Medical Evaluation

- At new business time, any dependents enrolling for coverage are Guaranteed Issue and not subject to Evidence of Insurability (EOI).
- 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/questionnaire.

Case Size	*Basic Term Life Amount*
2 – 9 eligible employees	$20,000
10 – 25 eligible employees	$75,000
26 – 50 eligible employees	$100,000

Only those employees who have an unacceptable medical condition will be reduced to the Guaranteed Issue amount. The rest of the employees will be issued the higher amount if they medically qualify.

Example:
Applying for $50,000

54-year-old male

Heart attack 6 months ago, no surgery

Reduced to $15,000 Life. All other employees will be issued $50,000.

In those states that have a case size differential for completing different sections of the health questions, the determining factor is based on the number of enrolled employees and not the number of eligible employees.

EVIDENCE OF INSURABILITY (EOI)

Evidence of Insurability (evidence of good health) is required when one or more of the following conditions exist:

- Life amounts are above the maximum Guaranteed Issue amount.
- Late Entrant — coverage is not requested within 31 days of eligibility for contributory coverage.
- Reinstatement or restoration of coverage is requested.
- New coverage is requested during the anniversary period.
- Coverage is requested outside of the employer's anniversary period due to qualifying life event (marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.).
- Dependent coverage option was initially refused by employee but requested later. The dependent would be considered a late entrant and subject to EOI, and may be declined for medical reasons.

NEW HIRES

- New hires wishing to obtain insurance amounts above the Guaranteed Issue amounts will be required to submit Evidence of Insurability (EOI), which means they must complete a medical questionnaire.
- If the employee has an unacceptable medical condition, the employee will be reduced to the Guaranteed Issue amount.

FULL-TIME HOURS

Full-time hour guideline will agree with the Medical guidelines.

GUARANTEED ISSUE NO MEDICAL UNDERWRITING

Coverage is Guaranteed Issue and does not require an employee to answer any medical questions or submit to medical records or a medical exam unless:

- Reinstatement or restoration of coverage is requested, and/or
- Coverage is not requested within 31 days of eligibility for contributory coverage, and the employee is a late entrant.

EMPLOYER ELIGIBILITY

- The same employer eligibility guidelines that apply to medical apply to STD coverage. Underwriters may require IRS forms or other documents to demonstrate proof of business and employee eligibility.
- The employer must have Workers' Compensation coverage.
- 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.

LIMITATIONS AND EXCLUSIONS

These plans do not cover all health care expenses and include exclusions and limitations. Employers and members should refer to their plan documents to determine which health care services are covered and to what extent.

MEDICAL

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.

Groups of one will be offered the following Connecticut State Mandated Plans pursuant to Connecticut state law: CSEHRP HMO or CSEHRP TC. For plan design benefit descriptions, please refer to Aetna's Producer World® website at **www.aetna.com** or contact your licensed agent or Aetna Sales Representative.

Aetna Open Access QPOS plan

Services and supplies that are generally not covered include, but are not limited to:

- 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)
- 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
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents

Aetna Open Access Managed Choice plan and Traditional Choice plan

Services and supplies that are generally not covered include, but are not limited to:

- 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
- 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 or counseling
- Special duty nursing

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 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 & root planing (4 quadrants every 2 years)
  - Osseous surgery (1 per quadrant every 3 years)
- All other limitations and exclusions in your plan documents. Disability Limitations and Exclusions

*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.

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)
- Commission of or attempt to commit a criminal act
- Voluntary use of any controlled substance, as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended; unless as prescribed by a physician
- Use of alcohol or intoxicants, an accident in which the blood alcohol level of the 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 you committing, or attempting to commit, a criminal act
- Is due to insurrection, rebellion or taking part in a riot or civil commotion
- Is due to war or any act of war (declared or not declared)
- Is not a non-occupational disease (STD only)
- Is not a non-occupational injury (STD only)
- Results from driving an automobile while 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.

GROUP ENROLLMENT CHECKLIST

STEP 1

Complete/Review Employer Application

- ❒ HMO/PPO/Dental/Life Application
- ❒ UC-5A or other applicable tax documents (Proof of Eligibility Form, if owner/officer/partner not on tax form)
- ❒ Initial premium check made payable to Aetna, Inc.
- ❒ Copy of current/prior medical carrier's latest bill with employee roster and premium summary page
- ❒ Employer Funding Certification and Statement of Understanding

STEP 2

Complete/Review Employee Enrollment/Change Form

- ❒ Employee (EE) Enrollment Form for each employee (HMO/PPO/Dental/Life)
- ❒ All individuals waiving coverage must complete and sign Section B and E on the enrollment form
- ❒ Each employee must complete a Family Health Statement Form

STEP 3

Complete/Review Broker Information

- ❒ Illustrative signed rates and copy of census (Employee Listing Report) from Aetna rating tool
- ❒ Agent/broker must be licensed in Connecticut and appointed by Aetna

Effective dates may be the first or fifteenth of the month only. All required paperwork must be received by Aetna at least five business days prior to the requested effective date.

Send all information to:

Aetna Small Group
3 Independence Way, 4th floor
Princeton, NJ 08540

E-mail:
CranSGNBSubmissions@Aetna.com

Aetna Avenue® — Your Destination for Small Business Solutions®

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. 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. 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. Plan for Your Health is a public education program from Aetna and The Financial Planning Association. Providers are independent contractors and not agents of Aetna. 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. 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**.

Aetna®
www.aetna.com

14.02.970.1-CT A (3/10)