Quality health plans & benefits
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Intelligent solutions

Pennsylvania ACA underwriting brochure

Groups effective January 1, 2018 and later
For businesses with 1-50 total average employees

www.aetna.com
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This material is intended for brokers and agents, and is for informational purposes only.

Underwriting guidelines

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

Note: State and federal legislation/regulations, including Small Group Reform and ACA, take precedence over any and all underwriting rules. Exceptions to underwriting rules require approval of the Underwriting Director. This information is the property of Aetna and its affiliates ("Aetna"), and may only be used or transmitted with respect to Aetna products and procedures, as specifically authorized by Aetna, in writing.

All underwriting guidelines are subject to change without notice.

Product Availability

Medical

- Groups may be written standalone or with ancillary coverage.
- May select up to 2 plans and we only require enrollment in 1 plan. The other plan can have zero member enrollment.

Dental

- 1 eligible employee - not available
- 2 eligible employees
  - Non-voluntary - all plans if packaged with medical.
  - Voluntary - not available.
- 3 to 50 eligible employees
  - Non-voluntary and voluntary plans with or without medical.
  - Voluntary dual option plans are not permitted.
- Orthodontic coverage
  - 2-9: not available
  - 10-50: available with 10 or more eligible employees with a minimum of 5 enrolled
  - Available for:
    - children only (standard handling)
    - adults and children in:
      - CA
      - FL Options 9A, 10A
      - GA Option 12A
      - MO DMO Options 1A - 6A
      - TN Option 5A
      - TX DMO Only (1A & 2A)

Vision

- Available to groups with 2 or more eligible employees
- Single option only (dual option, triple option not available)
- Vision only is allowed; or can be sold with medical and ancillary products

Life and Short Term Disability

- 2 to 9 eligible employees - if packaged with medical
- 10 to 25 eligible employees - if packaged with medical or dental
- 26 to 50 eligible employees - on a stand-alone basis

	• COBRA/State continuation enrollees and retirees are not eligible. • Product packaging rule is a group level requirement. Employees will be able to individually elect Life and/or Disability even if they do not elect medical coverage.
Case Submission Dates	• 1st of the month effective date - must be received by the 10th of the prior month. • 15th of the month effective date - must be received by the 25th of the prior month. • If the cut-off falls on a weekend or Holiday, next available business day will be the cut-off. • Incomplete cases will be moved to the next available effective date because we cannot process cases that are missing vital information.

COBRA and State Continuation

- COBRA applies to - group health plans sponsored by employers with 20 or more employees on more than 50% of its typical business days in the previous calendar year.
- Employers with less than 20 employees (full and part time) are eligible for state continuation.
- COBRA counting:
  - Include: full time, part time, seasonal, temporary, union, owners, partners, officers
  - Exclude: self-employed persons, independent contractors (1099), directors
  - Each part time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part time employee worked divided by the hours an employee must work to be considered full time
- COBRA is an employer directed law. Employers are responsible for notifying eligible plan participants of their COBRA rights upon loss of coverage.
- Because COBRA is directed at employers, the decision to comply with COBRA should be made by the employer. In situations where it may appear the employer is not subject to COBRA, for example a three life group requesting COBRA, we will ask the employer to "validate" the number of employees in the prior calendar year in order to determine the number of employees for COBRA purposes.
- Companies under common ownership are included in the count.
- COBRA and State Continuation is not billed separately and is included with the group bill.
- If the COBRA/state continuation participant does not reside in an Aetna service area, they are only eligible for out-of-network benefits if applicable or urgent/emergency care.
- Life and Disability - COBRA/state continuation participants are not eligible.
- Eligible enrollees are required to be included on the census.
- The qualifying event, length, start date and end date must be provided.
- COBRA/state continuation participants are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined according to the law applicable to the group, COBRA/state continuation participants can be included for coverage subject to normal underwriting guidelines.

Counting Employees to Determine Group Size based on the previous calendar year	• Total Average Employees (TAE) will be the method used in counting employees for determination of group size eligibility between the 1-50 market and 51-100 market. • Once the segment size is determined (1 to 50 or 51-100), we will use the applicable guidelines for product availability, participation, contribution, etc. • To calculate the TAE: 1. Count any employee receiving a W-2. This includes full time, part time, and seasonal workers who may or may not have been eligible for your medical coverage (this does not include 1099 independent contractors). 2. When calculating the average, consider all months of the **previous calendar year** regardless of whether the group has coverage with Aetna, or another carrier, or no coverage at all. 3. Add each month's number to get an annual total, and then divide by 12. (Example: 253 ÷ 12 = 21) 4. Use whole numbers only (no decimals, fractions, or ranges). Round up or down to the nearest whole number. (Example: 24.6 = 25) 5. Newly formed business - calculate the prior year average using only those months the group was in business; or use reasonable expected total employees if the group was not in business the prior year. • Illustrative Quote - use TAE count at time of quote. • New business submission - complete the 'Affordable Care Act (ACA) Medical Loss Ratio Requirement' field on the employer application. • Groups with 50 or fewer total average employees based on **previous calendar year** are rated as a small employer. • Groups with 51 or more total average employees based on **previous calendar year** are rated as a large employer. If the TAE is 51+ based on **previous calendar year** and the eligible is less than 51+, this is a 51+ group. Example: 90 TAE based on previous calendar year; 40 eligible - this would be a 51+ group.

Dependent Eligibility	• Spouse of employee. If both employee and spouse/partner work for the same company they may enroll together or separately, with the exception of two life groups, in which case the spouse must enroll separately.
	• A domestic partner may be covered as an eligible dependent if the employer elects this designation at contract effective or renewal date. If not elected at time of enrollment, approval of future request to add coverage for domestic partners will be postponed until the group's next anniversary date. If the plan sponsor elects to cover domestic partners, the plan sponsor is responsible for determining whether the domestic partner is eligible.
	• Children - medical and dental coverage
	  - Children are eligible as defined in plan documents in accordance with applicable state and federal laws, up to the end of the month when turning age 26, regardless of financial dependency, employment, eligibility of other coverage, student status, marital status, tax dependency or residency. This requirement applies to natural and adopted children, stepchildren and children subject to legal guardianship.
	  - At the request of the employer at contract effective or renewal date, medical coverage for dependent children may be extended to age 30 and must meet all of the following:
	    · Need not be a full time student
	    · Is not married
	    · Has no dependents
	    · Is a resident of this commonwealth or is enrolled as a full time student at an institution of higher education
	    · Is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program
	  - Children can only be covered under one parent's plan when both parents work for the same company.
	  - Grandchildren are eligible if court ordered. A copy of the court order must be submitted.
	  - Incapacitated child - attainment of limiting age will not terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance. The employee or member must provide to us proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as we may require, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
	• Children - life coverage
	  - Dependent children are eligible from birth up to their 26th birthday.
	• Individuals cannot be covered as an employee and dependent under the same plan.
	• Dependents must enroll in the same benefit option as the employee (participation is not required).
	• Dependents are not eligible for AD&D and disability.
	• Employee must elect life to purchase dependent life.

Effective Date	• The effective date must be the 1st or the 15th of the month. • The effective date requested by the employer must be within 60 days of the submission date.

Electronic Funds Transfer/ACH	• The first month's premium for new business can be processed via an electronic funds transfer/ACH. • Once the group is issued, customers can pay their monthly premiums online or by calling an automated phone number, **1-866-350-7644**, using their checking account and routing number. • There is no extra charge for this service.
Employee Enrollment	• Employee enrollment may be submitted via a paper enrollment or Aetna's eList Tool. The preferred method is eList. • If the eList tool is used be sure the employer keeps a copy of the paper applications on file for auditing purposes. • The eList tool is available on Producer World. • IMPORTANT: Be sure and download a fresh tool from Producer World for every group instead of saving one version to your desktop. • Enable the macros prior to entering data. • The tool must be completed in full. • The eList Tool format should not be amended in any manner. • When the eList Tool is used, the employee enrollment forms do not need to be included in the sold case submission. All the required information must be entered into the eList Tool. • Plan Selection column - be sure to include the Plan Name or Plan ID for each enrolling member and dependent. • Waivers should also be recorded in the eList tool. • COBRA/State continuation participants should be included and noted as COBRA/state continuation.
Employee Eligibility	• Eligible employees are those employees and active owners who are permanent and work on a full time basis, as defined by the employer, and who meet any authorized waiting period requirements. Our minimum acceptable hours per week is 25. • This includes a sole proprietor or partner of a partnership, if included as an employee in the health benefits plan of employer. • Coverage must be extended to all employees who meet the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. • Employees/individuals not eligible for coverage include 1099 contractors, temporary, seasonal, substitute or uncompensated employees, employees making less than equivalent minimum wage, volunteers, inactive owners, shareholders, officers or managing members who are not active, investors or silent partners. • Retirees are not eligible for any coverage - medical, dental, vision, life or disability. • Life and Disability - employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full time work for one full day.

Employer Contribution	**Medical**
	• Minimum of 50% of the employee-only cost of the lowest cost plan offered.
	• The employer may elect a defined-contribution strategy by defining the amount to contribute, which can be no less than 50% of the employee-only cost. For example, a minimum of $150 per employee.
	• Groups that do not meet contribution guidelines are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date.
	
	Dental
	• Non-voluntary:
	  • 2-50 with medical or standalone - employer must contribute at least 25% of the total cost or 50% of the cost of employee only coverage for Dental plans.
	• Voluntary:
	  • 3-50 with medical or standalone - employer contributes less than 25% of the total cost or 50% of the cost of employee only coverage, or if the coverage is 100% paid by the employee.
	
	Life and Disability
	• 2 to 9 eligible employees, employer must contribute 100% of the cost
	• 10 to 50 eligible employees
	  o Employer may contribute 100% of the cost or
	  o If employer contributes a portion, it must be at least 50% of the cost

Employer Definition	• The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code shall be treated as one employer. • Groups that do not meet the above definition of a small employer are not eligible for coverage.
Employer Eligibility	• There must be at least one enrolled W-2 employee who is not an owner and not an owner’s spouse. • Partners and LLCs filing as a partnership are eligible even if there are no W-2 employees. Husband and wife groups are not eligible. • Medical plans can be offered to sole proprietorships, partnerships or corporations. • Organizations must not be formed solely for the purpose of obtaining health coverage. • Associations, Taft Hartley groups, professional employer organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible. • Dental and Disability has ineligible industries. • The dental ineligible industry list does not apply when dental is sold in combination with medical.

Excluded Class/Carve Outs	**Medical** • Union employees are the only class of employees that may be excluded. Union employees are included in the total count of eligible employees in determining the case size. • Management carve-outs and other carve-outs are not allowed. • Groups that do not meet participation criteria are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date. **Dental** • 2-50: Allow Union employees to be excluded if excluded for medical, they may also be excluded for dental. • See the Underwriting Brochures in SalesWeb for state specific handling. **Life and Disability** • Union employees may be excluded if packaged with medical.
Forms	• Enrollment forms are available on Producer World.
Guaranteed Renewability	A group must be renewed unless one or more of the following exceptions apply: • Nonpayment of premium. • Fraud or intentional misrepresentation of material facts. • Failure to comply with participation or contribution requirements. • For network plans, failure to meet an insurer's service area requirements if no enrollee lives, works, or resides in service area. • Membership by a participating group in the association ceases if association group coverage. • Insurer discontinues a particular type of coverage or discontinues all coverage from the market.
Initial Premium	• The initial premium should be the total amount of the first month's premium for all products and may be in the form of a check or electronic funds transfer (EFT). • Submit a "copy" of the initial premium check payable to Aetna or complete the EFT/ACH form (Aetna form) with the new business group enrollment applications. When an EFT/ACH form is submitted, the form must be fully completed including the amount of the premium. • If a copy of the check is provided, once coverage is approved, you will be notified to send the check to the bank lockbox. If the check is not submitted, coverage will terminate retroactive to the case effective date. • If the EFT method is selected, we will withdraw the first initial premium from the checking account when the group is approved. This is a one-time authorization for the first month's premium only. • The initial premium check is not a binder check and does not bind Aetna to provide coverage. • If the request for coverage is withdrawn or denied due to business ineligibility, participation and/or contributions not met, the premium payment will not be processed. • If the initial premium is returned for nonsufficient funds, the standard termination process will be followed. • If the plan sponsor is currently with Aetna and adding additional products (medical, dental, life, disability, vision), no premium check is required.

Late Applicants	• An employee or dependent enrolling for coverage more than 31 days from the date first eligible or more than 31 days from a qualifying event is considered a late enrollee.
	• Applicants without a qualifying life event (that is, marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the late entrant guidelines as noted below.
	• Voluntary cancellation of coverage is not a qualifying event unless it is done at open enrollment. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event for being added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open enrollment to be eligible to enroll. However, if each spouse has different open enrollment dates and one drops coverage during their annual open enrollment period, that spouse is eligible to enroll.
	
	Medical
	• Late applicants without a qualifying life event (that is, marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) will be deferred to the next plan anniversary date of the group and may apply for coverage 30 days before the anniversary date.
	
	Dental
	• The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:
	    o The first 31 days the person is eligible for this coverage or
	    o Any period of open enrollment agreed to by the employer and us
	• This does not apply to charges incurred for any of the following:
	    o After the person has been covered by the plan for 12 months (24 months for ortho)
	    o As a result of injuries sustained while covered by the plan
	    o For services listed as visits and exams, images and pathology in the schedule of benefits.
	
	Life and Disability
	• Late applicants will be deferred to the next plan anniversary date of the group and may apply for coverage 30 days before the anniversary date.
	• The applicant will be required to complete an individual health statement/questionnaire and provide EOI.
	Example
	  o Group has $50,000 life with $20,000 guaranteed issue limit
	  o Late enrollee enrolling for $50,000 would not automatically get the $20,000
	  o Since the applicant is late he or she must medically qualify for the entire $50,000

Licensed, Appointed Producers	• Only appropriately licensed agents/producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna products. • License and appointment requirements vary by state and are based on the contract state of the small employer group being submitted. • To become appointed with Aetna, go to Producer World.

Live/Work Situs	**Medical** • Eligible employees who live or work in PA, NJ, DE, MD, DC, VA, NY and CT (the situs region) will receive the same rates and benefits as the headquarters location. **Dental** • If a subscriber Lives or Works within a specified mileage range of a Plan Network, they are offered the Plan and Rates for that Network. **Life and Disability** • Employees are eligible for the plan selected by the employer.
Medicare (MSP) for CMS Reporting	• Each year, all carriers must report to CMS (Centers for Medicare & Medicaid Services) the number of Medicare secondary payer (MSP) groups and the number of employees based on the number of employees provided by the employer. • MSP is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the Aetna plan would pay primary to Medicare for active employees and would pay first when there are 20 or more total employees (full and part time) for 20 or more weeks during this calendar year or prior calendar year. - Include: full and part time, seasonal, temporary, union, owners, partners, officers - Exclude: self-employed persons, independent contractors (1099), directors, leased employees
Municipalities and Townships	A township is generally a small unit that has the status and powers of local government. A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town or village. A municipality is typically governed by a mayor and city council, or municipal council. • Groups must provide a Quarterly wage and tax statement (QWTS). • W-2 - Elected or appointed officials and trustees “may” be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS; rather, they may be paid via W-2. In that case, obtain a copy of their prior year W-2. • If elected officials are to be covered, provide a copy of the charter or contract indicating which classes or employees are to be covered, the minimum hours required to work per week to be eligible for coverage, and confirmation that coverage will be offered to all employees meeting the minimum number of required hours and that minimum participation will be maintained.
Newly Formed Business (in operation less than three months)	Groups must provide the following: • Proof of employer identification number/federal tax ID number; and • Quarterly wage and tax statement. • If a QWTS is not available, the most recent two consecutive weeks of payroll records that include hours worked, taxes withheld, check number and wages earned.

Open Enrollment for Groups Not Meeting Standard Participation or Contribution Requirements (medical only)	• Groups that do not meet our standard participation or contribution requirements are eligible to enroll for medical coverage during an annual open enrollment period. • Groups must be submitted between November 15 and December 15 of each year for a January 1 effective date. • Other Underwriting Guidelines still apply for all coverages including Medical. • Groups must provide the quarterly wage and tax statement. • Standard W-2 rules apply. • Groups must be complete and have all requirements in by December 15. No exceptions for missing items. • Ancillary coverage (life, disability, dental and vision) may be included along with medical during this open enrollment period. Standard participation and contribution requirements apply to ancillary coverage. • Groups that do not meet Aetna's standard participation and contribution requirements can only obtain coverage during this open enrollment period.
Out-of-Area	**Medical** • Out-of-area employees must be enrolled in a PPO plan if available. **Life and Disability** • Employees are eligible for the plan selected by the employer.

Out-of-Situs employees	**Medical** • Any active employee who lives in a state other than where the company is domiciled is considered an out-of-state employee. • Out-of-state employees must be enrolled in a PPO if available. • Health coverage is not available in Hawaii or Vermont to any group or resident located in these states. • Massachusetts employees - if the employee/group proceeds with a plan that does not meet Massachusetts credibility, the Massachusetts employee(s) could be subject to fines/penalties associated with Massachusetts credibility. For more information on Massachusetts credibility, please contact your CPA or financial advisor. • Groups located outside the state of Missouri with employees residing in the state of Missouri, those employees residing in Missouri are not allowed an OAMC or MC plan. They are only eligible for a PPO if available. **Dental** • Any active employee who lives and works outside of PA, NJ, DE, MD, DC, VA, NY and CT is considered outside the situs region. • Out-of-situs employees will be offered one of the dental PPO plans. Employees who fall outside a dental PPO network area will default to a comparable indemnity plan. These plans will not count as one of the two dual option plans. **Life and Disability** • Employees are eligible for the plan selected by the employer.

Participation Medical

Non-contributory plans (employer pays all)

- 100% excluding valid waivers

Contributory plans

- 60% excluding valid waivers, rounding down
  Example
  12 eligible employees; 4 covered under spouse's plan
  12 minus 4 = 8 x 60% = 4.8 = 4 (rounding down) must enroll

Valid Waivers

- Spousal coverage
- Parental group coverage
- Medicare, Medicaid
- TRICARE/CHAMPUS/CHAMPVA
- Military coverage
- Religious reasons
- Retiree coverage through a previous employer
- Group coverage through a second full time job
- Surviving spouse
- Association coverage
- COBRA from previous employer

All Plans

- Groups that do not meet the participation guidelines are eligible to enroll during open enrollment, November 15 through December 15, for a January 1 effective date.
- All eligible employees waiving coverage must complete the waiver section of the employee application.
- Waivers may be sent in a separate excel spreadsheet - it must include the employee name and reason for waiving. Be sure the employer keeps a copy of the paper applications on file for auditing purposes.
- Dependent participation is not required.

Participation Dental

Non-voluntary

2 to 50 with medical or standalone (round to the nearest)

- 2 to 3: 100% excluding valid waivers with a minimum of 2 enrolled employees
- 4 to 50 non-contributory: 100% excluding valid waivers
- 4 to 50 contributory: 75% excluding valid waivers. Minimum of 2 and 50% of total eligible employees must enroll.

Voluntary with medical or standalone (round to the nearest whole number)

3 to 50 with medical or standalone (round to the nearest)

- 3 to 50 contributory: minimum 30% excluding valid waivers and a minimum of 3 enrolled

Valid waivers

- Waivers are required.
- Example of a valid wavier:
  - Spousal waiver

Census Data

- 2-50: Census data must be provided which includes age/date of birth, gender, dependent status, residence zip code and industry of all eligible employees, retirees and COBRA/State Continuation enrollees.

Change in rates due to number of Employees

- 2-9: Not allowed.
- 10-50: An employer with a change in the total base of eligible and/or enrolled employees of 10% or more (increase or decrease) will be reviewed for a possible rerate.

Small Market Aetna Rating Tool (SMART)

- Select non-voluntary/standard or voluntary - don't select both or rates will be identical as SMART can only calculate one participation.
- If the participation is unknown, select 75% participation to get an idea of the rates.
- If requesting voluntary or dental is employee pay all, select 30% participation.

Participation Life and Disability	**Life and Packaged Plans 2-50 eligible employees**
	• 2-9 eligible employees, 100% employee participation is required
	• 10-50 eligible employees
	  o If Employer contributes 100% of the cost, then 100% participation is required
	  o If employer contributes 50% or more of the cost, then 75% participation is required
	• Coverage can be denied based on inadequate participation.
	• COBRA and state continuation participants are not eligible.
	• Retirees are not eligible.
	• Employees may elect life and/or disability even if they do not elect medical coverage and the group must meet the required participation percentage. If not, then life and/or disability will be declined for the group.
	Example
	  o 9 employees
	  o 3 waiving medical
	  o 9 must enroll for life

PEO (Professional Employer Organization) Groups covered under a PEO	• Groups that use the services of a PEO generally do not meet the definition of a small employer as the transfer of employees to the PEO in effect ends/severs the employer/employee relationship. The employees become part of the large PEO group, are considered employees of the PEO and are paid by the PEO. • Groups currently with a PEO that offers health coverage through the PEO are not eligible for coverage with Aetna. • Groups currently with a PEO who indicate health coverage is not available through the PEO must provide a letter from the PEO indicating health coverage is not available. • Groups that indicate they are with a PEO when sent in as a sold group and subsequently indicate they have terminated their PEO contract must provide a copy of the contract termination letter sent from the PEO to the client (employer) business. This letter must verify the cancellation of the leasing arrangement as well as the cancellation date. • Groups only using "payroll services" are eligible subject to meeting the standard underwriting guidelines for eligibility, participation, etc. The most recent Quarterly Wage and tax statement (QWTS) filed for the group is required. However, if health coverage is offered through the payroll company, the group is not eligible for health coverage with Aetna.
Plan Change Employee Level	**Medical** • Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events). **Dental** • Freedom-of-Choice - may change from DMO to PPO and vice versa at any time but must be received in Aetna underwriting by the 15th to be effective the next month. **Life and Disability** • Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events).
Plan Change Group Level	**Medical** • Groups may change plans on the plan anniversary date only. **Dental** • Dental plans must be requested 5 days before the desired effective date. • The future renewal date of the change will be the same as the medical plan anniversary

	date. **Life and Disability** • Groups may add or change life and/or disability on the anniversary date only. • The future renewal date of the change will be the same as the medical plan anniversary date.
Prior Aetna Coverage	• Groups that were terminated with Aetna in the past 12 months due to nonpayment must pay all premiums still owed on the prior Aetna plan before the new plan will be issued.
Rating Information	• Rates are member level rating based on each member's age and based on final enrollment. • Illustrative quotes should be processed via the quoting tools in Producer World. • Rates are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in census. • If any of the information we receive is determined to be incomplete or incorrect, we reserve the right to adjust rates.
Replacing Other Group Coverage	• Do not cancel any existing medical coverage until the employer has been notified of approval from the Aetna Underwriting Unit. • Dental - provide a copy of the benefit summary to receive credit for major and orthodontic coverage. - Preventive and Basic Plans DO qualify as having prior major coverage. These plans DO NOT qualify as having prior ortho coverage. - Preventive Only Plans DO NOT qualify as having prior coverage. - Discount Plans DO NOT qualify as having prior coverage.
Signature Dates	• The Aetna employer application and all employee applications must be signed and dated before and within 90 days of the requested effective date. • All employee applications must be completed by the employee himself/herself. • Electronic signatures are acceptable.

Spin-Off Groups (current Aetna customers leaving an Aetna group only)	We will consider the group with the following: • A letter from the group or broker indicating the group is enrolling as a spin-off. Letter needs to include the name of the group they are spinning off from and the name of the new spin-off group. • Ownership documents showing that the spin-off company is a newly formed separate entity. • A minimum of two weeks' payroll. If the group that is spinning off has been in business longer than two weeks, payroll will be required for the amount of time in business up to a maximum of six consecutive weeks.
Tax Documents 1 to 50 Employees	• Groups must provide a copy of the most recent Quarterly Wage and Tax Statement (QWTS): - Containing the names, salaries, etc., of all employees of the employer group. - Newly hired employees should be written in on the QWTS. - Terminated or part time employees should be noted accordingly on the QWTS. - Reconciled QWTS should be signed and dated by the employer. - If a QWTS is not available, explain why and provide a copy of payroll records. - The underwriter may request additional documentation, if necessary. • Sole proprietors, partners, and officers not listed on the QWTS are not required to submit tax documents. • For seasonal industries such as lawn and garden services, construction, concrete and paving, golf courses, farm laborers, etc., must provide four consecutive quarters of wage and tax reports should be submitted to verify the full time, consistent, continuous, employment of the eligible employees. • Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours, which must match the totals on Form 941.
Two or More Companies, Affiliated, Associated, Multiple Companies, Common Ownership	• All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. • Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following are met: - One owner has controlling interest of all businesses to be included; or - The owner files (or is eligible to file) an Affiliations Schedule, IRS Form 851, a combined tax return for all companies to be included. If they are eligible but choose not to file Form 851, please indicate as such. - All businesses filed under one combined tax return must be enrolled as one group. For example, if the employer has three businesses and files all three under one combined tax return, then all three businesses must be enrolled for coverage. If the request is for only two of the three businesses to be enrolled, the group will be considered a carve-out. - There are 50 or fewer employees in the combined employer groups. - Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups. - Underwriting reserves the right to final underwriting review, and may consider common ownership on a case-by-case basis. Example o One owner has controlling interest of all companies to be included: o Company 1 - Jim owns 75% and Jack owns 25% o Company 2 - Jim owns 55% and Jack owns 45% o Both companies can be written as one group since Jim has controlling interest in both

Benefit Waiting Period

- Insurers may not set waiting periods. Employers may set a waiting period for new employees from 0-90 days.
- Insurers must give newly eligible employees an enrollment period of at least 30 days.
- At initial submission of the group, the benefit waiting period (BWP) may be waived upon the employer's request. This should be checked on the employer application.
- The BWP for future employees may be the 1st or 15th of the month following 0 days, 30 days, 60 days, or exactly 90 days following the date of hire.
- A change to the BWP may only be made on the plan anniversary date.
- No retroactive changes will be allowed.
- Date of hire BWP is not available.
- Only one waiting period is available.
- BWPs must be consistently applied to all employees, including newly hired key employees.
- For new hires, the eligibility date will be the first day of the policy month following the waiting period, not to exceed 90 calendar days from the date of hire. Policy month refers to the contract effective date of the 1st or 15th.
  - If "0" days is selected, and the employee is hired on the 1st of the month, the effective date will be the date of hire.
  - If "0" days is selected, and the group has a 15th of the month bill cycle, and the employee is hired on the 15th of the month, the effective date will be the date of hire.
  - If "Exactly 90 Days" is selected, the enrollment eligibility date will begin 90 calendar days from the date of hire.
  - If the group has a 15th of the month bill cycle, the new hire will be effective on the 15th of the month following date of hire.

Examples	1st of the month following the BWP	15th of the month following the BWP
0 days	Date of hire: 4/1 Effective date: 4/1	Date of hire: 4/1 Effective date: 4/15
0 days	Date of hire: 4/18 Effective date: 5/1	Date of hire: 4/18 Effective date: 5/15
30 days	Date of hire: 4/18 Effective date: 6/1	Date of hire: 4/18 Effective date: 6/15
60 days	Date of hire: 4/18 Effective date: 7/1	Date of hire: 4/18 Effective date: 7/15
90 days exact	Date of hire: 4/18 Effective date: 7/16 not 8/1 – exactly 90 days from the date of hire	Date of hire: 4/18 Effective date: 7/16 not 8/15 – exactly 90 days from the date of hire

Vision

Guidelines

- Available to groups with 2 or more eligible employees.
- No minimum participation or contribution is required.
- The employer may only offer one vision plan to all employees.
- To enroll, submit a list of employees and dependents with vision plan indicated. The list can be sent via e-mail, Word doc, Excel spreadsheet or eList Tool. You can also mark “vision” on the employee application.
- The initial premium can be included with payment for medical, dental or life, or can be separate.
- Waivers are not needed as participation is not required.
- Retirees are not eligible.

Dental

Coverage Waiting Period

Non-voluntary 2 to 9 eligible employees and Voluntary 3 to 50 eligible employees

- Applies to 2-9 non-voluntary and all voluntary PPO and Indemnity: For Major and Orthodontic Services: employees must be an enrolled member of the employer's plan for 1 year before becoming eligible. Waiting Periods do not apply to DMO and 10+ non-voluntary.
- **2 to 9 eligible employees:**
  - Discount and preventive only plans do not qualify as previous coverage.
  - Virgin group (no prior coverage) - the waiting periods apply to employees at case inception as well as any future hires.
  - Takeover Groups (Prior coverage) – waiting period does not apply
- **3 to 50 eligible employees with medical and standalone**:
  - Discount and preventive only plans do not qualify as previous coverage.
  - Virgin group (no prior coverage) - the waiting periods apply to employees at case inception as well as any future hires.
  - Takeover Groups (Prior coverage)
  - Waiting Period waived for members enrolled at the time of takeover
  - Waiting Period applies to new enrollees
  - Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires must be covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage.
  - Discount dental and preventive only plans do not apply.
- Takeover/Replacement cases (prior coverage) need a copy of the last billing statement and schedule of benefits in order to provide credit. If a group's prior coverage did not lapse more than 90 days, the waiting periods are waived.
- In order for the waiting period to be waived, the group must have had a dental plan in place that covered Major (and Ortho, if applicable) **immediately preceding** our takeover of the business.
- The prior carrier plan does not have to have been in force for 12 months to be considered takeover. As long as the group had prior coverage for ortho and/or major services before the Aetna plan, the waiting period is waived at the group level.

Example:

- Prior Major coverage but no Ortho coverage.
- Aetna plan has coverage for both Major and Ortho.
- The Waiting Period is waived for Major services but not for Ortho services

Creditable Prior Coverage

- Must receive a copy of the benefit summary to receive credit for major and orthodontic coverage
- Preventive & Basic Plans DO qualify as having prior coverage of major.   These plans do NOT qualify as having prior coverage of ortho.
- Preventive Only Plans do NOT qualify as having prior coverage.
- Discount Plans do NOT qualify as having prior coverage.

Dental

Ineligible Industries

- All industries are eligible if sold with medical.
- The following industries are not eligible when dental is sold standalone or packaged only with life.

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

Open Enrollment

- Small Group non-voluntary/non-contributory plans with 10 - 50 lives are allowed open enrollments after the initial period. Employees/dependents who do not enroll when initially eligible are now eligible to enroll during a subsequent open enrollment period without being subject to the late entrant provision. This exception does not apply to voluntary Dental plans.
- If the Employer's enrollment policy permits enrollment outside open enrollment or life qualifying event date, the member would be subject to the "Late Entrant" Provision.
- 2 to 9 eligible employees and 2-50 voluntary: No exceptions will be made for Small group. Open enrollments after the initial one will not be allowed. Employees and dependent must enroll when initially eligible.

Dental

Product Packaging	• Refer to the dental benefit grid notes for plan availability.
	• DMO *(if available)* can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled (based on state requirements).
	• PPO can be sold standalone or packaged with the DMO *(if available)* as a Dual Option with a *minimum* of 2 enrolled, excluding Preventive Plans, , consumer directed and preventative /basic combination. *(Based on state requirements).*
	• Freedom-of-Choice *(if available)* cannot be packaged with any other option. It must be the only plan sold.
	• Triple option not available.
	• **Voluntary Plans**
	    o Dual Option
	        ▪ 3-9 - Not available for voluntary unless the state requires it.
	        ▪ 10-50 – Same as standard non-voluntary plans

Reinstatement	• Voluntary plans only- Members once enrolled who have previously terminated their coverage by discontinuing their contributions may not re-enroll for a period of 24 months. All coverage rules will apply from the new effective date including, but not limited to, the Coverage Waiting Period.

Life and Disability

Actively-at-Work	• Employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full time work for one full day.
Class Schedules	• 2- 9 eligible employees: one class only • 2 – 50 eligible employees: Up to 3 classes with a minimum requirement of 3 employees in each class; highest class cannot be more than 5 times the benefit of the lowest class if only 2 classes are offered.
Dependent Basic Life	• 10 to 50: o Dependent flat amounts available o AD&PL and Waiver of premium not available

Evidence of Insurability (EOI) / Proof of Good Health

Proof of Good Health/Evidence of insurability (EOI) means the person must complete an individual health statement and may have to submit to medical evidence through medical records at their expense. EOI is required when one or more of the following conditions exist:

- Life insurance coverage amounts requested are above the guaranteed standard issue limit.
- Late enrollee - coverage is not requested within 31 days of eligibility for contributory coverage.
- New coverage is requested during the anniversary period.
- Coverage is requested outside of the employer's anniversary period due to qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.)
- Reinstatement or restoration of coverage is requested.
- Dependent coverage option was initially refused by employee but requested later. The dependent would be considered a late entrant and subject to EOI, and may be declined for medical reasons.
- Requesting life insurance at the individual level and they are a late enrollee even if enrolling on the case anniversary date. Late enrollees are not eligible for the guarantee issue limit.

  Example

  - Group has $50,000 life with $20,000 guarantee issue limit
  - Late enrollee enrolling for $50,000 would not automatically get the $20,000
  - Since the applicant is late, they must medically qualify for the entire $50,000

Guaranteed Issue Coverage

- We provide certain amounts of life insurance to all timely entrants without requiring an employee to answer any medical questions. These insurance amounts are called "guaranteed issue."

Term Life	Guarantee Issue Amounts
2 - 9 Eligible Employees	$20,000
10 - 25 eligible employees	$75,000
26 - 50 eligible employees	$100,000

- Employees wishing to obtain increased insurance amounts will be required to submit evidence of insurability, which means they must complete a medical questionnaire and may be required to provide medical records.
- On-time enrollees will receive the guaranteed issue life amount.
- Late enrollees are required to submit evidence of insurability, must qualify for the entire amount and are not guaranteed any coverage.

Basic Life and AD&PL Schedule	• 2 – 9 eligible employees: Flat $10,000, $15,000, $20,000, $50,000 • 10 – 50 eligible employees: Flat $10,000, $15,000, $20,000, $50,000, $75,000, $100,000, $125,000
Basic Spouse Life	• 2-9: Not available • 10 – 50: $5,000 Flat: $5,000 Guarantee Issue for on-time enrollees; AD&PL and Waiver of Premium not available
Basic Child Life	• 2 – 9: Not available • 10 – 50: $2,000 Flat: $5,000 Guarantee Issue for on-time enrollees; AD&PL and Waiver of Premium not available.
Age Reduction Schedule	• Employees' original life amount reduces to: o 65% at age 65; 40% at age 70; 25% at age 75
Disability Definition	• Total disability and earnings loss of 20% or more • Non-occupational coverage
Disability weekly amount	• Weekly flat amount options: $100, $200, $300, $400, or $500 with a percentage of salary cap
Disability Elimination Period: Day Benefits begin	• Injury options: 1st day or 8th day • Illness: 8th day
Pre-existing Conditions Rule	• 3/12
Disability Duration	• 26 weeks

Life and Disability

Ineligible Industries

Disability 2-50 eligible employees

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

Job Classifications (Position) Schedules

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

Position/Job Class	Basic Term Life
Executives	$75,000
Managers, Supervisors	$ 50,000
All Other Employees	$20,000

Open Enrollment

- Not allowed

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