

Group Admin Manual

Aetna Medicare



Secondary Benefit

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Table of contents

Overview 1

- General Overview 1
- Medicare Overview 1
- Product Overview..... 1

Overview of the Plans 2

- Aetna Medicare Advantage HMO —
The Aetna Golden Medicare Plan..... 2
- Aetna Medicare Advantage PPO —
The Aetna Golden Choice Plan..... 2
- Aetna Medicare Advantage PFFS —
The Aetna Medicare OpenSM Plan..... 3
- Medicare Advantage —
Prescription Drug (MA-PD) Plans 3
- Standalone Medicare
Prescription Drug (PDP) Plans 3

Eligibility Requirements ... 4

- Aetna’s Medicare Eligibility
Requirements for Employer
Group Health Plans 4
- Eligibility Requirements
for Medicare Advantage Plans
(MA, MA-PD and PDP) 4
- Purchasing Medicare
Part A or Part B 4
- Single Coverage Tier 4
- Non-Medicare Eligible Dependents..... 4
- Limited Income Subsidy
Eligibility Requirements 4
- Proof of Creditable Coverage
and Late Penalty Process 5

Enrollment 6

- Electronic Enrollment 6
- Paper Enrollment/Applications..... 6
- Overview of Enrollment
and Confirmation Process
between Aetna and CMS..... 6
- Obtaining Employer Group
Enrollment Forms..... 7
- Aetna Group-Specific
Election Forms 7
- CMS-Approved Group Medicare
Advantage Plan Materials..... 7
- Plan Sponsor-Specific Material..... 7
- Completing Enrollment Forms..... 7

Effective Dates of Coverage 9

- Effective Dates 9

Disenrollment Processes... 10

- Disenrollment Process
Entire Group (Single or
Multiple Service Areas)..... 10
- Disenrollment Process
Specific Member 11
- Disenrollment Process
Member Initiated 12
- Disenrollment Process
Retroactive Terminations 12

Miscellaneous Enrollment Transactions..... 13

- 1. Address Changes 13
- 2. Name Changes, SSN
Corrections, DOB Corrections 13
- 3. Plan Changes..... 13
- Renewal Process 13
- Group Benefits and Rate Release..... 13
- Mandated Benefits Changes 13
- Member Notification of Changes 13

Billing 14

- Miscellaneous Information 16
- Aetna Navigator™ 16
- Contracts/Group Agreements 17
- Form 5500 Disclosure 17
- Premium Billing Set Up..... 17
- Appendix 1 — Sample Letters..... ?
- Appendix II — Enrollment Forms ?

Overview

General Overview

The Aetna Medicare plans are offered through a Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS). These plans include the Aetna Golden Medicare Plan[®], an HMO; the Aetna Golden Choice[™] Plan, a PPO; the Aetna Medicare OpenSM Plan, a Private Fee-For-Service Plan (PFFS); and the Aetna Medicare RxSM Plan, a stand alone Medicare Prescription Drug Plan (PDP).

Aetna developed its reputation as a pioneer in Medicare with the payment of the first Medicare claim in 1966 and has since expanded its scope to become even more supportive of the rapidly aging population. With the increasing costs of health care, it is more important than ever to extend focus on retirees, the largest consumer group of health-related services, to build a stronger and more effective health care system.

Aetna maintains a commitment to providing solutions for both the plan sponsors and beneficiaries of Medicare-related products. Consistent with the company's overall mission, Aetna continues to place emphasis on helping people achieve health and financial security by providing easy access to safe, cost-effective, high-quality health care and helping them to protect their finances against health-related risks.

Since the creation of Medicare HMOs in 1976, the federal Medicare program has viewed Medicare beneficiaries as individuals. As a result, the regulations that were developed to protect beneficiaries do not reflect circumstances where an employer group health plan, a plan sponsor, may be involved. It is critical, therefore, that plan sponsors understand how the federal requirements differ from policies that the plan sponsor may follow for its other employees and retirees.

For purposes of this manual, the term "Aetna Medicare Advantage Plans" will refer to the Aetna Golden Medicare Plan, Aetna Golden Choice Plan and the Aetna Medicare Rx Plan. In most cases, the administration of each plan is the same; only the rules pertaining to access of care or benefits differ.

We appreciate the confidence you have expressed in Aetna by providing Aetna Medicare Advantage plans to your retirees.

Medicare Overview

Medicare is a federal health insurance program established for people age 65 and over and qualified disabled individuals who meet certain eligibility requirements. When an employee or dependent spouse approaches age 65, the Age Discrimination and Employment Act (ADEA) requires that an employer counsel these individuals regarding Medicare benefits. Individuals should be informed of eligibility requirements, how to apply for Medicare and how Medicare coverage operates in relation to your group health plan. Please consult with your legal counsel regarding your Medicare responsibilities.

Overview of the Plans

Aetna Medicare Advantage plans provide greater coverage than the Original Medicare plan, including routine vision exams, hearing aids and coordination of care. Each Aetna Medicare Advantage plan also includes preventive care, such as routine physical and hearing exams and access to complimentary health education programs.

Aetna Medicare Advantage HMO — the Aetna Golden Medicare Plan

HMO plans offer a network of doctors, medical specialists and hospitals for members to choose from. Features include low monthly premiums, no deductibles and virtually no paperwork. Members must select a primary care doctor to coordinate care, including referrals to specialists. All covered services must be provided by doctors and hospitals within the network.

Aetna Medicare Advantage PPO — the Aetna Golden Choice Plan

PPO plans provide all the benefits of HMOs, but also allow the member to visit any doctor or hospital for covered services, both inside or outside the network. Some benefits, however, may not be available outside the network. Members should consult the plan's Summary of Benefits for more information.

Medicare Advantage Private Fee-For-Service Plans (PFFS) — Aetna Medicare OpenSM Plans

Aetna Medicare Open Plans are Medicare Advantage Plans that provide access to health care from any licensed doctor or hospital that is eligible to receive payment from Medicare, agrees to treat the individual and accepts the Aetna Medicare Open Plan terms and conditions of payment. These plans are not limited by geography or network affiliation. Members should consult the plan's Summary of Benefits for more information.

Plan sponsors can offer our Medicare Advantage HMO or PPO plans in our network service areas, and offer a non-network HMO-style Aetna Medicare Advantage PFFS plan in all other areas, providing consistency of plan design to all their retirees nationally. Or, plan sponsors can choose to offer an Aetna Medicare Advantage PFFS plan exclusively in all areas nationally.*

*Restrictions may apply in New Mexico. See underwriting guidelines.

Medicare Advantage — Prescription Drug (MA-PD) Plans

By integrating our Medicare Advantage plans with our Medicare prescription drug coverage (known as an MA-PD plan), we offer a complete health coverage solution. In addition, we also have access to complete claim data, so we can better evaluate each member's health situation and bring the benefits of coordinated medical management programs to our members.

Since our MA-PD plans help maximize the health of our members, the long-term costs may be minimized. MA-PD integration also simplifies enrollment, billing, administration and communications, since it's all coordinated by one source.

Standalone Medicare Prescription Drug (PDP) Plans

Aetna offers a standard Part D prescription drug plan and enhanced plans in all 50 states that provide a broad menu of plan designs with different levels of pricing and coverage. There are more than 52,000 participating pharmacies in the Aetna network nationwide and a convenient mail order pharmacy service — Aetna Rx Home Delivery.

Members should refer to their Summary Plan documents for information about the plan of benefits in which they are enrolled.

Eligibility Requirements

Aetna's Medicare Eligibility Requirements for Plan Sponsors

Eligibility Requirements for Medicare Advantage Plans (MA, MA-PD)

To enroll in an Aetna Medicare Advantage plan, there are certain eligibility requirements that must be met. Retirees must:

- Be entitled to Medicare Part A (Hospital Insurance)
- Be enrolled in Medicare Part B (Medical Insurance)
- Reside within the Centers for Medicare and Medicaid Services (CMS)-approved Aetna Medicare Advantage plan service area (subject to change every January 1)
- Comply with the CMS guidelines regarding end-stage renal disease

Eligibility Requirements for Medicare Advantage Prescription Drug Plan (PDP)

To enroll in an Aetna Medicare Prescription Drug Plan, Retirees must meet these eligibility requirements:

- Be enrolled in Medicare Part A or Part B (Medical Insurance)
- Reside within the Centers for Medicare and Medicaid Services (CMS)-approved Aetna Medicare Prescription Drug Plan service area (subject to change every January 1)

Purchasing Medicare Part A or Part B

Retirees who need to purchase Part A or enroll in Part B should contact their Social Security office.

Single Coverage Tier

Medicare Advantage coverage is available only as "single" coverage. All dependents must qualify for Medicare Advantage coverage individually under their own Medicare claim number. Each Medicare Advantage member will have his/her own separate Aetna ID card and ID number.

Non-Medicare Eligible Dependents

If the employee/retiree is eligible to enroll in the Aetna Medicare Advantage Plan and has a spouse or dependents who are not Medicare eligible, the spouse or dependents may enroll in a non-Medicare group plan if a plan is offered by the plan sponsor (a "commercial plan"). The time frame for processing the commercial plan enrollment forms and release of the Aetna ID cards may differ from the processing time requirements for the Aetna Medicare Advantage Plan enrollment forms.

Limited Income Subsidy Eligibility Requirements

The Medicare Modernization Act also provides extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the federal government to the drug plan in which the Medicare beneficiary enrolls. The subsidy provides assistance with the premium, deductible and copayments of the program. Beneficiaries may apply for the Limited-Income Subsidy (LIS) with the Social Security Administration (SSA) or with their state Medicaid agency.

| TRANSACTION | | APPLIES TO INVOICE | REFERENCE | MEMBER NUMBER | NAME | SOCIAL SECURITY NUMBER | EFF DATE | POST DATE | CHARGE | CREDIT |
|---|----------|----------------------|-----------|---------------|-------------|------------------------|----------|-----------|--------|--------|
| ADJUSTMENTS TO AMOUNTS PREVIOUSLY BILLED: | | | | | | | | | | |
| SUBSIDY ADJ | 11223000 | 123456-005-PA01-0000 | MEJSXBJA | BRANNOCK | 080 XX 4589 | 021705 | 021705 | XXX.XX | | |
| SUBSIDY ADJ | 11223000 | 123456-005-PA01-0000 | MEQK0010 | MORAN | 004 XX 7445 | 021705 | 021505 | XXX.XX | | |
| TERM | 1122159 | 123456-005-PA01-0000 | MEGXHNSA | CONNOR | 223 XX 4589 | 020105 | 021705 | | | XX.XX |
| TERM | 11223000 | 123456-005-PA01-0000 | MEGXHNSA | CONNOR | 223 XX 9589 | 010105 | 021705 | | | XX.XX |
| TERM | 1122159 | 123456-005-PA01-0000 | METXHNNA | D KES | 224 XX 8858 | 020105 | 021705 | | | XX.XX |
| TERM | 11223000 | 123456-005-PA01-0000 | METXHNNA | D KES | 224 XX 8858 | 010105 | 021705 | | | XX.XX |
| SUBTOTAL | | | | | | | | | \$0.00 | \$0.00 |
| CASH APPLC | 11223000 | | | | | | 021005 | | | XXXX |
| AR ADJ | 11223000 | | | | | | 020805 | XXXX | | |
| NET ADJUSTMENTS CREDITS | | | | | | | | | | \$0.00 |
| SUMMARY OF NET ADJUSTMENTS BY INVOICE | | | | | | | | | | |
| INVOICE NUMBER 11222159 | | | | | | | | | | \$0.00 |
| INVOICE NUMBER 11223000 | | | | | | | | | | \$0.00 |
| TOTAL | | | | | | | | | | \$0.00 |

LOW-RESOLUTION
FOR PLACEMENT
ONLY

For information on how to apply or to determine eligibility, individuals may contact the Social Security Administration by mail, by telephone, on the Internet at www.ssa.gov or in person.

A copy of a Group Bill is provided above to outline how information on the Subsidy Eligibles is provided.

Proof of Creditable Coverage and Late Penalty Process

During the Aetna enrollment process, for any applications received after May 15, 2006, Aetna will require an applicant to provide valid proof about his/her coverage history in order to determine if there were uncovered months and if the Part D late enrollment penalty (LEP) applies, specifically if there were gaps of coverage of 63 days or more. Group members do have a Special Election Period (SEP)

that allows them to enroll after May 15, 2006, but if they incur a period of over 63 consecutive days without a Part D plan or other creditable coverage after their Initial Election Period (IEP) ends (May 15, 2006 for those beneficiaries who were Medicare eligible on or before January 1, 2006), the beneficiary may be responsible for a LEP.

Aetna Plan Sponsor Services must enter the number of “uncovered months” between the beneficiary’s original eligibility end date and the date for which they are applying for Part D coverage and submit that data to CMS. Since CMS does not count the first half of the month of May, the earliest enrollment date that would be subject to a penalty is August 1, 2006. CMS then computes the penalty. For example, for each “uncovered” month, CMS will assess the beneficiary 1% of the current year’s national base

beneficiary premium amount [e.g., 1% x \$32.70.00 x 10 months = \$3.27]. Even in the case where the beneficiary is enrolling in a \$0 Premium plan, CMS will assess the beneficiary. That data is relayed to Aetna and is provided to the plan sponsor on the month invoice.

When CMS responds to Aetna regarding the member’s enrollment, the LEP amount will be supplied to Aetna and automatically loaded into the Aetna eligibility system. The plan sponsor will be able to see the late penalty fee on the current premium page of the bill, under the column entitled “late fee.”

For electronically transmitted enrollment, the plan sponsor is held accountable for the integrity of the data it sends to Aetna, which is then sent on to CMS.

Enrollment

Electronic Enrollment

CMS now allows Medicare Advantage Plans to process group enrollment forms and voluntary disenrollment requests electronically. There are very specific requirements for electronic eligibility submission including data elements, submission requirements, use of approved forms, and record retention and CMS audit availability requirements. Aetna offers this option to qualified plan sponsors based on company size and electronic data processing capabilities.

At this time, Aetna EZenroll[®] and EZLink[™] are not available for the submission of Medicare Advantage enrollment records.

Your Aetna Account Executive can work with you and the Aetna eligibility team to determine if electronic eligibility submission is an option for your plan.

Paper Enrollment/Applications

- Overview of Enrollment and Confirmation Process between Aetna and CMS
- Obtaining Employer Group Enrollment Forms and Other Employer Group-Specific Material
- Completing Enrollment Forms

Overview of Enrollment and Confirmation Process between Aetna and CMS

After an enrollment form is entered into the Aetna eligibility system, an electronic file is created that is sent and used by CMS to verify Medicare Parts A, B and D eligibility for each person enrolled in a Medicare Advantage plan. After this verification process is completed, a Plan Acceptance Letter is sent to the Medicare beneficiary with information about the proposed effective date of coverage. The Aetna Medicare Advantage plan ID card is issued within a few days of the Plan Acceptance Letter and mailed to the retiree's permanent home address. In general, a member can expect to receive an ID card within 7 to 10 days after the enrollment record is entered into the Aetna eligibility system. CMS requirements provide that enrollment forms that contain all necessary information be processed within 14 days of receipt by the plan.

If the group enrollment form is incomplete or Medicare eligibility cannot be verified, a letter is generated by the Aetna Plan Sponsor Services Unit to the retiree requesting the additional information needed to complete the enrollment. **The enrollment process will not continue until the additional information is**

received and Medicare eligibility is verified. Three outbound attempts are made by Plan Sponsor Services to obtain the missing information. If the needed information is not provided by the retiree within 21 calendar days, the application will be rejected as it is assumed the retiree is no longer interested in the Medicare Advantage plan.

The final step in completing enrollment in the Medicare Advantage plan is confirmation by CMS. At least once each month, CMS will review the transaction files submitted by Aetna and provide an electronic confirmation or reply tape to Aetna. After this is done, Aetna will send the member a Confirmation of Enrollment Letter advising the retiree the enrollment process is complete.

In the event CMS denies the enrollment in the plan, the retiree will be held responsible for services received through the plan.

Samples of some of the common enrollment letters are shown in Appendix I:

- Plan Acceptance Letter
- Missing Information Letter
- Pre-Enrollment Denial Letter
- Denial Letter

Obtaining Plan Sponsor Enrollment Forms

Please contact your Aetna Account Executive to obtain the appropriate Aetna Medicare Advantage Employer Group enrollment form. Samples of enrollment forms are shown in Appendix II.

Aetna Group-Specific Election Forms

Please make sure that the Employer Group enrollment forms are used. If a group-sponsored retiree completes an “individual” enrollment form, the retiree will be enrolled in an individual Medicare Advantage plan without any enhanced group benefits. If the employee/retiree has a Medicare-eligible spouse who is eligible to enroll through the group plan, the spouse must complete a separate Aetna Medicare Advantage enrollment form to enroll. Each person enrolled will receive an Aetna Medicare Advantage ID card.

CMS-Approved Group Medicare Advantage Plan Materials

Aetna has group-specific Medicare Advantage enrollment materials that have been approved by CMS for use with beneficiaries. These materials include group Medicare Advantage enrollment forms, group copay sheets, provider directories and plan brochures.

Plan Sponsor-Specific Material

Plan sponsors are encouraged to develop their own material to describe contributions, benefits and enrollment procedures. Plan sponsor-developed material does not require CMS approval prior to use, except employer-specific Medicare Advantage enrollment forms. If a plan sponsor requires a unique Medicare Advantage enrollment form, CMS approval must be obtained prior to use and annually thereafter. The approval must also be on file with Aetna’s Compliance department. As an additional service to plan sponsors, Aetna encourages review of any plan sponsor materials by our Marketing and Legal teams to help ensure accuracy. If a review or CMS approval of plan sponsor materials is desired, please contact your Aetna Account Executive to coordinate.

Any requests by a plan sponsor for Aetna to develop and/or mail sponsor-specific materials may require approval from CMS and Aetna’s legal department.

Aetna’s Customized Communication Group provides a wide variety of creative services to assist plan sponsors with the development and production of customized, plan sponsor-specific materials. Your Aetna Account Executive can provide you more information about CCG and its services and assist with obtaining approval of customized forms and materials.

Completing Enrollment Forms

Retirees must complete a group Medicare Advantage enrollment form to enroll. Please review all enrollment forms for completeness to ensure proper processing and timely issuance of ID cards and forward it to Aetna at the address below. Employers should keep “Employer Copy” and the retiree should keep the “Applicant Copy” of the form for their records.

Third-party administrators (TPA) may submit paper enrollment forms to Aetna at the address below. The TPA should keep “Employer Copy” and the retiree should keep the “Applicant Copy” of the enrollment form for their records.

The following data elements must be completed on the group enrollment form in order for Aetna to submit the eligibility record to CMS and issue and ID card:

- Name
- Permanent Address
- Social Security Number
- Medicare Claim Number (HICN Number)
- Gender
- Birth Date
- Plan Selection
- Provider Selection (for the Aetna Medicare Advantage HMO Plan)
- Employer Name and Group Number if known
- Employer Authorization Signature (or verbal employer confirmation)
- Proposed Effective Date of Coverage
- Enrollment Questions
- Applicant Signature (must be prior to requested effective date)
- Signature Date

- If anyone assists the employee in completing the enrollment form, he or she must also sign the enrollment form. (Please Note: If the retiree is unable to sign, a court-appointed legal guardian or designee authorized by state law must sign the enrollment form and attach a copy of the documentation that designates this person as the beneficiary's representative.)

Completed enrollment forms should be sent via USPS or any overnight carrier to:

Aetna — Retiree Markets
1425 Union Meeting Road
P.O. Box 963
Blue Bell, PA 19422
Attn: Medicare Plan Sponsor
Services Unit

Please enclose a cover page with the applications that shows:

- Number of applications submitted
- Name and phone number of sender in the event there are questions about the applications submitted.
- Date shipped or mailed

It is very helpful to provide an advance e-mail notification to the Medicare Plan Sponsor Services Unit in Blue Bell, Pennsylvania, of the pending arrival of applications. This will assist in the monitoring of applications and workflow. E-mails can be sent to **MedicarePSSBB@aetna.com**. In the subject line, please write: "Incoming Applications + the Group Name."

If Aetna determines that the group Medicare Advantage enrollment form is incomplete, the form cannot be processed and will be sent back to the beneficiary. The employer should keep the employer copy and the retiree should keep the applicant copy of the enrollment form for their records.

Effective Dates of Coverage

Effective Dates

Completed group Medicare Advantage and PDP enrollment forms received by the last business day of the month will be processed for an effective date of the first day of the following month.

Example:

A group Medicare Advantage enrollment form received on July 12 will be processed for an effective date of August 1.

Group enrollment forms may also be processed for a future effective date up to 90 days from the current enrollment cycle date when the following criteria are met:

- Enrollment form must be signed prior to the requested effective date
- Effective date must be indicated on the enrollment form

Example:

A group Medicare Advantage enrollment form received on July 12 that indicates a requested effective date of September 1 may be processed for a September 1 effective date.

CMS will allow Aetna to submit group Medicare Advantage & PDP enrollment forms with a retroactive effective date; however, the date cannot be prior to the signature date on the enrollment form and may not exceed 90 days prior to the current enrollment cycle date.

Example 1:

A group Medicare Advantage enrollment form received on June 12 that indicates a requested effective date of June 1 with a signature date of May 27 may be processed for a June 1 effective date.

Example 2:

A group Medicare Advantage enrollment form received on June 12 that indicates a requested effective date of June 1 but that has a signature date of June 11 will be processed for a July 1 effective date.

Disenrollment Process

Disenrollment Process — Entire Group (Single or Multiple Service Areas)

If the plan sponsor wishes to terminate the group Medicare Advantage and PDP plans in any or all of their service areas, a written request must be sent to the Medicare Plan Sponsor Services Unit for processing. The written request must include documentation of the proposed termination date, the group name, the group number and the service areas affected.

Please note that it is very important that a plan sponsor's written request for disenrollment be forwarded to the Medicare Plan Sponsor Services Unit as quickly as possible to help ensure timely notice from Aetna to the Plan Sponsor Medicare Advantage member(s) regarding disenrollment. All disenrollment requests should be sent to Aetna 60 days prior to the requested effective date. According to CMS, disenrollments of the entire plan sponsor may be processed when the plan sponsor or TPA agrees to notify its members of the termination and inform them of other health benefit options that may be available to them through the plan sponsor.

CMS requirements permit an entire group disenrollment if the plan sponsor agrees to send a letter/notification to affected members, alerting them of the

termination event and other insurance options that may be available to them through their employer, and provide timely notice (i.e., not retroactive) to Aetna of the entire group termination, so that Aetna may provide timely notice (as described below) to plan sponsor members.

In addition, Aetna must notify Plan Sponsor Medicare Advantage members at least 30 days prior to a plan sponsor termination that they have the option to enroll in an Aetna Medicare Advantage Plan as an individual member. Aetna will provide affected plan sponsor members with this notice 30 days prior to the plan termination. If Aetna receives written notice from a plan sponsor of a Medicare Advantage plan termination within 30 days or less of the requested termination date, Aetna will extend the termination date for such Plan Sponsor Medicare Advantage contract by one month in order to meet the required time frame for this member notification.

In summary, please note that the written member notification from Aetna advising the Medicare Advantage member of the plan sponsor contract/service area termination must: (1) be mailed to affected Plan Sponsor Medicare Advantage members at least 30 days prior to the proposed termination

effective date, and (2) advise Plan Sponsor Medicare Advantage members of the right to enroll in the Aetna Medicare Advantage Plan as an individual if available in their service area. These beneficiary protections are required by CMS for any Plan Sponsor Medicare Advantage termination, whether the plan sponsor chooses to terminate the entire contract or only certain service areas or counties within the contract.

Entire group termination and service area reduction dates can only be processed prospectively.

Once the written termination request has been received by the Medicare Plan Sponsor Services Unit, the following process will be used:

- A termination transaction will be entered in the Aetna system for all members within the Medicare Advantage group.
- The termination transactions will be forwarded to CMS for processing.
- The termination transaction will remain in pending status in the Aetna system until CMS confirms the termination.

- The Group Termination Letter will be sent to each affected Medicare Advantage member. The letter confirms that the member will be covered under Original Medicare, unless the member enrolls in the individual Aetna Medicare Advantage Plan, if available, or in another Medicare Advantage plan prior to the group plan disenrollment date.
- The Disenrollment Confirmation Letter will be generated to the member upon CMS approval of the termination transaction. If the plan sponsor requests that all existing Medicare Advantage service areas be terminated, Aetna will cancel the group plan once CMS confirms that all members have been terminated.

Please note that the Group Termination Letter and Disenrollment Confirmation Letter are CMS approved and cannot be modified by Aetna for specific plan sponsor requests without resubmitting to CMS for approval. Plan sponsors are encouraged to send their own notification regarding additional or alternate coverage provided to the retiree and the process for enrolling in that alternative plan.

Retroactive disenrollments are not allowed. Contact Aetna's Medicare Unit at Medicare Plan Sponsor Services, Attn: Appeal Request, to review the specific case for additional guidance.

Appeals must be sent in writing, with a letter signed by the member to:

Medicare Appeals Request
 Aetna — Retiree Markets
 1425 Union Meeting Road
 P.O. Box 963
 Blue Bell, PA 19422
 Attn: Medicare Plan Sponsor
 Services Unit — Appeals Request

Requests must indicate the following information:

Submission Date
 Group Name
 Group Number
 Aetna PSS Unit Number
 Submitted By
 Telephone Number
 Requested Termination Date
 Reason/Comments

All disenrollment requests should be forwarded to the Medicare Plan Sponsor Services Unit.

Medicare Disenrollment Forms/Requests

Aetna — Retiree Markets
 1425 Union Meeting Road
 P.O. Box 963
 Blue Bell, PA 19422
 Attn: Medicare Plan Sponsor Services Unit

Disenrollment Process — Specific Member

Employers establish criteria for their retirees to participate in an employer group-sponsored Medicare Advantage plan. CMS recognizes that this criteria is exclusive of the eligibility rules for enrollment in a Medicare Advantage plan.

For example, eligibility criteria to participate and receive employer sponsored benefits may include spouse/family status, payment to the employer of the members' part of the plan premium, or other criteria determined by the employer.

If an employer requests a specific Medicare Advantage member termination, the following must be received in the Medicare Plan Sponsor Services Unit, in written form or by completing the Employer Group Health Plan (Plan Sponsor) Medicare Disenrollment Form to disenroll a Medicare Advantage member from the plan sponsor. Please indicate in your written request if the basis for disenrollment is the loss of eligibility. If you do not indicate the basis for your disenrollment request, we will assume that the basis is the loss of eligibility. In addition, if the reason for the disenrollment request is due to the death of the member, please note this in your request so we may issue the most appropriate notice.

- Submission Date
- Group Name
- Group Number
- Aetna Plan Sponsor Services
- Unit Number
- Member Name
- Submitted By
- Telephone Number
- Requested Termination Date
- Reason/Comments

According to CMS requirements, CMS will permit a member's disenrollment due to loss of eligibility if the plan sponsor agrees to send a letter/notification to the affected members, alerting them of the termination event and other insurance options that may be available to them through their employer, and provide timely notice (i.e., not retroactive) to Aetna of the member's ineligibility, so that Aetna may provide timely notice (as described below) to the member.

Furthermore, at least 30 days prior to their termination, Aetna must notify Plan Sponsor Medicare Advantage members that have lost their eligibility to participate in a plan sponsor and that they have the option to enroll in an Aetna Medicare Advantage Plan as an individual member. Aetna will provide affected plan sponsor members with this notice 30 days prior to the date that the member becomes ineligible for participation in the plan sponsor. If Aetna receives written notice from a plan sponsor of a member's loss of eligibility within 30 days or less of the requested termination date, Aetna will extend the termination date for such member by one month in order to meet the required time frame for this member notification.

Example 1: On March 2nd an employer group sends Aetna notification to terminate a member, effective 4/1; however, the employer group shows proof that notification to the member

was sent prior to 30 days from the requested termination date, for example February 23rd. Aetna will terminate the member with an April 1st effective date.

Example 2: On March 2nd an employer group sends Aetna notification to terminate a member, effective April 1st; however, the employer group does not have proof that notification to the member was sent prior to 30 days from the requested termination date. Aetna will terminate the member with a May 1st effective date, as the notification to Aetna is less than 30 days from the requested effective date.

Aetna requests that all disenrollment requests be submitted to the Medicare PSS Unit 45 days prior to the requested date of termination.

Disenrollment Process — Member Initiated

Medicare Advantage plan members may independently submit a written disenrollment request directly to Aetna or through their local Social Security office. CMS requires Aetna to process these disenrollment requests regardless of plan sponsor enrollment. If Aetna receives written disenrollment requests directly from members, the requests are processed for an effective date of the first of the month following receipt of the request.

Generally, a Medicare Advantage disenrollment request will be processed for the first of the month following the written notification. If a Medicare Advantage member enrolls in another Medicare Advantage health plan, he/she will be automatically disenrolled from Aetna upon CMS approval of the new plan election.

In order to re-enroll, Plan Sponsor Medicare Advantage members will need to complete a new group enrollment form approved by the plan sponsor.

Disenrollment Process — Retroactive Terminations

Generally, retroactive disenrollments are not allowed. Retroactive disenrollments may be allowed when the Medicare Advantage member acted to disenroll in a timely fashion, but the plan sponsor was late in providing the disenrollment documentation to Aetna. CMS approval is required for such exceptions.

Your Aetna Account Executive can assist a plan sponsor with a review of individual Medicare Advantage materials or other plan options that a plan sponsor may send to participants in a plan that is terminated.

Miscellaneous Enrollment Transactions

1. Address Changes
2. Name Changes, SSN Corrections, DOB Corrections
3. Plan Changes

1. Address Changes

Member address changes should be communicated by the member directly with Aetna Member Services using the toll-free number listed on each member's Aetna ID card. If a member moves outside of the Aetna Medicare Advantage Plan service area, the member will no longer meet the CMS eligibility requirements and must disenroll from the plan.

2. Name Changes, SSN Corrections, DOB Corrections

If a name change is needed due to a typing error (i.e., application says "Willams" and name is "William"), a request can be sent to Plan Sponsor Services by mail or electronically by e-mail to MedicarePSSBB@Aetna.com.

Corrections to identifying information such as a Social Security number or date of birth, as well as a name change due to marriage or divorce, must be initiated by the Social Security Administration. The retiree should contact the local Social Security office.

Aetna is notified of these changes each month electronically. After the change is processed, if a new ID card is required by the member, it is sent automatically.

3. Plan Changes

All plan changes must be submitted on a plan change form and sent to Medicare Plan Sponsor Services BB for handling. Plan changes allow retirees to change their plan selection, provided another plan type is available. Sample plan change forms are provided in Appendix II

Renewal Process

Group Benefits and Rate Release

Your Aetna Account Executive will present a plan renewal package prior to the new plan year and will work with the plan sponsor to renew the benefits requested by the plan sponsor, taking into account the rates and benefits and members served by the plan that is offered.

Mandated Benefits Changes

During the year, Congress may mandate Medicare to provide coverage for specific items. These changes generally are effective the first of the year; however, effective dates may vary. CMS requires Medicare Advantage member notification of these benefits enhancements, as well as any other plan benefits changes.

Member Notification of Changes — Annual Notice of Change (ANOC)

Each October, CMS requires Medicare Advantage organizations to provide written notification to each Medicare Advantage member detailing all mandated benefits changes or enhancements, as well as any service area changes that affect all Medicare Advantage members. This Annual Notice of Change is sent to individual and group members.

In addition, group Medicare Advantage members must be provided with written notice of any change in benefits, contributions or service areas at least 30 days prior to the effective date of the change. This is called a "30-Day Change in Rules" notice.

This notice of plan changes is usually sent by the plan sponsor prior to December 1st each year. Records of the notification and the dates should be retained for possible CMS audits. For some plans, including those billed directly to members (see below), Aetna mails the Annual Notice of Change. Your Aetna Account Executive can assist you with understanding the notification and record retention requirements.

Billing

Medicare Advantage plans are billed each month. Bills are provided on a Group Bill, List Bill or Direct Bill basis. The following pages will provide additional data on each type of billing.

Group Bill — Bills are produced on the group level and sent directly to the plan sponsor/employer group. An example of a group bill is provided at right:

| MEMBER NUMBER | | NAME | SOCIAL SECURITY NUMBER | GRP-CLS-REG-PLAN | P V D M H I E S M S N F | COV | RATE \$ | LATE FEE | AMOUNT DUE |
|---|--|------------|------------------------|----------------------|-------------------------|-----|------------|------------|------------|
| MEJXXFXA | | AMER | 083 XX 5743 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEJXNDRA | | BELL | 008 XX | | D | SGL | \$337.70 | \$10.00 | \$347.70 |
| MEJSXBJA | | BRANNOCK | 080 XX | | D | SGL | \$219.70 | | \$219.70 |
| MEKXL010 | | CHAPMAN | 070 XX | | D | SGL | \$337.70 | | \$337.70 |
| MEJTXRKA | | CIAVARELLI | 060 XX | | D | SGL | \$109.70 | | \$109.70 |
| MEWVX010 | | COWDREY | 568 XX | | D | SGL | \$109.70 | \$10.00 | \$119.70 |
| MEJNX1JA | | CRAWLEY | 056 XX 5743 | 123456-005-PA01-0000 | D | CPL | \$219.70 | | \$219.70 |
| MEJZXTVA | | DACRES | 083 XX 7890 | 123456-005-PA01-0000 | D | PC | \$224.40 | | \$224.40 |
| MEKV1010 | | DIMMICK | 084 XX 4443 | 123456-005-PA01-0000 | D | FAM | \$337.70 | | \$337.70 |
| MEJNX1QA | | DUVAL | 074 XX 8800 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEKXG6LA | | FUCHELL | 800 XX 9000 | 123456-005-PA01-0000 | D | CPL | \$219.70 | \$10.00 | \$229.70 |
| MEFX010 | | GALDO | 800 XX 8844 | 123456-005-PA01-0000 | D | SGL | \$109.70 | \$10.00 | \$119.70 |
| MEHX2010 | | HALL | 086 XX 7899 | 123456-005-PA01-0000 | D | SGL | \$109.70 | \$10.00 | \$119.70 |
| MEJZXXVA | | HERRING | 073 XX 8833 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEB9X010 | | HOFFMANN | 045 XX 8880 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEJ0XP7A | | SARFIN | 584 XX 0000 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEKJVVYA | | VEERHAREN | 086 XX 8888 | 123456-005-PA01-0000 | D | PC | \$224.40 | | \$224.40 |
| MEBX1010 | | WARD | 075 XX 3564 | 123456-005-PA01-0000 | D | PC | \$224.40 | \$10.00 | \$234.40 |
| MEG8XMQA | | WARNER | 008 XX 0896 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MELY9010 | | WELSH | 008 XX 3064 | 123456-005-PA01-0000 | D | FAM | \$337.70 | | \$337.70 |
| MEZX9010 | | WHITE | 080 XX 7680 | 123456-005-PA01-0000 | D | SGL | \$109.70 | | \$109.70 |
| MEKGNQA | | WILCHER | 080 XX 8888 | 123456-005-PA01-0000 | D | FAM | \$337.70 | | \$337.70 |
| CHARGES FOR COVERAGE THIS PERIOD | | | | | | | \$4,227.50 | \$60.00 | \$4,287.50 |
| CHARGES FOR COVERAGE IN PRIOR MONTHS NOT PREVIOUSLY BILLED (SEE PAGE 3) | | | | | | | | | XXXX |
| TOTAL INVOICE 11223344 | | | | | | | | | XXXXX |
| ***** ITEMIZED COVERAGE AMOUNTS ***** | | | | | | | | | |
| 19 SINGLES | | | | | | | = | \$2,084.30 | |
| 9 FAMILIES | | | | | | | = | \$3,039.30 | |
| 5 COUPLES | | | | | | | = | \$1,098.50 | |
| 3 P/CHLDREN | | | | | | | = | \$673.20 | |
| 2 P/CHILD | | | | | | | = | \$448.80 | |
| 38 EMPLOYEES COVERED | | | | | | | = | \$7,344.10 | |

Adjustments each month are made at the end of each bill and include credits and charges that have been recorded since the last bill. A transaction description provides information on what type of adjustment is being applied to the account (late fee, subsidy adjustment, etc.). Please see the example at right:

| TRANSACTION | | APPLIES TO INVOICE | REFERENCE | MEMBER NUMBER | NAME | SOCIAL SECURITY NUMBER | EFF DATE | EFF TYPE | AMOUNT | CHARGE | CREDIT |
|---|----------|----------------------|-----------|---------------|-------------|------------------------|----------|----------|--------|--------|--------|
| ADJUSTMENTS TO AMOUNTS PREVIOUSLY BILLED: | | | | | | | | | | | |
| SUBSIDY ADJ | 11223000 | 123456-005-PA01-0000 | MEJSXBJA | BRANNOCK | 080 XX 4330 | 020105 | 021505 | XX | XX | | |
| SUBSIDY ADJ | 11223000 | 123456-005-PA01-0000 | MEK0010 | CONNOR | 004 XX 7445 | 020105 | 021505 | XX | XX | | |
| TERM | 11222159 | 123456-005-PA01-0000 | MEKXNSA | CONNOR | 223 XX 9589 | 020105 | 021705 | | | | XX.XX |
| TERM | 11223000 | 123456-005-PA01-0000 | MEKXNSA | CONNOR | 223 XX 9589 | 011005 | 021705 | | | | XX.XX |
| TERM | 11222159 | 123456-005-PA01-0000 | MEJXHNNA | DYKES | 221 XX 8853 | 020105 | 021705 | | | | XX.XX |
| TERM | 11223000 | 123456-005-PA01-0000 | MEJXHNNA | DYKES | 221 XX 8853 | 011005 | 021705 | | | | XX.XX |
| SUBTOTAL | | | | | | | | | \$0.00 | | \$0.00 |
| CASH APPLC AR ADJ | | | | | | | | | | | XXXX |
| NET ADJUSTMENTS CREDITS | | | | | | | | | | | \$0.00 |
| SUMMARY OF NET ADJUSTMENTS BY INVOICE | | | | | | | | | | | |
| INVOICE NUMBER 11222159 | | | | | | | | | | | \$0.00 |
| INVOICE NUMBER 11223000 | | | | | | | | | | | \$0.00 |
| TOTAL | | | | | | | | | | | \$0.00 |

| COV (COVERAGE) | | TRANSACTION DESCRIPTION | |
|----------------|-------------------|-------------------------|---|
| SGL | - SINGLE | AR ADJ | - ACCOUNTS RECEIVABLE ADJUSTMENT |
| CPL | - COUPLE | CALC COVG | - COVERAGE CALCULATION |
| PC | - PARENT CHILD | COB TERM | - COBRA TERMINATION |
| PQ | - PARENT CHILDREN | COB REINS | - COBRA REINSTATEMENT |
| FAM | - FAMILY | DEATH | - DEATH TERMINATION |
| | | DEP ADD | - DEPENDENT ADDITION |
| | | DEP REIN | - DEPENDENT REINSTATEMENT |
| | | DEP TERM | - DEPENDENT TERMINATION |
| | | DEP TERM CG | - DEPENDENT TERMINATION CHANGE |
| | | EFF DTE CG | - EFFECTIVE DATE CHANGE |
| | | GRP PLAN CH | - GROUP TO GROUP TRANSFER / PLAN CHANGE |
| | | NEW SUB | - NEW SUBSCRIBER |
| | | REINSTAT | - REINSTATEMENT |
| | | TERM | - TERMINATION |
| | | TERM DT CHG | - TERMINATION DATE CHANGE |
| | | CASH ADJ | - ACCOUNTS RECEIVABLE ADJUSTMENT |
| | | BILL PERIOD | - GROUPS BILLING PERIOD HAS CHANGED |
| | | RATE ADJ | - RATE ADJUSTMENT DUE TO RATE CHANGE |

| ABBREVIATION & DESCRIPTIONS | |
|-----------------------------|--|
| LILP | - Low Income Late Penalty Subsidy |
| LIS | - Low Income Subsidy |
| RBC | - Retirement Benefits Check |
| SPAP | - State Pharmaceutical Assistance programs |

LOW-RESOLUTION
FOR PLACEMENT

Finally, an index of terms is provided at the end of the bill. Please see the example at right

The last page of the bill contains information on how to contact your Aetna Billing Representative for any questions. Please see the example at right

| | | |
|---|---|--|
| ABC CORP 123 ANYWHERE ST PHILADELPHIA PA 19144 ATTN: JANL DOL (215) 775-0000 | numbers help to expedite the handling of your inquiry when contacting the billing assistance number below. | INVOICE NUMBER: 11223344 CUSTOMER NUMBER: AT 123456-0001 DATE PREPARED : 02 19 06 COVERAGE PERIOD : 03 01 06 - 03 31 06 |
| PLEASE INSERT SO OUR ADDRESS: | | |
| AETNA P O BOX 7777 - W8260 - 04 PHILADELPHIA, PA 19175 8260 (215) 775-2600 | MAIL CHECK IN THE ENCLOSED WINDOW ENVELOPE. QUESTIONS ABOUT THIS BILL CAN BE RESOLVED BY CALLING AN AETNA BILLING SERVICE REPRESENTATIVE AT (800) 444-2211. | NOTICE: AMOUNT DUE IS PAYABLE ON THE FIRST DAY OF THE MONTHLY COVERAGE PERIOD COVERED BY THE INVOICE. |
| SHOWS IN WINDOW OF RETURN ENVELOPE | | |
| INVOICE NUMBER: XXXXXX | ADDRESS FOR PROPER AND PROMPT HANDLING IS LISTED ON EACH STATEMENT. | BILLING ASSISTANCE NUMBER PROVIDED FOR STATEMENT FOR QUESTIONS. |
| PREVIOUS BALANCE: XXXXXX | CURRENT INVOICE: XXXXXX | ACTIVITY: XXXXXX |
| *** IF YOUR ORIGINAL RATE QUOTE(S) INDICATED PENDING RATES, YOUR INVOICE MAY REFLECT ADJUSTMENTS TO THE PENDING RATES DUE TO STATE REGULATORY DETERMINATIONS. ANY RATE ADJUSTMENT WILL BE REFLECTED ON THE DEBIT/CREDIT PAGE OF YOUR INVOICE. *** | | |
| TOTAL AMOUNT DUE | | |

LOW-RESOLUTION
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Direct Bill — Bills are produced on the member level and sent directly to the member. In order for a group to have direct bill, there must be a minimum of five eligible retirees enrolled in one of our Medicare Advantage (MA) or Prescription Drug Plans (PDP). The plan sponsor is obligated to select the plan design and communicate changes in benefits and/or billing rates to home-billed retirees. Upon renewal, there is a high probability that Aetna will charge an administrative fee for the direct billing service. If you wish to have direct bill, please communicate this to your Account Executive, who will then communicate to PSS to initiate the process.

Self Bill — available to groups with 300+ eligibles. The plan sponsor is responsible for all retroactive charges and credits that are generated from additions, deletions and changes that appear on their electronic roster. The plan sponsor must provide a summary sheet to identify payment submitted based on the group profiles. The payment must equal the total on the summary sheet. The service center that will be responsible for servicing the account has final discretion over the decision allowing a new or existing customer to utilize the self-billing format. For more information on Self Bill, kindly consult with your Aetna Account Executive.

Bills are produced by Aetna the third weekend of each month. Plan sponsors should receive their bills within 7-10 days from that time.

Please Note: List Billing, Service Fee Billing and Summary Billing are billing types available for Aetna Point-of-Service products only. They are not utilized by Medicare. In addition, consolidated billing is not available for Medicare.

Hold Bill — If a plan sponsor wishes to have a bill suppressed, or “hold bill,” they should contact the phone number provided on their statement for further instructions.

Miscellaneous Information

- Aetna Navigator™
- Contracts/Group Agreements
- Form 5500 Disclosure Section
- Premium Billing Set Up

Aetna Navigator™

Aetna Navigator is our secure member website. Aetna members can use Aetna Navigator to view personalized benefits and health information and complete a variety of self-service transactions online 24 hours a day, 7 days a week. Key features* for members include reviewing benefits information, performing transactions, accessing sources of health information, utilized tools to manage health care, and viewing personalized health topics and messages.

Members may visit Aetna Navigator at www.aetna.com. Once members register on the site, they can:

Review Benefits Information:

- Find out who is covered and primary care physician (PCP) or primary care dentist (PCD) selections; check claim status and EOB statements.
- Access Aetna’s pharmacy information, including our Preferred Drug List (formulary), participating pharmacies, Aetna’s mail-order drug program and prescription drug cost tools.
- Check Flexible Spending Account status, account balance(s), payment details and tools.

Perform Transactions:

- View temporary member identification information and request member ID cards.
- Obtain Aetna Member Services contact information and send an e-mail to Aetna Member Services, (also available in Spanish).
- Search our DocFind® online provider directory in English or Spanish.
- Change PCP selections.
- Print Aetna standard forms.
- Request e-mail alerts on the home page when new information is available.

Access Sources of Health Information:

- Visit Aetna IntelliHealth® website, our award-winning consumer website, for credible health, dental and wellness information.
- Use Healthwise® Knowledgebase, a user-friendly online medical encyclopedia and decision-support tool.

Utilize Resources to Manage Health Care:

- Compare the estimated average cost for health care services. Review costs for medical and dental procedures, office visits, medical tests, medical diseases and conditions, and prescription drugs.
- Access the Aetna Navigator Hospital Comparison Tool to review hospitals based on selected criteria.
- Use the Simple Steps To A Healthier Life® tool to complete a health assessment survey and received a tailored action plan.
- “Rate Your Medical Professional” through an online survey that allows members to provide feedback on Aetna providers.

Contracts/Group Agreements

Each plan sponsor will receive a contract, also known as a Group Agreement, from Aetna every year. The plan sponsor is required to review the document and send to Aetna a signed and dated group agreement within 30 days. In addition, each group Medicare Advantage member will receive a CMS-approved Evidence of Coverage document that will describe the benefits and rules available under the Medicare Advantage plan. The Evidence of Coverage document will be updated each year and mailed directly to retirees. Typically, this is done by the end of the first quarter or within 30 days of enrollment if the enrollment is recorded after the start of the new plan year.

Form 5500 Disclosure

Aetna provides plan sponsor with a Form 5500 Disclosure Statement that provides information that can be used to complete Schedule A of Form 5500. The Disclosure Statement summarizes the premium billed and paid for the calendar or plan year.

Your Aetna Account Executive can assist you with requesting a Form 5500 Disclosure Statement.

Premium Billing Set Up

For electronic premium billing set up, plan sponsors are encouraged to send their Medicare plan payments separate from the other plans to ensure accuracy of posting and reconciliation. For additional information about Premium Billing Set Up, please contact your Aetna Account Executive. He/she will contact the appropriate area, based on group account size.

Ongoing Reconciliation — This is handled by the billing contact in each market segment. For questions, please call the phone number located on your statement.

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

Aetna Medicare Advantage Plans: Coverage is provided through a Medicare Advantage organization with a Medicare contract and benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Aetna Medicare RxSM Plans: Coverage is provided through a Medicare Prescription Drug Plan Sponsor with a Medicare contract and benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

Information supplied by Aetna IntelliHealth[®] is for informational purposes only, is not medical advice and is not intended to be a substitute for proper medical care provided by a physician.

NOT FOR DISTRIBUTION TO MEDICARE BENEFICIARIES

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