CBIA

Aetna U.S. Healthcare

Administration Manual

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SECTION I – GENERAL INFORMATION

General Information

Thank you for choosing CBIA/Aetna U.S. Healthcare's insurance program for your employee benefit plan. This manual describes how to administer your plan.

CBIA/Aetna U.S. Healthcare's insurance plan is only one of a number of services offered by CBIA. Our organization and its services are described below.

What CBIA Does For You

CBIA is the largest statewide business organization in the country, with more than 10,000 member companies. We're committed to giving you consistently superior service. In survey after survey, our professional staff is ranked highly by our members on responsiveness, expertise and courtesy.

CBIA is the voice of business and industry at the state Capitol. Our highly respected public policy staff works with state legislators and officials to help shape specific laws and to promote a regulatory system that responds to businesses' needs.

When you want help managing your company, we'll give you exactly what you need to keep up with an increasingly complicated business environment. CBIA can update you and your employees on state or federal laws affecting your business; give you expert advice on personnel issues, taxes, and safety and environmental regulations; and help you make use of the latest advances in business management.

CBIA's Main Mission Is Advocacy on Your Behalf

CBIA has been a partner with Connecticut businesses for more than 175 years. In addition to our work with state legislators and officials, we offer the following groups through which you can make your voice heard:

- Legislative Breakfast Meetings (LBMs) provide a forum where members meet with their state representatives and senators to talk about business problems and pending legislation.

- The Environmental Policies Council (EPC) keeps its members up-to-date on the latest developments in state environmental compliance requirements, represents its members at the state Capitol and the Department of Environmental Protection, and regularly provides education and networking opportunities for its members.

- CBIA's Connecticut Manufacturers Council shares information and serves the interests of manufacturing companies. This essential segment of state business creates jobs and sells products that provide high returns to the state.

- CBIA's Education Foundation runs programs that help teachers and schools prepare students for careers in business and industry, especially in the areas of math, science and technology. CBIA is the statewide business partner in Connecticut's new school-to-career system. In cooperation with the state Department of Labor, CBIA offers matching funds to Connecticut's manufacturers to help defray the cost of basic skills, technical and ISO 9000 training. CBIA is also helping to run the Technologies Academy at Hartford Public High

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School. We also develop customized job training programs for entry-level workers, depending upon funding availability.

In addition, CBIA sponsors programs and events that bring together business, government, education and private enterprise to work on common problems. Among them are:

- *Connecticut Business Day*, when CBIA and chamber of commerce members meet in Hartford with their state legislators and the governor on key issues affecting business.

- *Made In Connecticut Day*, which brings Connecticut manufacturers together at the state Capitol to showcase their products and to discuss manufacturing issues with legislators.

- *Connecticut Economic Conferences*, which bring together economists, federal and state officials, and businesspeople to discuss the future of Connecticut's economy. International trade and exporting conferences are also held.

CBIA's Business Services

- CBIA sponsors scores of seminars and training programs every year to help companies manage, compete and comply. Whether through morning workshops or all-day conferences, we respond to members' needs in both technical and managerial areas. In addition to presenting these high-quality, affordable programs throughout Connecticut, CBIA annually holds major human resource and tax conferences and the largest safety, health and environmental conference in New England. Our recently introduced Human Resources Audit, Handbook Review and Handbook Writing services have proven very popular. Further, our members keep abreast of important industry issues by joining our Safety and Health Roundtable and our Human Resources Council.

- CBIA's free telephone consulting service on labor, tax, employment and environmental issues helps members understand state and federal regulations concerning human resources and management issues.

- We survey our members and publish reports on what companies pay their employees, what benefits they provide, and what their personnel policies are. Reports are offered at no cost to members that participate in the surveys.

- CBIA's research department tracks economic trends and vital statistics essential for business planning and management.

- CBIA's International Trade Council highlights export opportunities for state manufacturers and service exporters. Members can attend periodic meetings and special conferences.

- CBIA health insurance programs for small businesses offer competitive coverage at competitive prices. Employers can choose from either of our two programs. CBIA/Aetna U.S. Healthcare offers groups with 1-200 employees a full range of benefit options, all provided by Aetna U.S. Healthcare. CBIA Health Connections allows employers with 3-50 employees to choose between four health plan companies and four levels of benefits. We encourage you to join the over 7,000 Connecticut companies currently purchasing their health insur-

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ance through CBIA.

- CBIA Retirement Plans offer small employers affordable full-service retirement plans. These include a wide range of plan designs and investment options from a number of well-known investment companies, all under one CBIA program.

- CBIA's Workplace Safety Services offer training and information programs; consulting services; resources for employee safety; and help with regulatory compliance, including OSHA standards and handling of hazardous materials.

- CBIA's On-Site Consulting Services provide convenient and economical training and consulting assistance, with free referral and easy access to some of Connecticut's finest business consultants and trainers. Areas of expertise include staff development, process improvement, management, business planning, human resources, safety and health, and more.

- We have cost reduction plans that can save your company money every day. Among these are programs for airport parking, car rental and eyewear.

Helping to keep members well-informed is an important element of CBIA's member services. Our publications include:

- Our monthly journal, *CBIA News*, which covers trends affecting your company
- Our weekly *Government Affairs Report* presents an account of activities at the state legislature and in state agencies that affect your business
- *Connecticut Enterprise*, a publication specifically addressing issues of interest to our smaller member companies
- Regular reviews of state economic trends
- Monthly news on managing your human resources
- Compensation, benefits and personnel policies reports
- State manufacturers and services directories
- Reference guides covering tax and workplace laws and regulations, affirmative action, COBRA and insurance continuation, and safety and human resources issues
- A monthly environmental newsletter featuring updates on environmental regulations

SECTION II – EMPLOYEE INFORMATION

Employee Information

How to Add an Employee

All new, active, full-time employees regularly scheduled to work at least 30 hours per week are eligible for CBIA/Aetna U.S. Healthcare coverage. All new-employee coverages will be effective the first of the month following your company's probationary period. Eligible employees who previously waived coverage are eligible to enroll during your company's annual open enrollment or at the time of a qualifying event. To add a new or newly eligible employee to your insurance plan, the following steps must be completed:

1. Complete a CBIA/Aetna U.S. Healthcare enrollment/change form and have the employee complete the section pertaining to employees.
2. Have the enrollee complete a Family Health Statement (if applicable*). The information will be kept confidential.
3. If the employee is being added due to the loss of other coverage, you must obtain a certificate of creditable coverage from the prior carrier documenting that the employee/dependents were covered.
4. Send the completed enrollment/change form, Family Health Statement (if applicable*), and, when necessary, the certificate of creditable coverage to CBIA Service Corp., 350 Church St., Hartford, CT 06103-1106 within 30 days of the employee's loss of other coverage or hire.
5. Advise the enrollee of the effective date of his or her coverage. In determining the effective date for a new employee or dependent, keep in mind the employee's employment date and the waiting period you selected. If the enrollee is being added following one of the qualifying events listed on **Page 14**, the effective date is the first of the month following the date of the qualifying event. In the case of a birth or adoption, the effective date is the date of birth or placement.
6. If you have any questions about any of the forms that need to be completed, please contact your agent for assistance.
7. Check your monthly statement on the month coverage should start for new employees to verify their active status. Should you note any problems on your monthly statement, please call CBIA Service Corp.'s Customer Service at 860-525-2242.

***Note: For all employers with 50 or fewer employees, a Family Health Statement must be completed for medical coverage.**

CBIA will not assume responsibility for enrollment or changes when the CBIA procedures outlined herein are not followed.

Processing will be delayed and forms may be returned to you for any of the following reasons:

- Enrollment/change form not signed and dated by the employee and the employer
- Missing or incomplete information
- Family Health Statement not received, when applicable.

As a member of CBIA/Aetna U.S. Healthcare, your enrolled employees will receive the following from the health plan they have chosen:

- A Medical Identification Card
- New-member information, including how to use the plan and obtain care
- A summary of benefits
- Provider Directories, as applicable
- All pertinent telephone numbers

You or your employees should contact Aetna U.S. Healthcare's member service department directly for the following:

Employee Information

- To make changes in Primary Care Providers
- To obtain replacement Medical Identification Cards
- To ask questions regarding benefits
- To ask questions pertaining to claim payments
- To request medical claim forms

Ancillary Lines

Unless specified, all employees who are enrolling for medical coverage must also be enrolled for the group term life insurance. The same eligibility guidelines apply. The amount of insurance will be dependent on the plan you have selected for your employees. If your plan is based on earnings, all amounts are guaranteed up to $75,000. For any coverage amount over $75,000, evidence of insurability is required.

Life Only Coverage

Your employees can waive group medical coverage and elect life only coverage. Employees are eligible for life insurance upon completion of your company's waiting period. Employees who do not elect life insurance coverage at the time they are first eligible are not eligible for life insurance coverage until your company's next annual open enrollment. If the amount is $75,000 or more, evidence of insurability must be completed and the additional coverage is not guaranteed. All employees enrolling for life insurance coverage should be given a life insurance booklet provided to you by Aetna Life Insurance Company.

To enroll for life insurance coverage, follow these steps:

- Complete an enrollment/change form.
- Complete an Evidence of Insurability Statement for amounts over $75,000.
- Indicate life only coverage.
- Check the box indicating no medical coverage.
- Include the salary information, if applicable.
- Complete the section for beneficiary.
- Have it signed and dated by the employee and employer.
- Forward the completed form to CBIA, 350 Church St., Hartford, CT 06103-1106 for processing.

Dental with Medical and Life

If you are offering dental coverage to your employees, the eligibility guidelines and procedures for enrollment are the same as for medical. It is important to note that the type of coverage for both medical and dental must be the same (for example, family medical and family dental.)

To enroll your employees for dental with medical and life, follow the procedure outlined in the above sections and do the following:

- Complete the section for dental coverage on the enrollment/change form.
- Have the form signed and dated by the employee and employer.
- Forward the form to CBIA, 350 Church St., Hartford, CT 06103-1106 for processing.

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Dental Coverage

Employees can waive medical coverage and enroll for dental and life coverage. The eligibility guidelines are the same as for medical coverage. If your employee waives medical coverage when first eligible, and at a later time requests dental coverage, the employee is not eligible for coverage until your company's next annual open enrollment unless a loss of dental coverage occurs. If your employee was covered under another dental plan and lost that coverage, the employee may enroll under the provisions of a qualifying event.

To enroll your employees, follow these steps:

- Coverage must be requested within 30 days of the loss of coverage or at the time of hire
- Complete an enrollment/change form
- Attach documentation of loss of coverage from the prior dental carrier, if applicable
- Forward forms to CBIA, 350 Church St., Hartford, CT 06103-1106 for processing.

Short-term Disability

If Short-term Disability (STD) is part of your group benefit package, all of the standard medical eligibility guidelines apply.

Employees may waive medical coverage and enroll for life and short-term disability coverage only. Short-term disability coverage can be elected at the time of hire without having to submit evidence of insurability. It should be noted that coverage is not guaranteed when submitting evidence of insurability.

To enroll, complete the following steps:

- Complete an enrollment/change form
- Fill in the box for Short-term Disability
- Complete the earnings section (for benefit calculation)
- Have the form signed and dated by both the employee and employer
- Complete an evidence of insurability form, if necessary
- Forward the completed forms to CBIA, 350 Church St., Hartford, CT 06103-1106 for processing.

Long-term Disability

If you have selected Long-term Disability (LTD) as one of the benefits offered to your employees, the guidelines may differ slightly from your medical plan.

- The waiting period for coverage is dependent upon the LTD plan you select
- It may not match your company's standard waiting period for benefits

Employees are eligible to enroll for LTD coverage when they are first hired. If they do not elect coverage at this time, coverage is only available after the successful completion of evidence of insurability. Also, coverage is not guaranteed.

To enroll your employees for this benefit, complete the following steps:

- Complete an enrollment/change form
- Fill out the LTD coverage section
- Complete the earnings section
- Have the form signed and dated by both the employee and employer
- Complete an evidence of insurability form, if necessary
- Forward all forms to CBIA, 350 Church St., Hartford, CT 06103-1106 for processing.

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How to Add a Dependent

Dependents of an employee are eligible for coverage if they fall into one of the following categories:

- A legal spouse.
- Any unmarried child or stepchild (natural or adopted) under age 19 who is financially dependent on the employee. A dependent can be covered until reaching age 19, or until age 23 if a full-time student in an accredited college or university.
- Dependents over the coverage age limits who are incapable of supporting themselves because of a physical or mental disability. This disability must have existed before the dependent reached the coverage age limit. An Attending Physicians Statement (APS) must be completed and sent to Aetna U.S. Healthcare for approval.
- Children for whom a court order requires coverage under the employee's health insurance plan.

Employees who enroll in CBIA/Aetna U.S. Healthcare can enroll their dependents at the same time. In addition, employees may enroll dependents after a qualifying event has occurred. The qualifying events are:

- Adoption or placement for adoption
- Birth
- Court-ordered dependents
- Exhaustion of continuation-of-coverage
- Legal guardianship
- Loss of coverage
- Marriage
- New stepchildren

For more information on qualifying events, see **Page 14**.

Dependents must enroll in the same coverage and benefit level as the employee. To make changes affecting your employee's dependent coverage, the following steps must be completed:

1. Complete a CBIA/Aetna U.S. Healthcare enrollment/change form and have the employee complete the section pertaining to his or her dependents.
2. Have the dependent complete a Family Health Statement, if applicable*(See Note, next page.) The information will be kept confidential.
3. If the dependent is being added due to the loss of other coverage, you must obtain a certificate of creditable coverage from the prior carrier documenting that the dependent was covered.
4. Send the completed enrollment/change form, Family Health Statement (if applicable*), and, when necessary, the certificate of creditable coverage to CBIA Service Corp., 350 Church St., Hartford, CT 06103-1106 within 30 days of the qualifying event.
5. Advise the enrollee of the effective date of their dependent's coverage. If the dependent is being added following a qualifying event, the effective date of coverage is the first of the month following the date of the qualifying event. In the case of a birth or adoption, the effective date is the date of birth or placement.
6. If you have any questions about any of the forms that need to be completed, please contact your agent for assistance.
7. Check your monthly statement on the month coverage should begin for the new dependent(s) to verify their active status. Should you note any problems on your monthly statement, please call CBIA Service Corp.'s Customer Service at 860-525-2242.

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***Note: For all employers with 50 or fewer employees, a Family Health Statement must be completed for medical coverage.**

CBIA will not assume responsibility for enrollment or changes when the CBIA procedures outlined herein are not followed.

Processing will be delayed and forms may be returned to you for any of the following reasons:

- Enrollment/change form not signed and dated by the employee and the employer
- Missing or incomplete information
- Family Health Statement not received, when applicable

Active Employee Cancelling Coverage for a Dependent

An employee may cancel one or more of their dependent(s) from coverage. To do so, the following steps must be completed:

1. Complete an enrollment/change form indicating the dependent(s) to be cancelled.
2. Advise your employee that the effective date of cancellation will be the first of the month following the dependent(s) loss of eligibility or the employee's request to cancel.
3. Indicate this effective date on the completed enrollment/change form and forward it to CBIA within 30 days. Delay in notification to CBIA will jeopardize any allowable credit.
4. Advise the employee and dependent of possible continuation-of-coverage rights (for example, under COBRA), as required under applicable state or federal law. Please see the "Continuation-of-coverage" chart on **Page 41**.

Cancelling All Coverage for Individual Employees and Dependents

When an employee or dependent is no longer eligible for coverage or wishes to cancel coverage, the effective date of cancellation will be the first of the month following the employee's or dependent's loss of eligibility or request to cancel the employee's coverage. You must notify CBIA of the cancellation immediately.

If the cancellation is retroactive, a premium credit will be given for the month in which the notice of cancellation is received and the prior month only.

While cancellation requests that are not timely received will be processed, premium credit will only be issued for the month in which notification is received and the prior month.

1. There are four ways you or your agent can cancel all coverages for an employee or dependent:
   - You can record the effective date of cancellation by the employee's name on your monthly bill.
   - You can call a CBIA Customer Service representative. Be sure to have the Social Security number and cancellation date.
   - You can notify CBIA in writing on company letterhead, indicating the employee's name, Social Security number and effective date of cancellation.
   - Complete an enrollment/change form and send it to CBIA.

   Note: To cancel your entire account, refer to Page 22 for instructions.
2. You must notify CBIA of all cancellations of coverage whether the employee or dependent elects continuation-of-coverage or not. If the employee or dependent elects continuation-of-coverage,

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coverage must be activated to the original cancellation date. For more information on continuation-of-coverage, see "State and Federal Continuation Laws" starting on **Page 40**.

3. Any adjustment or credit due will appear on the next bill to be processed. Monthly bills are produced on the eighth of the month.

Exception: Medicare Risk members must submit their requests to cancel coverage in writing. Cancellation cannot be submitted by the employer or agent, and cannot be retroactive.

Active Employee Cancelling a Coverage

An employee may cancel one or more of their coverages. To do so, the following steps must occur:

1. The employee must complete an enrollment/change form indicating the coverage(s) to be cancelled.
2. Advise your employee that the effective date of cancellation will be the first of the next month.
3. Indicate this effective date on the completed enrollment/change form and forward the signed form to CBIA, 350 Church St., Hartford, CT 06103-1106 within 30 days. Delay in notification to CBIA will jeopardize any allowable credit.

Note: Continuation-of-coverage should be offered to the employee and any dependent(s) at this time. Please refer to the "State and Federal Continuation Laws" description on Page 40.

Where to Submit Your Adjustments

Adjustments (additions, cancellations and changes) that are received at CBIA by the last day of the month will appear on your next bill. The standard processing time for adjustments is four working days from the date received at CBIA.

You can either mail or fax (do not do both) your adjustments and correspondence to:

CBIA Service Corp.
Insurance Operations Dept.
350 Church St.
Hartford, CT 06103-1106
Fax: 860-278-0883

Employee Change of Address

You or your employee must notify the Aetna U.S. Healthcare member services department of any new addresses. The member services telephone number is on the back of your employees' ID cards.

Primary Care Physician (PCP) Changes

A Primary Care Physician (PCP) change may be made at any time. Your employees need to contact

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the Aetna U.S. Healthcare member service department with the name of their new PCP. The member services telephone number is on the back of your employees' ID cards. PCP changes for Select Choice are effective on the first of the month following the change. All other PCP changes are effective within 24 hours of the change.

ID Cards

Medical ID cards will be provided directly to your employees by Aetna U.S. Healthcare.

Managed Choice/Select Choice/QPOS Medical ID Cards

For employees enrolled in Managed Choice (MC or QPOS) or Select Choice (HMO), Aetna U.S. Healthcare will mail the ID cards directly to your employees' homes within two to three weeks from the date their information is received by CBIA. Each covered member will receive a medical ID card. Replacement ID cards can be ordered by calling Aetna U.S. Healthcare's member service department. The member service telephone number is on the back of your employees' ID cards.

Important: Employees and dependents must select a Primary Care Physician (PCP) upon enrollment. A PCP can be a family practitioner, general practitioner, internist or pediatrician and may be different for each family member. PCP selection is made from the Provider Directory for the plan selected by your employee. Please note that employees who have not chosen a PCP will receive a no-election ID card, and must call Aetna U.S. Healthcare member services at the number on the back to select a PCP in order to receive the preferred level of benefits.

Traditional Choice (Indemnity) ID Cards

For employees enrolled in Traditional Choice, medical ID cards will be mailed directly to your employees' homes two to three weeks from the date their information is received by CBIA. Replacement ID cards can be ordered by calling Aetna U.S. Healthcare's member service department. The member service telephone number is on the back of your employees' ID cards.

SECTION III – QUALIFYING EVENTS

Qualifying Events

Changes That May Affect Coverage

There are many types of changes, called "qualifying events," that affect your employees and their benefits. Qualifying events include:

- Adoption or placement for adoption
- Birth of a child
- Change from part-time to full-time status
- Court-ordered dependents
- Death
- Divorce
- Exhaustion of continuation-of-coverage
- Legal guardianship
- Loss of coverage
- Loss of dependent/student status
- Marriage
- New stepchildren
- Reaching age 65
- Reduction of hours worked
- Retirement

Whenever a qualifying event occurs, you, the employer, must communicate the change to CBIA Service Corp. When adding an employee or his or her dependents to the plan, you must submit the employee's completed enrollment/change form, a completed Family Health Statement (if applicable), and, if necessary, a certificate of creditable coverage within 30 days of the qualifying event. Your failure to do so will jeopardize your employee's coverage. A description of the various qualifying events follows.

Adoption or Placement for Adoption

An employee may add an adopted dependent to the plan within 30 days of the adoption or placement for adoption. Coverage will be effective on the date the child is placed in the home. A completed enrollment/change form, a Family Health Statement, if applicable, and a copy of the adoption certificate should be submitted to CBIA. If the enrollment/change form is not received within 30 days of the adoption, the dependent will be considered a late applicant and will not be eligible for coverage until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

Birth of a Child

An employee may add a newborn dependent to the plan within 30 days of the date of birth. The child will have coverage from the date of birth. Premiums will change on the first of the month following the child's date of birth. A completed enrollment/change form and a Family Health Statement must be submitted to CBIA. If the enrollment/change form is not received within 30 days of the birth, the dependent will be considered a late applicant and will not be eligible for coverage until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

Qualifying Events

Change from Part-time to Full-time Status

If a part-time employee changes to a full-time employee — and is then scheduled to regularly work 30 or more hours per week — the employee and any dependents become eligible to enroll in CBIA/Aetna U.S. Healthcare. A completed enrollment/change form and a Family Health Statement, if applicable, must be submitted to CBIA. The employee and dependents must be added within 30 days of the date on which the employee becomes full-time and has completed the company's probationary period. Otherwise, the employee will be considered a late applicant and will not be eligible for coverage until your company's next annual open enrollment. See **Page 6** for instructions on how to add an employee.

Court-Ordered Dependent

An employee may add a court-ordered dependent to the plan within 30 days of the date of the court order. Coverage will be effective on the date of the court order. A copy of the court documents, in addition to a completed enrollment/change form and a Family Health Statement, if applicable, must be submitted to CBIA. If the forms are not received within 30 days of the court order, the dependent will be considered a late applicant and will not be eligible for coverage until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

If an employee is ordered by the court to provide health coverage for a child, but the employee fails to enroll the child, Connecticut Public Act 95-305 requires the employer to enroll the child upon application of the other parent. Also, once a child is enrolled in accordance with a court order, the employer is prohibited from terminating the child's coverage unless provided with written evidence that the court order is no longer in effect or that the child is enrolled in comparable health care coverage.

Death

If your employee dies while covered under your plan, you must notify CBIA. The surviving spouse and any dependents may be eligible for continuation-of-coverage. Please refer to the "State and Federal Continuation Laws" section starting on **Page 40** for further information.

If your employee originally waived coverage under your plan because he or she was covered by a spouse's plan, and then requests enrollment because of the death of his or her spouse, your employee may elect coverage under your plan. See the "Loss of Coverage" definition in this section for more information and instructions.

Divorce

If an employee becomes divorced, the former spouse is no longer eligible as a dependent but is eligible for continuation-of-coverage at his or her own expense. After a divorce, coverage for the spouse must be cancelled even if continuation-of-coverage is chosen. Notification must be submitted in writing to CBIA within 30 days of the date of divorce. See **Page 10** for instructions on active employees cancelling a dependent. If the spouse elects to continue coverage, a completed enrollment/change form and Family Health Statement, if applicable, must be mailed to CBIA. Please refer to the "State and

Qualifying Events

Federal Continuation Laws" section starting on **Page 40** for more information on continuation-of-coverage.

Exhaustion of Continuation – Eligibility

If you have a new employee who is currently covered under continuation-of-coverage from his or her previous employer, he or she will be eligible to enroll in your plan at one of the following times:

- At the end of your company's probationary period
- When the continuation period has expired
- During your company's annual open enrollment

Notification must be submitted to CBIA within 30 days of the exhaustion of continuation. A completed enrollment/change form, Family Health Statement, if applicable, and certificate of creditable coverage must be mailed to CBIA. The employee will be considered a late applicant if coverage is not requested within 30 days and will not be eligible to enroll until your company's next annual open enrollment. See **Page 6** for instructions on how to add an employee.

Legal Guardianship

If an employee is granted custody of a child by probate court, coverage can be added within 30 days of the court appointment. A completed enrollment/change form, Family Health Statement, if applicable, and a copy of the court document must be mailed to CBIA. The dependent will be considered a late applicant if coverage is not requested within 30 days and will not be eligible to enroll until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

Loss of Coverage

If an employee or the employee's dependents lose the health coverage they have from another source, they are eligible to enroll within 30 days of the loss of coverage. A completed enrollment/change form, Family Health Statement, if applicable, and a certificate of creditable coverage from the prior carrier or employer must be submitted to CBIA. If the CBIA/Aetna U.S. Healthcare coverage is not requested within 30 days, the employee and dependents will be considered late applicants and will not be eligible to enroll until your company's next annual open enrollment. See **Page 6** for instructions on how to add an employee, and **Page 9** for instructions on how to add a dependent.

Loss of Dependent/Student Status

Dependents who reach age 19 or who lose full-time student status are no longer eligible for coverage as of the last day of the month in which the dependent is no longer eligible as a dependent or student. Notification of the change must be submitted to CBIA in writing. See **Page 10** for instructions on how an active employee cancels coverage for a dependent.

If the dependent elects to continue coverage, a completed enrollment/change form and Family Health Statement, if applicable, must be mailed to CBIA within 30 days. Refer to the "State and Federal Continuation Laws" section starting on **Page 40** for more information on continuation-of-coverage.

Qualifying Events

Marriage

An employee may add a new spouse to the plan within 30 days of the date of marriage. The effective date of coverage will be the first of the month following the date of marriage. A completed enrollment/change form and Family Health Statement, if applicable, must be submitted to CBIA. If the spouse is not added to the plan within 30 days, the spouse will be considered a late applicant and will not be eligible to enroll until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

New Stepchildren

An employee may add new stepchildren to the plan within 30 days of the date when the stepchildren become dependent on the employee. If the stepchildren are not added at the time of marriage but a court order later requires the stepchildren to be covered, a copy of the court document indicating that coverage is required, along with a completed enrollment/change form and Family Health Statement, if applicable, must be submitted to CBIA. If the stepchildren are not added to the plan within 30 days of the marriage or court order, the stepchildren will be considered late applicants and will not be eligible to enroll until your company's next annual open enrollment. See **Page 9** for instructions on how to add a dependent.

Reaching Age 65

As employees or their dependents reach age 65, they become eligible for Medicare. Several changes in their benefits may need to occur at this time. The changes may involve life insurance reduction, the plan of benefits or the premium, depending on who the primary payer will be. For more specific information on reaching age 65, please see the "Medicare," "Life" and "Retirement" sections of this manual. A completed enrollment/change form with any changes must be submitted to CBIA.

Reduction in Hours

When an employee is no longer regularly scheduled to work 30 or more hours per week, eligibility for group coverage ceases. The employee and any covered dependents are eligible for continuation-of-coverage at their own expense. Regular group coverage must be cancelled even if continuation-of-coverage is chosen. Notification must be submitted to CBIA in writing within 30 days of the reduction in hours. See **Page 10** for instructions on how to cancel coverage for individual employees and dependents.

Retirement

An employee must have worked for a company a minimum of 10 years to be considered a retiree. As an employer, you have the option of selecting whether or not coverage for employees who retire should continue beyond active employment. When an employee retires, you need to notify CBIA of any changes that are necessary. For more specific information on retirement, please see the "Medicare," "Life," and "Retirement" sections of this manual. A completed enrollment/change form with any changes must be submitted to CBIA. (See "Note" next page.)

Qualifying Events

Note: Retirees cannot make up more than 10 percent of the total group enrollment. For out-of-state retirees, the only coverage available is Aetna U.S. Healthcare Traditional Choice.

SECTION IV – LIFE INSURANCE CHANGES

Life Insurance Changes

If your life insurance benefit is based on earnings, changes in the dollar volume payable will occur when salary changes occur or annually on the date you specify. Complete these steps to notify CBIA of any salary changes:

1. On your monthly bill, indicate the effective date of the salary change and the new salary, OR
2. Provide CBIA with a detailed list of changes on company letterhead. Include the employee name, Social Security number, new salary and effective date.

Salary changes will affect all salary-based coverages that your employees have selected.

Note: CBIA reserves the right to request supporting documentation of an individual's earnings at any time.

Age Reduction Rule (Life Insurance)

Most of CBIA's life insurance plans have an age reduction provision that applies when your employees reach age 65. To determine if age reduction applies to your employees, refer to your Aetna U.S. Healthcare Life Insurance booklet. For most plans,** CBIA will automatically reduce the life amount by 35 percent (this does not apply to supplemental life $100,000 maximum policies). Life reductions will be effective the first of the month after the employee reaches age 65. If the employee is retiring, any necessary changes must be reported to CBIA based on your company-specific retirement options. Please see the "Retirement" section on **Page 17** for more specific information.

****Note: Employers whose life coverages are classified "custom" (CUST on your bill) must notify CBIA when an age reduction needs to be made. If you do not notify CBIA to reduce the life benefit and a claim is filed, the benefit paid may be processed at the reduced amount, and the premiums paid may not be refunded.**

Retiree Coverages

The employer should choose retiree options at the time of case installation. Option changes can be made at any time, but must be made only once during a 12-month period. Retirees cannot make up more than 10 percent of the total group. Retirement options are available for:

- Life
- Medical (for out-of-state retirees the only coverage available is Aetna U.S. Healthcare Traditional Choice)
- Dental

Life Options:

Retirement option at age 62 (choose one of the following):

A. Discontinue life insurance
B. Continue insurance at the amount of $1,500
C. Continue 65 percent of amount of life volume in force
D. Continue 32.5 percent of amount of life volume in force

Retirement option at age 65 (choose one of the following):

A. Discontinue life insurance
B. Continue insurance at the amount of $1,500
C. Continue 100 percent of amount of life volume in force
D. Continue 50 percent of amount of life volume in force

Note: To change your retirement options, contact your broker or CBIA.

SECTION V – CASE CHANGES

Case Changes

Adding Coverages or Changing Them, on an Existing Case

You may request changes or the addition of a new ancillary coverage at any time. Contact your agent for coverages available, rates and instructions. Once the decision to add or change a coverage has been made, you or your broker must give your Aetna U.S. Healthcare marketing office a 15-day prior notice. Remember the following:

1. When offering any new coverages, all employees must be offered the opportunity to enroll in the new coverages.
2. Updated enrollment/change forms are required for any employee changing a coverage.
3. If a change is to be made on any medical or dental coverages, employees on continuation-of-coverage must be notified of the changes.
4. Family Health Statements may be required for some coverages.

Case Address/Area Changes

Forward all address changes to CBIA, 350 Church St., Hartford, CT 06103-1106. If your address change impacts your rating area for billing, you must contact your agent, your Aetna U.S. Healthcare Account Manager or CBIA to discuss the rating area change. Rating area changes will be effective in the next billing cycle after CBIA has been notified.

Administrative Changes

Notify CBIA of any change in billing contact, telephone numbers or fax numbers. You can call, write or fax the new information to us.

Employer's Request for Cancellation

To cancel your entire case or just a specific coverage, you must complete the following steps:

1. Notify CBIA on you company letterhead no later than 15 days prior to the first of the month in which you want to cancel.

   Include your case number or numbers and the coverages to be cancelled.
2. Review your most recent bill and submit any necessary changes to CBIA with your cancellation notice.
3. CBIA will not accept changes on a cancelled case that are received more than 30 days after the cancellation date.
4. Any outstanding premiums or fees not received within 45 days of the cancellation date will be sent to our collection agency, Dun & Bradstreet, for resolution.

Note: Cancellation can only be effective on the first of the month after a minimum advance notice of 15 days.

SECTION VI – BILLING

Billing

About Your Bill

The bill for any month in which your insurance is effective will be produced on the eighth day of the month preceding the month of coverage. The bill will be based on the enrollment data in our system at that time. Any addition, termination or change that you have mailed to us that is not reflected on your bill will be included on the next month's bill. **Do not pre-deduct or add premium dollars to your bill for changes that are not reflected on the bill.** The new premium will automatically be included on your next bill even if you included the premium in your payment for the older bill.

How to Interpret Your Bill

The following terms may appear on the bill:

Case Number — Your unique account number with CBIA. This number is needed when making any inquiries to CBIA.

Bill Date — The date the bill was generated.

Amount Due — Total amount due on the Billing Summary.

Due Date — Premium is always due on the first day of each month.

Detail Page — The portion of your bill that lists everyone covered under your group health insurance plan. It specifies the benefits they are enrolled in, the benefit tier, the adjustment premium and the current premium. This page should be reviewed monthly and any changes should be submitted to CBIA immediately. **See Pages 6 and 10**, respectively, for instructions on how to add or cancel employees or change coverages.

Summary Page — The portion of your bill that indicates the active benefits on your case, the number of employees being billed as single employees (EMP), employees plus spouse (ESP), employees plus children (ECH), or employees plus family (FAM), and the total life insurance volume for your group.

Adjustment Premium — The amount credited to or debited from your case for retroactive adjustments.

Current Premium — The charge for the billed month only.

Total Premium — The total of any adjustment premium and the current premium.

Previous Balance — Amount due on last month's bill.

Payments Received — Any payments received and posted prior to the bill date.

Outstanding Balance — Any past-due balance owed on the case, minus any payments received prior to the bill date.

Adjustments — Total of retroactive adjustments on the bill.

Case Adjustment — Any fee charged to your case (for example, a reinstatement fee).

Total Amount Due — Outstanding balance plus any adjustments, plus the current premium.

Note: It is your responsibility to review, verify and submit any adjustments or corrections to CBIA to ensure that your billing is accurate. Mail your changes to:

CBIA Service Corp.
Insurance Operations Department
350 Church Street
Hartford, CT 06103-1106

Billing

Premium Payments

Your CBIA/Aetna U.S. Healthcare plan is a prepaid plan and the premium is due on the first day of each month of coverage. To avoid Reminder and Cancellation Notices and claim payment issues, please ensure your payments are received by CBIA prior to the first day of the month of coverage.

PAYMENTS (ONLY) SHOULD BE MAILED TO:

CBIA Service Corp.

P.O. Box 150495

Hartford, CT 06115

For your convenience, you can pay your premium using CBIA's Direct Debit Plan. You can authorize CBIA to deduct your monthly premium from your checking account. Each month, the deduction will be made on the seventh day of the month of coverage. For more information, call your CBIA Customer Service representative at 860-525-2242.

You should submit your enrollments or changes as they occur throughout the month. **Do not include any adjustments or correspondence with your premium payment.** CBIA does not accept personal checks. Payments must be made with a company check, money order, etc. Premiums for individuals on continuation-of-coverage must be included in your monthly payment.

Reminder Notices

Your premium is due on the first day of the effective month of coverage. If CBIA has not received your premium by the first day of the month of coverage, you will receive a Reminder Notice. The notice will advise you that your case is past due and that coverage will be cancelled at the end of the month if premium is not received. This notice will also advise you of your company's responsibility to notify your employees if coverage is to be cancelled.

Cancellation Due to Nonpayment of Premium

CBIA will send two notices to employers that have not paid their current month's premium. If payment is still not received within the required time, CBIA will cancel your case effective the first of the next month. Any outstanding premiums or fees not received within 45 days of the cancellation date will be sent to our collection agency, Dun & Bradstreet, for resolution.

Cancellation Due to Nonpayment of CBIA Dues

To participate in the CBIA/Aetna U.S. Healthcare insurance program, you must be a member of CBIA. Membership dues are billed annually. Nonpayment of CBIA dues will result in the cancellation of your

Billing

group insurance plan. To avoid cancellation of your insurance benefits, your dues payments must be received by Jan. 31 of each year. **Because billing for dues is separate from the insurance billing, please send a separate check for your dues payment to:**

CBIA Membership Dues
P.O. Box 5620
Hartford, CT 06103-5620

Note: You have an obligation under the Connecticut General Statutes Section 38-262C to give advance written notice of cancellation of insurance to each employee. When a case is no longer active, regardless of the reason, there are no continuation-of-coverage options available for employees wishing to continue coverage under the CBIA/Aetna U.S. Healthcare plan. Employees may convert to an individual policy. For more information, please contact your agent, your Aetna U.S. Healthcare Account Manager or CBIA.

Reinstatement

A reinstatement is defined as reactivating your case back to the effective date of cancellation. If a case is cancelled, all coverages can be reinstated by written request received by CBIA within 30 days of the cancellation. In addition, all monies owed (premiums, dues and fees) must be paid by a certified check or bank check. Premiums for the current month must also be paid. A reinstatement fee of $250 or 10 percent of outstanding premium, whichever is greater, will also be required.

When the reinstatement has been completed, CBIA will notify the claims office to reactivate eligibility. In general, the processing time is approximately seven days. During this time, if any claims are denied due to cancellation of the case, the employee or provider must resubmit the claim for processing.

If CBIA does not receive a request to reinstate your case within 45 days from the effective date of cancellation, your case can only be activated as "new business," and all "new business" certifications will be required.

Collection

When your case is cancelled and there is money owed to CBIA, that balance will be given to our collection agency, Dun & Bradstreet, approximately 45 days after the date of cancellation.

Note: If you have any questions on billing or premium payment, please contact our Customer Service Department at 860-525-2242.

Billing

Example of Monthly Cycle

The following is an example of the monthly schedule for bills, reminder notices, cancellation notices, case cancellation and reinstatement:

April 8	May bills are produced by CBIA.
April 10	May bills are mailed to all active cases.
May 1	May premium is due.
May 8	June bills are produced by CBIA. Reminder Notices are mailed if May premium is not received.
May 10	June bills are mailed to all active cases.
May 18	Last day the May premium can be received to avoid case cancellation and reinstatement fees.
May 22	If all outstanding premiums are not received by May 18, a Cancellation Notice is mailed advising you that the case is cancelled effective June 1.
June 8	If you were cancelled for nonpayment of the May premium, a final bill for May is produced that indicates any transactions submitted after the original May bill was produced on April 8. A letter informing you of your reinstatement option and a reinstatement form will be mailed to you.
June 8	The monthly billing cycle begins again, as stated above.
June 30	The reinstatement form and all monies owed (any outstanding balance plus May, June and July premium) and fees must be received. Reinstatement bills are processed and mailed.

SECTION VII – DEFINITIONS

Definitions

Ancillary Lines of Coverage

All non-medical coverages are considered ancillary lines. Examples are short-term and long-term disability and dental.

Cancellation of Employee Coverage

An employee may cancel coverage at any time. The effective date of any cancellation will be the first day of the next month. You must notify CBIA immediately of cancellations to ensure proper credit on your bill. You must offer continuation-of-coverage to the employee and any dependents losing coverage. Retroactive premium credit will not be issued for more than the month in which the cancellation is received and the prior month, if applicable. See **Page 10** for the procedure on how to cancel an employee's coverage.

Note: If the employee or dependent is covered by a Medicare Risk plan, the cancellation must be sent to CBIA in writing from each Medicare enrollee. Cancellation cannot be submitted by the employer or agent. The enrollee must notify CBIA in advance of his or her intent to cancel. There is no retroactivity for Medicare cancellations.

Cancellation of Case Coverage

You may cancel one or all of your group benefits. To do so, you must notify CBIA at least 15 days prior to the requested cancellation. Coverages can only be cancelled as of the first of the month with proper notification.

If notification is not received 15 days prior to the requested cancellation date, coverage(s) will be cancelled as of the first of the next month. See **Page 22** for further instruction.

COBRA

COBRA is the federal law that requires certain employers to offer continuation-of-coverage to employees and their dependents when they become ineligible for coverage. See the "State and Federal Continuation Laws" section starting on **Page 40** for more information.

Continuation-of-Coverage

Federal and state laws require employers to offer employees continuance of their existing group insurance at their own expense when the employee or dependent is no longer eligible for the coverage. The employee or dependent remains on your group insurance bill, and the employee makes premium payments directly to you. See the "State and Federal Continuation Laws" section starting on **Page 40** for more information.

Definitions

Contributory

A benefit is considered contributory if you require your employees to share in the cost of that benefit through payroll deductions.

Conversion (To an Individual Policy)

Medical

After cancellation of coverage, employees may want to convert their medical insurance to individual policies. Benefits and premiums are not the same. Such employees will need to complete a Conversion form. The form is available by calling Aetna U.S. Healthcare. This form can be used at either of the following times:

1. Upon termination of an employee's individual coverage, if the employee does not elect continuation-of-coverage (for example, COBRA)
2. Following the termination of continuation-of-coverage

Note: The form must be submitted within 30 days of the last day of group coverage.

Life

After cancellation of coverage, employees may want to convert their life insurance to individual policies. The employee may convert any amount of life insurance up to, but not exceeding, the volume in force on the last day of coverage. The following steps are to be followed:

1. The employee will need to complete a Life Conversion form.
2. The form must be submitted within 30 days of the last day of group coverage.
3. The form is available by calling Aetna U.S. Healthcare.

Covered Employee

An employee is considered covered when he or she has been accepted and enrolled for benefits under the CBIA/Aetna U.S. Healthcare plan.

Disabled Employee

When an employee becomes totally disabled, you may continue coverage for the disabled employee (and dependents) as an active employee. You may continue coverage for the disabled employee for a length of time consistent with your personnel policy, but not to exceed 30 months. Once a disabled employee is no longer considered an active employee, he or she may be eligible for one or more of the following options:

- Continuation-of-coverage for any medical or dental coverage in force at the time of termination of employment
- Conversion to an individual Medical or Life policy
- Extension of Benefits (for the disabling condition only)

Definitions

Updated March 2000

If an employee is approved for "Extension of Benefits" by Aetna U.S. Healthcare, the ability to convert to an individual plan or continuation-of-coverage is not available after electing the "Extension of Benefits." However, "Extension of Benefits" will be available at the end of the continuation-of-coverage period. The conversion option is concurrent with the "Extension of Benefits" and must be applied for within 30 days of the loss of group coverage. See **Page 32** for more information on extension of benefits and **Page 34** for information on premium waiver for life and long-term disability coverages.

Eligible Employee

Eligible employees are defined as full-time employees regularly scheduled to work 30 hours or more per week. Employees who fall below the 30-hour-per-week schedule are no longer eligible for employer group coverage. They must be cancelled from the plan and advised of their right to continuation-of-coverage or conversion options.

Note: Employees who are 1099 employees are not eligible. CBIA reserves the right to require supporting documentation for employees' information at any time and may refuse enrollment or changes if the documentation is not provided.

Eligible Dependent

The following are considered eligible dependents:

- Legal spouse
- Unmarried natural children
- Unmarried stepchildren living with the employee
- Unmarried children for whom your employee has legal guardianship
- Unmarried adopted children or children placed for adoption with the employee
- Unmarried court-appointed dependents

A child-dependent can be covered to age 19, or to age 23 if a full-time student. A child will not be eligible if he or she becomes independent. Coverage for a disabled dependent can be extended if the dependent is disabled prior to reaching the limiting age. An Attending Physician's Statement (APS) must be completed and sent to Aetna U.S. Healthcare for approval.

Eligible Group (Case or Account)

A firm is an eligible group if it is actively engaged in business in Connecticut. The business must have been in operation for at least three months and have a signing officer at the Connecticut location. Seventy-five percent of eligible employees must participate in all lines of coverage (excluding employees who have medical coverage on their spouse's plan). Annual CBIA membership dues must be paid to participate in the CBIA/Aetna U.S. Healthcare insurance program.

Note: 1099 employees are not eligible for CBIA/Aetna U.S. Healthcare.

Definitions

Eligibility Period

At the end of the probationary period, new employees have 30 days to enroll by filling out and signing an enrollment/change form and Family Health Statement, if applicable. If the employee does not complete an enrollment/change form and Family Health Statement (if applicable) within this period, the employee is considered a late applicant and must wait for your company's next annual open enrollment.

Extension of Benefits

"Extension of Benefits" is a provision in most medical plans that applies to members who become totally disabled while covered under the plan. If group coverage ends as a result of the disability, this provision allows for up to 12 months of coverage, for the disabling condition only, at no cost. For more information on "Extension of Benefits," see the Aetna U.S. Healthcare health plan certificate of coverage, or call the member services department at the number on the back of the medical ID card.

If an employee is approved for "Extension of Benefits" by Aetna U.S. Healthcare, the ability to convert to an individual plan or continuation-of-coverage is not available after electing the "Extension of Benefits." However, "Extension of Benefits" will be available at the end of the continuation-of-coverage period. The conversion option is concurrent with the "Extension of Benefits" and must be applied for within 30 days of the loss of group coverage. See **Page 30** for more information on disabled employees and **Page 34** for information on premium waiver for life and long-term disability coverages.

Handicapped or Disabled Dependent

If an employee has a mentally or physically disabled dependent, the dependent may be eligible for coverage. Eligibility will depend on when the disability began and whether the individual is totally dependent on the employee for support. An Attending Physician's Statement must be completed and sent to Aetna U.S. Healthcare for approval. You will be notified whether the dependent is eligible for coverage. Continued proof of disability may be requested by Aetna U.S. Healthcare.

Health Maintenance Organization (HMO)

An HMO is a health plan that provides for all covered medical services through its network of doctors, hospitals and other health care facilities. Employees choose a Primary Care Physician (PCP) in the network who will manage their care. The insured pays a small fee each time care is received. There is no coverage for medical services received outside the network, except for urgent care.

Indemnity

Indemnity, or traditional, insurance is a type of insurance in which the employee files a claim for benefit reimbursement after services have been rendered by any recognized provider of services (fee-

Definitions

for-service). Reimbursement is available for the benefits included in the benefit package.
Reimbursement may be subject to limitations.

Late Entrant – Medical, Life or Dental Coverages

1. A new employee who does not elect coverage by the end of the probationary period is considered a late entrant. Coverage is not available until your company's next annual open enrollment, unless a special enrollment or qualifying event occurs.

2. An existing employee who does not elect coverage within 30 days of a qualifying event is considered a late entrant. Coverage is not available until your company's next annual open enrollment, unless a special enrollment condition arises.

Late Entrant – Long-term and Short-term Disability Coverages

A late entrant is an employee (either new or existing) who did not elect coverage when first eligible. The employee may complete and submit an Aetna U.S. Healthcare Evidence of Insurability form to CBIA for processing. Approval of coverage is not guaranteed.

Managed Choice or QPOS Plans

Managed Choice (MC) or Quality Point of Service (QPOS) plans have networks of doctors, hospitals and health care facilities. Employees and their dependents choose a Primary Care Provider (PCP) from the network who will manage their care. Employees pay a small fee each time they receive care within the network. However, the MC or QPOS plans allow employees and their dependents to see non-network doctors if the employees are willing to pay more for those services.

Medicare

Medicare is the federal health insurance program for most people over 65 and for certain disabled people. Medicare may be the primary or secondary payer for your employees' claims, depending on your company's size and the individual's status. In addition, to be eligible for a Medicare primary plan, your employee must be enrolled in both parts of Medicare, Parts A & B. Refer to the "Medicare" section on **Page 38** for more information.

Noncontributory

If you do not require employees to share in the cost of their benefits through payroll deductions, coverage is considered noncontributory.

Definitions

Open Enrollment

As an employer, you are obligated to offer an annual open enrollment period for your employees. At that time, employees must be notified of any additions or changes to their benefits. At open enrollment employees may:

- Add coverages or dependents if they were previously considered late entrants for medical, life and dental coverage
- Change or cancel their plan of benefits
- Waive or elect not to be covered by any of the plans offered
- Cancel coverages

To ensure accessibility of benefits for employees, this enrollment process must be concluded no later than 30 days prior to the renewal date. All enrollment/change forms and Family Health Statements must be sent to CBIA immediately following open enrollment.

During open enrollment, employees are not eligible to enroll in any ancillary lines *except for dental and life insurance under $75,000*, if the ancillary lines were not chosen when first offered. Ancillary lines other than dental and life can be applied for only as a late entrant.

Premium Waiver

If your employee is under age 60 and becomes totally and permanently disabled while employed, a "waiver of premium" for life insurance is available. Premium waiver is continued life insurance coverage during a period of total disability, without the requirement for a monthly premium payment. You must apply to Aetna U.S. Healthcare for a "premium waiver" between the ninth and 12th month of the employee's total disability. This provision also applies to long-term disability coverage.

Note: For additional information and/or certification of disability, contact Aetna U.S. Healthcare.

Primary Care Provider (PCP)

The Primary Care Provider (PCP) is the physician whom your employee or dependent selects to be responsible for managing their health care services. The PCP will make referrals to specialists and hospitals as necessary. A PCP is defined as a family practitioner, general practitioner, internist or pediatrician.

Probationary Period

A probationary period is established by your company and is recorded on the Participation Agreement. During the probationary period, a new employee is not eligible for benefits. Coverages are effective the first of the month following the completion of the probationary period.

Definitions

Qualifying Event

A "qualifying event" is a life-status change that affects your employee or his or her dependent(s). A qualifying event may require your employee to add coverage or dependents to the plan, or it may result in the employee's or dependent's loss of eligibility for coverage.

In addition to the option of enrolling during the annual open enrollment period, an employee or dependent may enroll in one of the medical or dental plans offered by your company when a qualifying event occurs. When one or more of these changes occur, employees are also allowed to make changes in their other plan benefits. The following is a list of qualifying events. See **Pages 6 and 10**, respectively, for instructions on how to add or cancel employees or dependents. You will find a full explanation of qualifying events on **Page 14**.

- Adoption or placement for adoption
- Birth of a child
- Change from part-time to full-time status
- Court-ordered dependents
- Death
- Divorce
- Exhaustion of continuation-of-coverage
- Legal guardianship
- Loss of coverage
- Loss of dependent/student status
- Marriage
- New stepchildren
- Reaching age 65
- Reduction in hours
- Retirement
- Termination of employment

Rehire

An employee will be considered rehired if the employee returns to work within six months of the last day worked. Rehired employees can be returned to full-benefit status, based on your company policies. To be eligible for full-benefit status, the employee must have been enrolled for benefits prior to leaving your company. The employee is only eligible for the benefits/coverages that he or she had when as active employees. Coverage will begin on the first of the month following the rehire date. Employees who return to work after six months will be considered new employees and will need to satisfy the probationary period before becoming eligible for benefits.

Renewal

- Your renewal will occur once a year, depending on the effective date of your CBIA/Aetna U.S. Healthcare policy. To remain eligible for renewal, you must meet the definition of an eligible group and all participation requirements.
- At renewal time, the rates and benefits offered under the plan may change.
- As the employer, you are obligated once a year to offer an open enrollment period for your employ-

Definitions

ees. Your employees may switch benefit plans at this time.

- If you wish to change the coverages offered to your employees, your broker must notify your Aetna U.S. Healthcare account manager.
- Open enrollment is also the time when employees may enroll for benefits or add dependents if they previously waived coverage. (This does not apply to ancillary coverages except dental and life.)
- Employees who do not wish to make any changes at open enrollment do not have to complete any forms. The employee's current coverage will automatically be renewed.
- At renewal time, all employee birth dates are reviewed to ensure proper age-bracket rating.
- Your agent will provide you with the materials you will need to conduct open enrollment meetings.
- Materials will be available 60 days prior to your renewal and will be mailed to your agent.
- All employee changes that take place as a result of open enrollment should be sent to CBIA 30 days prior to your renewal date so that CBIA can process the information for billing and eligibility transfer.
- Employers must remain active members of CBIA.
- Employers who have outstanding premiums will not be renewed.

Termination of Employment

When an employee is no longer employed by your company, you must notify CBIA immediately to ensure proper credit on your bill. See **Page 10** for instructions on how to cancel an employee. You must offer continuation-of-coverage to the employee and any dependents who are losing coverage. See **Page 40** for more information on continuation-of-coverage. Retroactive premium credit will only be issued for the month in which notification is received and the prior month, if applicable.

Note: If the employee or dependent is covered by a Medicare Risk plan, the termination must be sent to CBIA in writing from each Medicare enrollee. There is no retroactivity for Medicare terminations. The enrollee must notify CBIA in advance to cancel.

SECTION VIII –
STATE AND FEDERAL REGULATIONS

State and Federal Regulations

MEDICARE OVERVIEW

When an employee reaches age 65, he or she becomes eligible for federal Medicare. Under your CBIA/Aetna U.S. Healthcare plan, two factors influence the options available to your employees and/or their dependents:

1. Whether or not your employee is going to remain actively at work or retire
2. Your group size (whether you have 20 or more full-time or part-time employees)

If your employee remains a full-time employee and you have *20 or more* full- and part-time employees, your group health plan is the primary payer, and Medicare will be the *secondary* payer for this employee's claims. The employee will remain on your bill at the regular active-employee group rates.

If your employee remains a full-time employee and you have *fewer than* 20 full- and part-time employees, Medicare will be the *primary* payer for this employee's claims. The employee will remain on your bill at a reduced premium.

If the employee retires, no matter how many employees you have, he or she will be eligible for the benefits you have selected for retirees. Medicare is always the primary payer for retirees as long as they are over 65 years of age.

You can change the retiree options for your company at any time, but not more than once a year. The change will be effective for all new retirees. To process a change, contact your agent, your Aetna U.S. Healthcare Account Manager or CBIA.

If your employee or any dependent is qualified under federal law as disabled, Medicare will be the secondary payer.

In cases where only one member of the family is over 65, Medicare is available (based on the above criteria) for that person. The remainder of the family will be covered by the active benefits from the regular CBIA/Aetna U.S. Healthcare plan.

Employees or dependents who elect enrollment in a Medicare Risk plan will need to complete both a CBIA/Aetna U.S. Healthcare enrollment/change form and the enrollment forms for the Aetna U.S. Healthcare Medicare plan they have chosen. For specific questions on eligibility, please contact your agent, your Aetna U.S. Healthcare Account Manager or CBIA.

TEFRA/DEFRA
CBIA/AETNA U.S. HEALTHCARE
Medicare Primary Status Chart

FEWER THAN 20 EMPLOYEES

Employee's Age/ Employment Status	Spouse's Age	Employee's Primary Carrier	Spouse's Primary Carrier
Under 65 and active	Over 65	Health Plan Company	Medicare A & B*
Under 65 and active	Under 65	Health Plan Company	Health Plan Company
Over 65 and active	Over 65	Medicare A & B*	Medicare A & B*
Over 65 and active	Under 65	Medicare A & B*	Health Plan Company
Under 65 and retired	Under 65	Health Plan Company	Health Plan Company
Under 65 and retired	Over 65	Health Plan Company	Medicare A & B*
Over 65 and retired	Under 65	Medicare A & B*	Health Plan Company
Over 65 and retired	Over 65	Medicare A & B*	Medicare A & B*

*Where Medicare is listed as the primary payer, the individual will be enrolled in the selected Medicare primary plan. In case of end-stage renal disease (ESRD), when enrolling in a Medicare risk plan, call Aetna U.S. Healthcare's Medicare Risk member services for clarification. The definition of employees is the total number of both full-time and part-time employees.

20 OR MORE EMPLOYEES

Employee's Age/ Employment Status	Spouse's Age	Employee's Primary Carrier	Spouse's Primary Carrier
Under 65 and active	Under 65	Health Plan Company	Health Plan Company
Under 65 and active	Over 65	Health Plan Company	Health Plan Company
Over 65 and active	Under 65	Health Plan Company	Health Plan Company
Over 65 and active	Over 65	Health Plan Company	Health Plan Company
Under 65 and retired	Under 65	Health Plan Company	Health Plan Company
Under 65 and retired	Over 65	Health Plan Company	Medicare A & B*
Over 65 and retired	Under 65	Medicare A & B*	Health Plan Company
Over 65 and retired	Over 65	Medicare A & B*	Medicare A & B*

*Where Medicare is listed as the primary payer, the individual will be enrolled in the selected Medicare primary plan. In case of end-stage renal disease (ESRD), when enrolling in a Medicare risk plan, call Aetna U.S. Healthcare's Medicare Risk member services for clarification. The definition of employees is the total number of both full-time and part-time employees.

State and Federal Regulations

State and Federal Continuation Laws

The federal Consolidated Omnibus Reconciliation Act of 1985 (commonly referred to as COBRA) and Connecticut state law (PA 97-268) require that covered employees or dependents who lose coverage under specified circumstances (qualifying events) be offered the right to continue health coverage at their own expense. Since there are severe tax penalties for employers affected by these laws who do not bring their plans into compliance, we strongly recommend that you review these laws to determine their impact on your company.

For employers who offer continuation-of-coverage, the following chart has been prepared for reference. In addition, CBIA has sample letters for your use to notify employees and dependents of their right to continuation. If you have any questions, please call your broker, your Aetna U.S. Healthcare Account Manger or your CBIA Customer Service representative.

	COBRA (FEDERAL)	STATE
Applies to	Employers with 20 or more employees, including state and local governments receiving certain federal funds; churches are exempt.	Employers with fewer than 20 employees, including state and local governments receiving certain federal funds; churches are exempt.
Plans covered	Hospital, medical, surgical, dental, prescription drug, hearing and vision group insurance plans.	Hospital, medical, surgical, dental, prescription drug, hearing and vision group insurance plans.
QUALIFYING EVENTS	**COVERAGE-CONTINUATION PERIODS COBRA (FEDERAL)**	**STATE**
Termination of employment — quit, fired, on strike, walk-out, or job elimination	Continuation is for a maximum of 18 months, unless termination was for "gross misconduct," in which case there is no continuation. (There is no definition of gross misconduct.)	Continuation is for a maximum of 18 months, unless termination was for "gross misconduct," in which case there is no continuation. (There is no definition of gross misconduct.)
Reduction of hours	18 months.	18 months.
Layoff	18 months.	18 months.
Death	The covered spouse and dependents may continue coverage for 36 months.	The covered spouse and dependents may continue coverage for 36 months.
Divorce and legal separation	The covered spouse and dependents may continue coverage for 36 months.	The covered spouse and dependents may continue coverage for 36 months.
Loss of dependent status	36 months.	36 months.
Disability	Individuals disabled within 60 days of a qualifying event may continue for 29 months.	Individuals disabled within 60 days of a qualifying event may continue for 29 months.
Multiple qualifying events	May extend the continuation period but not beyond 36 months.	May extend the continuation period but not beyond 36 months.
Notification	Plan administrators must notify qualified individuals of their legal rights within 14 days of the qualifying event. Spouses who become divorced or separated and dependents who reach the limiting age must notify the plan administrator within 60 days.	Under federal law, plan administrators must notify terminated employees, surviving dependents, and former spouses of their rights under the law within 14 days after eligibility of coverage ends. State law does not specifically address notification.
Election of continuation	Qualified individuals must notify the plan administrator of their intent to continue within 60 days of notification. All covered individuals have the right to make separate election.	Qualified individuals must notify the plan administrator of their intent to continue within 30 days of notification. All covered individuals have the right to make separate election.
First premium payment due	Within 45 days of election.	Within 30 days after eligibility for coverage ends.
Additional premiums	Are timely if received within 30 days of the due date (or the time allowed by the insurer, if longer). Premium must be paid directly to the employer.	Are timely if received by the employer by the due date; there is no grace period. Premium must be paid directly to the employer.
Continuation ceases when	Covered by another group plan; eligible for Medicare; employer terminates plan for all employees; person fails to pay premiums.	Covered by another group plan; eligible for Medicare; employer terminates plan for all employees; person fails to pay premiums.
Premiums employer may charge	Up to 102% of applicable group premium; in case of a disabled person, 102% for months 1-18, up to 150% for months 19-29. For self-insured plans, the charge may be based on actuarial estimates, or in certain cases, on the previous year's costs adjusted for inflation.	Up to 102% of applicable group premium; in case of a disabled person, 102% for months 1-18, up to 150% for months 19-29. For self-insured plans, the charge may be based on actuarial estimates, or in certain cases, on the previous year's costs adjusted for inflation.
Modifications to coverage	If coverage is modified (for better or worse) for active employees or their dependents, the benefits of continuees are similarly affected.	If coverage is modified (for better or worse) for active employees or their dependents, the benefits of continuees are similarly affected.
Plan packaging	Employers may not force continuees to accept separate vision or dental care coverages to receive medical coverage.	The person need not continue incidental coverages (dental, prescription drug, vision and hearing) if these are handled separately and the premiums can be broken out from the basic health coverage.
Conversion rights	Can choose to convert to an individual policy when the continuation period expires.	Can choose to convert to an individual policy when the continuation period expires.

State and Federal Regulations

HIPAA: Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 and applies to all group health plans with two or more participants who are current employees. HIPAA addresses nondiscrimination, enrollment rights and notices, health coverage certificates, and restrictions on pre-existing conditions.

Group health carriers may no longer establish eligibility rules for medical coverage based on health status factors. This means that evidence of insurability cannot be used to determine a late entrant's acceptance into the plan. All eligible applicants will be accepted into the plan provided the enrollment is requested within the 30-day time frame of becoming eligible to enroll, or at open enrollment. Family Health Statements, when applicable, will continue to be required to allow Aetna U.S. Healthcare the ability to make a determination about the Connecticut reinsurance risk pool.

Special enrollments were established to allow certain employees and/or dependents to enroll in a plan for medical (and dental) coverage without waiting until a company's next annual open enrollment. Employees who become enrolled through special enrollment cannot be subject to any pre-existing-condition exclusion longer than 12 months, and must be given credit for their prior coverage when certain requirements have been met.

Special Enrollments

The special-enrollment regulations allow an employee to enroll in a company plan when there is a loss of coverage. Enrollment due to loss of coverage must be requested within 30 days:

- after losing eligibility for previous coverage
- after employer contributions for a previous plan change
- after exhausting COBRA coverage that was in effect when the employee first declined a company's regular coverage

Special enrollment due to loss of coverage cannot be requested if the individual loses the other coverage as a result of failure to pay premiums or for cause.

- **New Dependents** — Special-enrollment regulations allow employees to enroll eligible dependents when the employee acquires new dependents through marriage, birth, adoption or placement for adoption. The employee may enroll the new dependent and any existing spouse or child who was previously not covered at this time. Requests to enroll new dependents must be made within 30 days of acquiring the new dependents.
- **Pre-existing Condition Notice** — A notice must be given to all existing and future employees advising them of any pre-existing condition exclusions and how the pre-existing condition period may be reduced or eliminated. To obtain a sample notice, contact CBIA Customer Service.
- **Certificate of Creditable Medical Coverage** — All employers and/or insurance carriers are obligated to send a "certificate of creditable coverage" to employees whose coverage was cancelled on Oct. 1, 1996, or thereafter. This document establishes that the employee and any dependents had coverage under the CBIA/Aetna U.S. Healthcare plan, thereby giving credit for that coverage against any pre-existing condition coverage exclusions that the new employer's plan may have. Notices are sent directly to cancelled employees by Aetna U.S. Healthcare. An individual may request a certificate of creditable coverage at any time within 24 months of the cancellation of coverage by calling Aetna U.S. Healthcare's member services. No certificates are available for coverage that terminated prior to July 1, 1996.

State and Federal Regulations

Family and Medical Leave Act (FMLA): What You Should Know

If your company is subject to the federal Family and Medical Leave Act (FMLA) and you have an employee who is out on FMLA leave, federal law mandates that you maintain the employee's group health coverage during the leave period. An FMLA leave is not a COBRA qualifying event.

Companies Affected

The federal FMLA applies to employers with 50 or more employees, including part-time and temporary employees, who have worked at least 20 weeks, not necessarily consecutively, in the current or preceding year. There is also a state Family and Medical Leave Act, which affects companies with 75 or more employees. The state law has additional leave requirements and different rules regarding employee eligibility and qualifying events. If you have questions about the state or federal FMLA, call CBIA's Management Services Division.

Employees Eligible for FMLA Leave

To be eligible for FMLA leave under the federal law, an employee must have been employed by the company for at least 12 months, not necessarily consecutively, and must have worked at least 1,250 hours in the 12-month period preceding the leave. The employee must also work at a site that has 50 employees, or at a site that is within 75 miles of other work sites of the company that together have at least 50 employees.

Acceptable Reasons for Taking FMLA Leave

Under the FMLA, eligible employees may take unpaid leave for any of the following reasons:

- The birth, adoption or the start of foster care
- To care for a spouse, child or parent who has a serious health condition
- For a serious health condition that makes the employee unable to perform one or more of the essential functions of his or her job

Notification and Certification

When a leave is foreseeable, an employer may require an employee to give a 30-day advance notice. In addition, the employer may require medical certification that a leave is necessary because of a serious health condition, and may require a second or third opinion at the employer's expense. When the leave period is up, the employer may require a fitness-for-duty report. The employer may deny or delay a leave request if these requirements are not met.

Job and Benefits Protection

For the duration of FMLA leave, the employer must maintain the employee's health coverage under any group health plan. Upon return from leave, the employee must be restored to his or her original or equivalent position, with pay, benefits and other employment terms that are equivalent to those the employee had before the leave. The use of FMLA leave cannot result in the loss of any employment benefit the employee had accrued before the start of leave.

State and Federal Regulations

Group Health Insurance Premium Payments During FMLA Leave

If an active employee normally pays part of the premiums for health coverage, the employee must continue to make these payments while on FMLA leave. If premiums are raised or lowered for active employees, the employee on leave must pay the new premium rate.

1. If a leave is substituted with paid leave (for example, if the employee uses vacation time for the leave), the employee's premium payments must be made in the same manner as during any other paid leave — for example, by payroll deduction.
2. If a leave is unpaid, an employee may be required to make payments to the employer, but no additional charges — such as for administrative expenses — may be added to the premium payment. The employer may require the employee to make premium payments in one of the following ways:
   - At the same time when payroll deductions would be made if the employee were still on active status
   - On a monthly basis
   - On a prepaid basis, if the employer has a "cafeteria" plan that meets the criteria of Section 125 of the Internal Revenue Service
   - Following the employer's existing rules for payment by employees on unpaid leave, as long as the rules do not require prepayment of premiums that will become due during the unpaid FMLA leave, and do not require higher premium payments than the employee would pay if on active status
   - By any system voluntarily agreed to by the employer and employee, including prepayment

When a leave is foreseeable, the employer must give the employee advance written notice of the method by which payments must be made. If the leave was not foreseeable, the notice must be given as soon as possible — usually within two business days — after the employer has learned of the leave.

ERISA Summary Plan Description (SPD)

The following information covering provisions of the Employee Retirement Income Security Act of 1974 (ERISA) is provided to you by the plan administrator. This information, together with the information contained in your employee's booklet-certificate, is the Summary Plan Description that plan administrators are required to provide to their employees by ERISA.

This information is provided so that you can comply with the ERISA reporting rules and regulations on a timely and accurate basis.

Claim Procedures

The booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna U.S. Healthcare. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted, in writing, within 60 days after you receive the notice. Include your reasons for requesting the review. Submit your request to the same Aetna U.S. Healthcare office to which you submitted your initial request for benefit payment.

State and Federal Regulations

Aetna U.S. Healthcare will review your claim and ordinarily notify you of its final decision within 60 days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 60 days following receipt of your request.

ERISA Rights

As a participant in the group insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

1. *Examine, without charge, at the Plan Administrator's office and at other specified locations such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports.*
2. *Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.*
3. *Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.*

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan.

The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- *the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory; or*
- *the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.*