# Aetna

# Fully-Insured 51-100

## Underwriting Guidelines

### Plans effective January 1, 2024 and later

- Aetna – AZ, CT, DE, FL, GA, IA, IL, KS, KY, ME, MI, MD, MO,NC, NE, NJ, OH, OK, PA, SC, TN, TX, VA, and WV
- Aetna – LA (Dental and Vision Only)
- Aetna – MA (Dental Only)
- Banner|Aetna – AZ
- Innovation Health® – VA

**The following guidelines apply only to the states listed above.**

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Banner|Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered, underwritten, and/or administered by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Banner|Aetna is an affiliate of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna).

Each insurer has sole financial responsibility for its own products. Aetna and Banner Health provide certain management services to Banner|Aetna.

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Health benefits and health insurance plans are offered and/or underwritten by Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna). Each insurer has sole financial responsibility for its ownproducts. Texas Health Aetna are affiliates of Texas Health Resources and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Texas Health Aetna. Self-funded plans are administered by Texas Health + Aetna Health Insurance Company.

PPO and indemnity dental policies are insured by Aetna Life Insurance Company (Aetna). In Texas, the dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN). DMO plans are insured by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products.

This material is intended for brokers and agents and is for informational purposes only.

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# Introduction — underwriting guidelines

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

Note: Federal and state legislation/regulations take precedence over any and all inconsistent underwriting rules. Exceptions to underwriting rules require approval of the Director of Underwriting or Management. 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.**

## 51 – 100 employer definition

- A 51-100 employer means any person, firm, corporation, limited liability company or partnership actively engaged in business or self-employed, on at least 50 percent of its working days during the current 12 months, employed at least 51 employees on the first day of the plan year, but no more than 100 eligible employees*.
- If the employer has not been in existence for at least three consecutive months, underwriting management approval is required because more documentation is required.
- For the purposes of determining the number of eligible employees under this subdivision:
  - Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation shall be considered one employer, unless contrary to state law/restriction.
  - Employees covered through the employer by health insurance plans, or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act, shall not be counted.
  - Employees who are not actively at work but are covered under the employer's health insurance plan pursuant to workers' compensation, continuation of benefits or other applicable laws shall not be counted.
  - A 51-100 employer will continue as a 51-100 group until the plan anniversary date following the date the employer no longer meets the requirements of this definition, may be offered different plans as required by the law.

*COBRA/State Continuation participants do not count towards the number of enrolled employees to determine employer eligibility for the Aetna Fully-Insured product.

## Carve-outs/Excluded class

- Management carve-outs and other carve-outs are not permitted.
- Union employees are included in the total count of eligible employees in determining case size unless the union is covered under a collective bargaining agreement.
  - New Jersey: Union employees are EXCLUDED from the count in determining case size

## COBRA/State continuation

- COBRA applies to employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.
  - 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 number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.
- The employer must inform Aetna of any State Continuation/Mini-COBRA/Spousal Continuation beneficiaries. Aetna will allow these beneficiaries to enroll as required by law.

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- 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 group of 19 enrolled employees requesting COBRA, we will ask the employer to validate the number of employees in the prior calendar year to determine the number of employees for COBRA purposes.
- Companies under common ownership are included in the count.
- COBRA/State Continuation beneficiaries are not billed separately and are included with the fully-insured employer's bill.
- If the COBRA/State Continuation beneficiary does not reside in an Aetna service area, they are only eligible for out-of-network benefits, if applicable; or urgent/emergency care.
- COBRA/State Continuation eligible beneficiaries are required to be included on the census.
- The qualifying event, length, start date and end date must be provided.
- COBRA/State Continuation beneficiaries are not to be included for the purpose of counting employees in determining the case size.
- Subject to applicable law, Aetna reserves the right to revise the rates or issue a Non-Quote Notification (NQN) if the total number of COBRA/State Continuation enrollees exceeds 10 percent of the total number of eligible employees.

## Coordination of benefits

- The policy assumes that the plan that is administered will always pay medical claims secondary to no-fault automobile insurance personal injury protection coverage according to state law.

## Counting employees to determine case size

- Union employees are included in the total count of eligible employees in determining case size except if the Union is covered under a collective bargaining agreement.
- New Jersey: Union employees are EXCLUDED from the count in determining the case size.
  - Once case size has been determined to be Small Group Plus, union employees, as a class, may be excluded by the employer as not being eligible for coverage if covered under a collective bargaining agreement.
- The following describes the counting methodologies known as the Total Average Employee (TAE) Counting Methodology, Full-time Equivalent (FTE) Counting Methodology and Eligible Employees Counting Methodology.
  - The counting methodologies are used to determine rating segment for the Fully-Insured product.
  - The table below shows counting methodologies by state.
  - Not all states listed below have the Fully Insured 51-100 product available.

| State | 51-100 FI counting method | State | 51-100 FI counting method | State | 51-100 FI counting method |
|---|---|---|---|---|---|
| AK | TAE | KY | TAE | NY | FTE |
| AL | Eligible | LA | TAE | OH | TAE |
| AR | TAE | MA | FTE | OK | FTE |
| AZ | Eligible | MD | FTE | OR | FTE |
| CA | FTE | ME | Eligible | PA | TAE |
| CO | FTE | MI | Eligible | SC | TAE |
| CT | FTE | MN | TAE | SD | TAE |
| DC | FTE | MO | Eligible | TN | Eligible |
| DE | Eligible | MS | Eligible | TX | TAE |
| FL | TAE | MT | Eligible | UT | Eligible |
| GA | FTE | NC | FTE | VA | TAE |

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| State | 51-100 FI counting method | State | 51-100 FI counting method | State | 51-100 FI counting method |
|---|---|---|---|---|---|
| IA | Eligible | ND | Eligible | WA | TAE |
| ID | Eligible | NE | Eligible | WI | TAE |
| IL | TAE | NH | Eligible | WV | FTE |
| IN | TAE | NJ | FTE | WY | Eligible |
| KS | Eligible | NV | TAE | | |

## Total average employee counting methodology

- Calculate the average number of employees you employed for the entire previous calendar year. Here's who you need to include:
  - Employees in the calendar year prior to your policy effective date
  - All employees – they do not need to be eligible for insurance coverage
  - All employees for whom the company issues a W-2. This includes full-time, part-time, temporary, seasonal, salaried, and hourly workers
  - If you have multiple locations, include employees in all company locations
  - If you have multiple corporate entities, include employees in all entities that are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m) or (o))
- How to calculate:
  1. Count the number of employees for each month
  2. Add each month's total to get an annual total
  3. Divide the annual total by 12 (or divide by the number of months you had employees).
  4. Round up or down to the nearest whole number (examples: 24.6 = 25 or 24.4 = 24)
  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.

### To determine case size

- Illustrative Quote: Use the TAE count at the time of the quote.
- Groups with 50 or fewer total average employees in the prior calendar year are rated as a small employer no matter the number of eligible or enrolling employees is.
  - If the TAE is 1-50 in the previous calendar year and the eligible is more than 50, this is a 1-50 group. Example: 45 TAE based on previous calendar year; 65 eligible - this is a 1-50 group.
- Groups with 51 or more total average employees in the previous calendar year are rated as a large employer.
  - If the TAE is 51-100 in the prior calendar year and the number eligible is less than 51, this is a 51-100 group. Example: 60 TAE based on prior calendar year; 45 eligible – this is a 51-100 group.
  - If the TAE is 100+ in the prior calendar year and the number eligible is less than 101, this is a 51-100 group. Example: 115 TAE based on prior calendar year; 45 eligible – this is a 51-100 group.

## Full-time equivalent counting methodology

- Group size is only determined on issuance and at the time of renewal based on the prior calendar year. Midyear fluctuations in the number of employees do not affect a determination of group size. Since employers average their number of employees across months in the year, fluctuations are considered ahead of time.
- A business not in existence the prior year should calculate the group size based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year.
- Full-time employees are those who worked average of 30 hours or more per week for more than 120 days in a year (even if they are not enrolling for health coverage); or the number of employees the employer expects to work these

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hours. If the total number of employees isn't a whole number, round it down to the nearest whole number.

- Include in the count (even if they are not eligible or enrolling for health coverage):
  - All full-time employees of a group if the business is affiliated with another employer, under common ownership or a part of a controlled group.
  - Part-time employees who worked an average of less than 30 hours per week.
  - Union employees.
- Don't include the following employee types (although they may still qualify for coverage):
  - Owners of a sole proprietorship.
  - Partners, shareholders owning more than 2 percent of an S corporation, and owners of more than 5 percent of other businesses. It is possible they could be included if they met the definition of a common law employee and would need to provide documentation as a common law employee.
  - Family members or members of the household who qualify as dependents on the individual income tax return of a person listed in the bullets above, including a:
    - > Spouse
    - > Child (or descendant of a child)
    - > Sibling or stepsibling
    - > Parent (or ancestor of a parent) or stepparent
    - > Aunt or uncle
    - > Niece or nephew
    - > Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law
  - Seasonal workers working 120 days or less in a year. There is a limited exception to counting seasonal workers if counting them is what triggered the employer to be large rather than small. Only then should they not be counted.
  - Independent contractors (form 1099 workers) who are not common law employees.
  - COBRA/State Continuation unless there is a permitted exception under 42 USC 300gg-91 (d) (5).
  - Retired enrollees.
- How to calculate
  - Full-time employees that work at least 30 hours per week in any month are counted as one full-time employee. This amount is added to the number of part-time employees.
  - Part-time employees are counted by taking the hours worked by all part-time employees in a week and dividing that amount by 30.
  - Seasonal employees working up to 120 days in a year are not counted in the calculation.

**Example 1:**

| | | |
|---|---|---|
| 15 full-time employees working 30 hours or more | **=** | **15** |
| 5 employees working 20 hours per week | **=** | **3** (5x20 = 100÷30 = 3.33 = 3) |
| | | **18 Average number of FTE** |

**Example 2:**

| | | |
|---|---|---|
| 35 employees working 30 hours or more | **=** | **35** |
| 30 employees working 25 hours per week | **=** | **25** (30x25 = 750÷30 = 25) |
| | | **60 Average number of FTE** |

  - When the FTE in the **prior calendar year** is 51 or more and the eligible count is 100 or less it will always be Small Group Plus 51-100.

**Examples:** 60 FTE in the prior calendar year; 40 eligible – this is a 51-100 group. 115 FTE in the prior calendar year; 45 eligible – this is a 51-100 group.

### Eligible employee counting methodology

Current eligible employees will be used as the counting methodology. Refer to the **Employee Eligibility section** for the definition and criteria of an eligible employee.

## Dependent eligibility (medical only)

- Spouse of employee, domestic partners (same and/or opposite sex) – If employee and spouse/domestic partner work for the same company, they may enroll together or separately. If enrolling together, the group must still meet the minimum number of enrolling employees as stated in the **Employer Eligibility section**.
- Children
  - Children are eligible as defined in accordance with applicable federal and state law, up to the end of the month that the dependent turns age 26, according to state legislation. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.
    - > **CT:** Children are eligible up to the end of the policy year when turning 26.
    - > **FL & GA:** Children are eligible up to the end of the calendar year when turning 26.
    - > **OH:** Children are eligible up to the end of the month when turning 28.
  - Children over the age limit may request to continue medical coverage, depending on eligibility criteria, as noted below for the following states:
    - > **FL:** At the election of an employer offering group medical coverage, or the subscriber, a dependent child between the ages of 26 and 30 may request to continue medical coverage as a dependent up to the end of the year when turning age 30, on his or her parent's group coverage even after the child reaches the limiting age under the terms of the policy if he or she is:
      - Not yet 30 years of age; is unmarried; has no dependents of his or her own; is a resident of FL, or if not a resident of FL, is a full-time or part-time student; is not eligible for Medicare; and is not actually covered under another group, blanket, or individual health plan. The Florida Supplemental Dependent Enrollment Form must be completed.
    - > **IA:** Unmarried dependents age 26 and over are eligible if they are a full-time student at an accredited post-secondary institution. Each eligible dependent must confirm eligibility annually before their birthday. The IA Young Adult Enrollment Form must be completed.
    - > **IL:** Eligible dependents who are military personnel to the age of 30, if the policy provides for dependent coverage and the insured chooses to elect dependent coverage. The dependent must:
      - Reside in Illinois; have served as an active or reserve member of the United States Armed Forces; and be discharged or released from duty for reasons other than a dishonorable discharge. The IL Supplemental Dependent Enrollment Form must be completed.
    - > **NE:** Medical coverage for dependents may be extended beyond age 26 to age 30. The dependent:
      - Must be unmarried; reside in Nebraska or be enrolled on a full-time basis in any college, university, or trade school; and not eligible for coverage under another plan, either fully-insured or self-funded. The Nebraska Young Adult Enrollment Form must be completed.
    - > **NJ:** At the election of the employer, dependents beyond age 26 may remain on their parent's New Jersey fully-insured medical plan through age 30, until their 31st birthday. To be eligible, the parents of the over-age dependent must be actively covered under a New Jersey–issued group health contract. This does not apply to small groups situs in another state, regardless of where the employee resides. Eligible dependents must be the insured's child (by blood or by law) and must meet the following criteria:
      - Is younger than 31 years of age; unmarried; has no dependents; is a New Jersey resident or is enrolled as a full-time student; is not provided coverage as a named subscriber, enrollee, or covered person under any other health plan (cannot be entitled to Medicare); elects coverage before his or her 30th birthday; and the employee completes the New Jersey mandated form to enroll dependents up to age 31. The HINT Supplemental Enrollment

Information Form must be completed.

> **PA:** At the request of the employer, medical coverage for dependent children may be extended to age 30 and must meet the following criteria:

  - Is not married; has no dependents; is a Pennsylvania resident or is enrolled as a full-time student at an institution of higher education; and 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. The Pennsylvania DU30 Supplemental Enrollment Form must be completed.

> **WI:** Dependent child may be covered if he or she returns from active military duty and he or she:

  - Is a full-time student attending an accredited institution of higher education; while a full-time student attending an accredited institution of higher education prior to reaching age 27, was called up to active military duty in the national guard or in a reserve component of the United States Armed Forces; must apply to an accredited institution of higher education as a full-time student within 12 months of the date of his or her return from active military duty; and proof of full-time student status must be submitted yearly. The Wisconsin Supplemental Enrollment Form for Military Veteran Dependents must be completed.

- Children can only be covered under one parent's plan when both parents work for the same company.
- When the child works for the same company as the parent, the child may enroll separately as an employee or as a dependent under the parent's plan.
- Grandchildren are eligible if court ordered or mandated by state law to cover the grandchild under the plan. A copy of the court order will be required if enrollment is not mandated by law.
- 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 is chiefly dependent upon the employee or spouse/domestic partner for support and maintenance. Proof of incapacity and dependency shall be furnished to Aetna within 31 days of the child's attainment of the limiting age and, subsequently, as we may require it, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

- Dependents must enroll in the same benefits as the employee.
- COBRA/State Continuation dependent beneficiaries should be included and noted as COBRA/State Continuation in enrollment submission.

## Domiciled state

- The domiciled state is considered where the permanent legal company headquarters resides unless an exception is warranted by a unique situation and granted by Aetna Underwriting management.

## Effective date

- The effective date must be the 1st of the month.
- The plan's effective date may be requested up to 90 days in advance.

## Employee eligibility

- Eligible employees include the partners of a partnership but do not include an employee who works on a seasonal, temporary or substitute basis. An eligible employee shall include any employee who is not actively at work but is covered under the small employer health insurance plan pursuant to workers' compensation and COBRA/State Continuation.
- To be an eligible employee, each employee must meet the eligibility guideline to be counted under the normal work week hours rule of 25 hours or more.
- Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement.
- Employees not eligible for coverage include independent contractors (1099s) unless mandated by state law, leased,

part-time (working less than 25 hours), temporary, seasonal or substitute employees, uncompensated employees, employees making less than equivalent minimum wage, volunteers, inactive owners, directors, shareholders, officers, outside consultants, managing individuals who are not active, investors or silent partners.
- Groups with more than 10 percent retirees will receive a Non-Quote Notification (NQN) letter.
- The retiree must be covered currently with present carrier (must be shown on the bill roster or provide a copy of the ID card).
- If there were no retirees covered by the prior carrier, the employee must be covered as an employee on the bill roster.
- Provide the census for retirees.
- Retirees are not to be included for purpose of counting employees in determining the size of the group.

## Employee enrollment

- All enrollments are required when the case is submitted. Once 51-100 One Census has been submitted there will be no additional changes or enrollments permitted.
- Keep a copy of the paper enrollment forms on file for auditing purposes.
- If a group satisfies participation requirements based on the business eligibility section of the employer application, waivers are not needed for 51-100 One Census.
- For groups not waiving the benefit waiting period, employees in the benefit waiting period should not be included.
- COBRA/State Continuation beneficiaries should be included and noted as COBRA/State Continuation.
- All enrollments, including COBRA/State Continuation enrollments, must be completed prior to the group's effective date or renewal/plan anniversary date.
- At the time of sale, Individual Medical Questionnaires are required for any COBRA/State Continuation enrollee not included on the initial underwritten quote. Once a group has been issued or renewed, the open enrollment period is closed, unless mandated by state law. Late enrollments are not permitted.

## Employer contribution

- We require the employer to pay 50 percent of the total contributions for the cost of coverage/premium of the lowest cost plan option selection; or
- 50 percent of employee-only contributions for the cost of coverage of the lowest cost plan option selection, unless mandated by state law.

## Employer deductible funding

- An employer should not fund the deductible of the quoted health plan through an HRA or HSA at more than 50 percent annually.

## Employer eligibility

- For all groups domiciled in an Aetna Fully-Insured 51-100 eligible state, companies that are affiliated companies under Section 414 of the Internal Revenue Code, or that are eligible to file a combined tax return for the purposes of taxation under state law, shall be treated as one employer.
- Employees covered through a collective bargaining agreement shall not be counted.
- Employees who work a normal work week of less than the required number of hours per week determined by state regulation shall not be counted, unless Aetna provides the group an exception to the state regulation requirement.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Medical plans can be offered to sole proprietorships, partnerships, or corporations with 51 or more eligible employees.
- A group must have: (a) less than 101 eligible and (b) meet all the requirements of the applicable eligible employer definition.
- COBRA/State Continuation participants do not count towards the number of enrolled employees to determine employer eligibility for the Aetna Fully-Insured product.
- Groups that terminate their Aetna Fully-Insured contract and request to be rewritten with Aetna must wait at least 6

months from the termination date to be rewritten as new business, unless Aetna Underwriting management has made an exception.

## Ineligible industries

- Below is a listing of ineligible industries, which is not all inclusive.

| 51-100 Fully Insured ineligible SIC codes / industries for staffing | |
|---|---|
| 7361 | Employment Agencies |
| 7363 | Help Supply Services |

## Late applicants

- An employee or dependent requesting to enroll for coverage after the effective date or renewal/plan anniversary date is considered a late applicant unless they have a qualifying life event.
- Voluntary termination of coverage is not a qualifying life event unless it is done at open enrollment. For example, if a spouse is covered through his/her employer and voluntarily terminates the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open enrollment period to be eligible to enroll. However, if each spouse has different open enrollment dates and drops coverage during their annual open enrollment period, the spouse is eligible to enroll.
- Late applicants without a qualifying life event (e.g., marriage, divorce, newborn child, adoption, loss of spousal coverage) are not allowed and will be deferred to the next Agreement Renewal Date of the plan and must reapply for coverage 30 days before the plan's renewal date.

## Licensed and appointed producers

- Only appropriately licensed agents/producers appointed by Aetna may market, present, sell and be paid consultant fees on the sale of Aetna Fully-Insured products.
- License and appointment requirements vary by state and are based on the employer situs state of the case being submitted.

## Live/Work situs

- Eligible employees that live within 60 miles of the headquarters location will receive the same rates and benefits.
- Eligible employees that live in the states within situs region will receive the same rates and benefits as the headquartered state.

| Group headquarters state | States within situs region |
|---|---|
| Connecticut | No situs |
| Delaware | CT, DC, DE, MD, NJ, NY, PA, VA |
| DC | CT, DC, DE, MD, NJ, NY, PA, VA |
| Illinois | IN |
| Maine | No situs |
| Maryland | CT, DC, DE, MD, NJ, NY, PA, VA |
| New Jersey | CT, DC, DE, MD, NJ, NY, PA, VA |
| Pennsylvania | All plans except LVP ACO<br>CT, DC, DE, MD, NJ, NY, PA, VA |
| | LVP ACO plans – no situs |

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|---|---|
| Virginia | CT, DC, DE, MD, NJ, NY, PA, VA |
| | Innovation Health® ACO Only – DC, MD, VA |

## Medical underwriting

- The submitted census must include all waivers as well as first and last names.
- 51-100 Fully-Insured Individual Medical Questionnaires (IMQs) are required to be completed if the following is true:
  - Groups with no current medical coverage
- We allow slice business of Aetna with Kaiser Health groups if the Aetna population meets 30% minimum participation.
- Claims experience for the last 12 months and large claims report for groups domiciled in Maine, Oklahoma, or Texas.
- Currently self-funded groups and groups with a PEO master health care plan must provide:
  - Current carrier documented renewal which includes current rates and renewal rates for each plan
  - Benefit summary for each plan
  - The most current existing carrier's claim experience reports (currently self-funded groups only)
- Underwriting reserves the right to request Individual Medical Questionnaires (IMQs) in certain situations as the member level census may be deemed insufficient.
- Full disclosure of all claims in excess of $25,000 is required at time of quote, along with copies of existing carrier's/ administrator's source reports.
- Medical conditions of COBRA/State Continuation beneficiaries are included in the premium.
- At the time of sale, Individual Medical Questionnaires are required for any COBRA/State Continuation enrollee not included on the initial underwritten quote.
- Medical claims may be reviewed for any individuals who had prior Aetna Fully-Insured coverage and used along with the health information included on the 51-100 Fully-Insured Individual Medical Questionnaire and included in the overall medical assessment of the case.
- If the above items are not available, please contact your Account Executive.

### State-specific IMQ requirements

**Groups exceeding the minimum IMQ requirement can be medically underwritten via member level census.**
**IMQ applications will be accepted for all group sizes.**

| | Size Segment by Enrolled | |
|---|---|---|
| State | ACA Incumbent [1] | Non-ACA Incumbent [2] |
| AZ (Maricopa County Only) | 2-24 | 2-4 |
| AZ (non-Maricopa County) | 2-9 | 2-4 |
| CT | 2-24 | 2-4 |
| DE | 5-14 | Not required |
| FL | 2-9 | 2-4 |
| GA | 2-9 | 2-4 |
| IA | 2-24 | 2-4 |
| IL | 2-24 | 2-4 |
| KS | 2-24 | 2-4 |
| KY | 5-24 | Not required |
| MD | 2-14 | 2-4 |

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| | | |
|---|---|---|
| ME | Not required | Not required |
| MI | 2-14 | 2-4 |
| MO | 2-24 | 2-4 |
| NC | 6-24 | Not required |
| NE | 2-24 | 2-4 |
| NJ | 2-9 | 2-4 |
| OH | 2-24 | 2-4 |
| OK | 2-24 | 2-4 |
| PA | 2-14 | 2-4 |
| SC | 2-24 | 2-4 |
| TN | 2-24 | 2-4 |
| TX [3] | 2-24 | 2-4 |
| VA | 2-14 | 2-4 |
| WV | 2-14 | 2-4 |

(1) Off-cycle renewals follow the ACA incumbent rules for the state.

(2) No IMQs are required for 5-50 enrolled in these states if current on-cycle renewal, at least 8 months of claims data (if coming from a level funded incumbent outside of a MEWA or PEO), member level census, and prior carrier/funding type provided. If it doesn't meet these requirements follow the ACA incumbent rules for the state.

(3) TX domiciled employers with 25-50 enrolling employees that are currently fully-insured must provide HB2015 claims reporting from the current policy period including detailed large claim report (Tier I & Tier II). IMQs will be required if the HB2015 claims reporting is not provided.

## Medicare secondary payer for CMS reporting

- Each year, all employers must provide the Centers for Medicare & Medicaid Services (CMS) the number of Medicare secondary payer (MSP) employees, based on the number of employees covered by the plan.
- MSP is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the 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 the prior calendar year.
  - Include: Full-time, part-time, seasonal, temporary, union, owners, partners, and officers
  - Exclude: Self-employed persons, independent contractors (1099), directors and leased employees

## Newly formed business

- A company must have been in business for a minimum of 3 months to be eligible for an Aetna Fully-Insured quote unless Aetna Underwriting Management has made an exception.

## Open enrollment

- Annual Group Open Enrollment may last up to 30 days and must end prior to the renewal/plan anniversary date, unless mandated state by law.

## Option sales

- All medical plans must be offered on a full-replacement basis.
- No other employer-sponsored medical plan can be offered.
  - Exception: we allow slice business of Aetna with Kaiser Health groups if the Aetna population meets 30% minimum participation.

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## Out-of-state (OOS) employees

- Out-of-state participants residing outside of the network may enroll in the Aetna Fully-Insured PPO, OAEPO, OAMC or Indemnity plan, depending on availability.
- 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.
- Employees residing in Idaho, Missouri, Montana, and Wyoming are not eligible for enrollment in Managed Choice or Open Access Managed Choice medical plans. They are eligible for the PPO plan, if available.
- Aetna reserves the right to revise the rates or issue a Non-Quote Notification (NQN) if:
  - The total number of Indemnity enrollees exceeds 10 percent of the total eligible employees.

## Participation Medical

### Non-contributory plans (employer pays all plan contributions)

- 100 percent of total eligible employees

### Contributory plans (plan contributions paid by the employer and enrolled employees)

- 30 percent of the total eligible employees
- Participation based on number of employees – excluding the union employees, unless mandated by state law

### Waivers

- If a group satisfies participation requirements based on the business eligibility section of the employer application, waivers are not needed for 51-100 One Census.
- Be sure the employer keeps a copy of the paper applications on file for auditing purposes.
- Dependent participation is not required.

## Plan change benefit level

- Customer changes to plans offered can be made on the renewal/plan anniversary date only.

## Plan change participant level

- Plan participants are not eligible to change benefit plan options until the plan's renewal/open enrollment period, which must also coincide with the renewal/plan anniversary (except for qualified special enrollment events).

## Premium/Billing

- ACH debit is available for premium payments.
  - The group will provide a banking consent form which will allow monthly ACH Debit withdrawal. The customer will have the flexibility to choose from one of the following:
    > Due date which is the 1st of the month, or the 15th of the month based on effective date
    > 2nd through the 28th of the month
    > The last banking day of the month
  - Banking only occurs Monday - Friday. If selected date falls on a weekend or holiday, the draft will occur on the preceding banking day.
  - Premiums will be withdrawn each month via ACH Debit withdrawal.
  - Other forms of payment are available. Plan Sponsor Services will contact the group regarding these payment options.
- Customers can also pay by check, electronic funds transfer (EFT), or by calling our automated phone system at **1-866-**

**350-7644**. When using the automated phone system, be sure to have the checking account and routing numbers available. There is no extra charge for this service.
- Billing invoices will be provided 10 days prior to the due date.
- Up to three billing divisions are allowed.

## Prior Aetna Coverage

- Medical claims will be reviewed along with the health information provided on the employee application and included in the overall medical assessment of the group.

## Product availability

- The Aetna Fully-Insured Product may be offered on a standalone basis or with fully-insured ancillary coverage. Refer to the State Specific Fully-Insured Underwriting Guidelines for ancillary products in Producer World.
- An employer may select up to four Aetna Fully-Insured medical plans.
- Groups may change or add plans only on the renewal/plan anniversary date.

## Professional employer organization (PEO)/co-employer groups

Small groups with a PEO master health care plan follow the same underwriting guidelines as groups currently on a self-funded plan with one exception – we do not require prior carrier claims experience. To receive a quote, we require:

- Renewal (including current and renewal rates)
- Benefit summary

## Rating information

- Rates are based on final enrollment and require that:
  - No portion of the member's cost sharing — including but not limited to copayments, deductibles and/or coinsurance balances — will be subsidized or funded by the employer except a federally qualified Health Reimbursement Account (HRA) or Health Savings Account (HSA), whether insured or self-funded — including but not limited to a partially self-funded Section 105 wraparound, now or in the future.
- All quotes are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in the census.
- All rates will be quoted on a four-tier structure: employee; employee + spouse; employee + child(ren); and family.
- For cases underwritten via member level census, groups may be re-rated if enrollment changes by more than +/- 10 percent from the initial quote enrollment projection.
- For cases requiring Individual Medical Questionnaires, 100 percent of all enrolling employees and dependents must submit an IMQ. Any census changes from the quote to sold case will impact the rates.
- For cases underwritten with IMQs, Aetna may revise the rates if census changes occur from the quote to sold case.
- Aetna reserves the right to revise the rates or issue a Non-Quote Notification (NQN) if the following are true:
  - Any of the information received is determined to be incomplete or incorrect.
  - The total number of COBRA/State Continuation enrollees exceeds 10 percent of the total eligible employees.
  - The total number of indemnity enrollees exceeds 10 percent of the total eligible employees.

## Replacing other group coverage

- Do not cancel any existing medical coverage until the employer has been notified of approval.

## Signature dates

- The Aetna Employer Application and all enrollment applications must be signed and dated before the requested effective date and within 90 days of the requested effective date respectively.
- All enrollment applications must be completed by the employee himself/herself.

## Tax documents

- No Quarterly Wage and Tax Statement (QWTS) is required unless requested by the underwriter.

## Two or more companies affiliated, associated, multiple companies or 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 may be treated as one employer. More information can be found at https://www.irs.gov/affordable-care-act/employers and https://www.irs.gov/pub/irs-tege/epchd704.pdf.
  - The underwriter may request a QWTS or other documentation and will notify you if needed.
  - Underwriting reserves the right to final underwriting review.
  - If a common ownership group wishes to be rated together, we only will produce quotes rating the common ownership group together.
  - If a common ownership group wishes to be rated separately, we only will produce separate quotes breaking the common ownership group apart.

## Waiting period

- The benefit waiting period (BWP), sometimes known as the probationary period, is the time that a member must be employed by the plan sponsor before they are eligible to enroll for benefits.
- At initial submission of the case, the BWP may be waived for current employees upon the employer's request. This must be indicated 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 the day after 90 calendar days has been completed including date of hire.
- Exact date of hire BWP is not available.
- One or two BWPs may be selected and must be consistently applied within a class of employees as defined by the employer, such as management versus non-management, hourly versus salaried, etc.
- A change to the BWP may only be made on the renewal/plan anniversary date.
- No retroactive changes will be allowed.
- BWP must be consistently applied to all plan participants, including newly hired key employees.
- A rehired employee is an employee who was previously employed by the same employer, but lost coverage due to termination of employment or reduction of hours.
  - If the employee is rehired within one year from the termination date, the employee does not have to serve the waiting period, unless otherwise specified in the plan sponsor contract.
  - If the employee is rehired after one year from the termination date, the waiting period must be met.
- For new hires, the benefit eligibility date will be either the 1st or 15th of the policy month following the BWP of 0 days, 30 days, 60 days, or the day after 90 days including date of hire. Policy month refers to the contract effective date of the 1st or 15th.
  - If 0 days is selected, and the plan has a 1st of the month bill cycle, 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 plan 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 90 Days is selected, the enrollment eligibility date will begin the day after 90 calendar days has been completed including 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<br>Effective date: 4/1 | Date of hire: 4/1<br>Effective date: 4/15 |

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| | | |
|---|---|---|
| 0 days | Date of hire: 4/18<br>Effective date: 5/1 | Date of hire: 4/18<br>Effective date: 5/15 |
| 30 days | Date of hire: 4/18<br>Effective date: 6/1 | Date of hire: 4/18<br>Effective date: 6/15 |
| 60 days | Date of hire: 4/18<br>Effective date: 7/1 | Date of hire: 4/18<br>Effective date: 7/15 |
| 90 days | Date of hire: 4/18<br>Effective date: 7/17 not 8/1 –<br>The day after 90 days is completed including date of hire. | Date of hire: 4/18<br>Effective date: 7/17 not 8/15 –<br>The day after 90 days is completed including date of hire. |

# Specific guidelines for Banner | Aetna

## Enrollment

- Employers meeting the enrollment requirement for a Banner | Aetna proposal can choose to offer the performance network (AZ Banner Perf OAMP) alongside Banner | Aetna's broad network (AZ Banner Broad OAMP), or as a standalone offering. The following counties make up the performance network territory: Coconino, Maricopa, Pima and Pinal.
- Employees residing outside of Arizona must select an out-of-state network plan (AZ OOS OAMC).

## Banner | Aetna plan availability

- Plans available if group is headquartered in the state of AZ.
  - AZ Banner Perf OAMP: Performance network for employees in Coconino, Maricopa, Pima and Pinal counties
  - AZ Banner Broad OAMP: Broad network for employees residing in Arizona
  - AZ OOS OAMC: Broad network for employees residing outside of Arizona

## Licensed and 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 employer group being submitted.
- To become appointed with Aetna, go to **Producer World** and click Register Now.

## Live/Work

- Employees who reside in the Banner | Aetna OAMP service area are eligible to enroll in the BannerIAetna OAMP plan offered by their employer.
- Employees who reside outside of the Banner | Aetna OAMP service area but live within a 60-mile radius of their work site that is within the Banner | Aetna OAMP service area may enroll in the Banner | Aetna plan offered by their employer.
- Product availability for group benefit offerings is always determined by the ZIP Code of the employer.
- If the employee resides at a distance farther than the 60-mile radius, you can make exception requests to the Underwriting department for a feasibility determination.
- Employees who are enrolling using the live/work guidelines should include their home address and ZIP Code, as well as the work site address and ZIP Code. We will mail any correspondence to the employee's home address as listed on the application.

## Pick five

- May select up to four Banner | Aetna plans. May choose an additional out-of-state plan, if necessary, for a total of five.

## Quoting

### New business

- Eligible counties for the Banner | Aetna performance network are Coconino, Maricopa, Pinal, and Pima.
- Employer ZIP Code and employee home and work ZIP Codes are required.
- Employees residing outside of an Arizona Aetna network service area will be enrolled in the Arizona OAMC plan (if available).

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# Specific guidelines for Innovation Health


## Enrollment

- Employees in VA, DC and MD will be enrolled in an Innovation Health broad network (does not apply to performance network multi-tier/integrated plans).
- Employees enrolled in the performance network plans (multi-tier/integrated plans) must reside or work within 60 miles of the network and must go in network to receive service. They will not have access to MD and DC providers.
- Any active employee who lives and works outside of the Innovation Health situs area of VA, DC, MD but are located in the Aetna VA sitused area of CT, DE, NJ, NY, and PA are eligible to receive an Aetna plan with the same rates and benefits as the headquarters location.
- Out-of-situs employees can enroll in an Aetna VA PPO plan (or indemnity plan if the PPO network is not available).

## Innovation Health Plan Availability

- To qualify for an Innovation Health plan, the group must be headquartered in one of the 19 counties/cities designated as Innovation Health.
- Innovation Health is licensed in VA, MD, and DC.
- All employees in VA, MD and DC are eligible for Innovation Health. Employees in VA, MD and DC that choose to enroll in a health plan may only enroll in the Innovation Health plan.
- Employees outside of VA, MD and DC must work within 60 miles of Innovation Health's 19 counties/cities to receive an Innovation Health plan.
- Employees not eligible for an Innovation Health plan will receive an Aetna VA plan, depending on network availability.
- Any active employee who lives and works outside of the Innovation Health situs area of VA, DC, MD but is located in the Aetna VA situs area of CT, DE, NJ, NY, and PA is eligible to receive an Aetna plan with the same rates and benefits as the headquarters location.
- Out-of-situs employees can enroll in an Aetna OAEPO or PPO plan (or indemnity plan if the PPO network is not available).
- Aetna reserves the right to revise the rates or withdraw the quote if:
  - The total number of Indemnity enrollees exceeds 10 percent of the total eligible employees.

## Licensed and appointed producers

- Only appropriately licensed agents/producers appointed by Aetna may market, present, sell and be paid commission on the sale of Innovation Health products.
- Visit Producer World from the Innovation Health website at **www.innovationhealth .com**.

## Live/Work

- Employees residing outside of the Innovation Health situs region of VA, DC or MD must work within the 19-county Innovation Health service area and their work location must be within 60 miles of where they live.

# Specific guidelines for Innovation Health (continued)

## Pick three

- In-state plans: The employer may select up to three plans; we only require enrollment in one of them. The other two plans can have zero-member enrollment.
- Out-of-state plans: Only if there are out-of-state employees may the employer select three additional out-of-state plans (PPO/Indemnity).
- The plans must include any COBRA plan(s).
- The Indemnity plan is only available if the employee resides outside of the PPO network service area.
- There are 6 plans total for Innovation Health/Aetna Groups: 3 Aetna and 3 Innovation Health.

## Quoting

### New business

- To quote an Innovation Health plan:
  - Employer must have its headquarters in one of the 19 counties/cities in Northern Virginia designated as the Innovation Health service area (jurisdiction one, two and three); and
  - 40 percent of the eligible employees must live in jurisdiction one.
  - If less than 40 percent of the eligible employees live in jurisdiction one, then 50 percent or greater must live within jurisdictions one, two and three.
- Employer ZIP Code and employee home and work ZIP Codes are required.

| Jurisdiction One | | Jurisdiction Two | | Jurisdiction Three | |
|---|---|---|---|---|---|
| **Counties** | **Cities** | **Counties** | **Cities** | **Counties** | **Cities** |
| Arlington<br>Fairfax<br>Loudoun | Alexandria<br>Fairfax<br>Falls Church | Prince William<br>Stafford<br>Spotsylvania | Fredericksburg<br>Manassas<br>Manassas Park | Fauquier<br>Frederick<br>Clarke<br>Shenandoah<br>Warren<br>Page | Winchester |

### Renewal business

- Renewing groups headquartered in one of the 19 designated counties/cities will be offered their existing plan and, where applicable, will also be provided a new Innovation Health plan as follows:
  - Groups will be quoted based on the rules stated above.
  - Employer ZIP Code and employee home and work ZIP codes are required.

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# Specific guidelines for 51-100 Dental*

***Effective February 1, 2023 and later, refer to Producer World for Ancillary (Dental) underwriting guidelines for the following states: CA, CT, DE, FL, GA, MD, MI, NC, NJ, OH, PA, TX and VA.**

## Coverage waiting period

**Non-voluntary**

- No waiting period

**Voluntary**
**51- 100 eligible employees with medical and standalone:**

- Waiting periods do not apply to DMO.
- Virgin group (no prior coverage) — waiting periods apply to employees at case inception, as well as any future hires.
- Takeover Groups (Prior coverage)
  - Waiting period waived for members enrolled under the prior carrier at the time of takeover
  - Waiting period applies to those not covered under the prior carrier at the time of takeover and new enrollees
  - Creditable coverage is allowed for new members enrolling in voluntary takeover groups (same waiting period waiver as the group at initial takeover applies). 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 and preventive only plans do not qualify as previous coverage.
- Waiting periods do not apply to Maine contract state and residents.

## Underwriting requirement

- Takeover/Replacement cases (prior coverage) need a copy of the last billing statement and schedule of benefits to provide credit. If a group's prior coverage did not lapse more than 90 days from the requested dental effective date, the waiting periods are waived.
- For the waiting period to be waived, the group must have had a dental plan in place that covered major services (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.

## Benefit waiting period

- Same as medical
- Waiting period must match medical (if dental is sold with medical)

## Credible prior coverage

- Complete in full the prior carrier information section of the employer application.
- Preventive and Basic Plans:
  - These plans 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.

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## Dependent eligibility

- Dependent children are eligible up to the end of the month when turning age 26.
  - **CT:** Children are eligible up to the end of the policy year when turning 26.
  - **FL:** If dental is sold with fully-insured medical, children are eligible up to the end of the calendar year when turning 26.

## Employee eligibility

- Same as medical
- Non-voluntary dental:
  - Retirees cannot comprise more than 10 percent of the group.
  - The total number of COBRA enrollees cannot comprise more than 10 percent of the total eligible employees.
- Voluntary dental — Retirees are not eligible

## Excluded class/Carve-outs

- The group being carved out must be based on a legitimate reason and not contrived for financial risk reasons.

## Employer contribution

- **Non-voluntary:**
  - 51-100 with medical or standalone — Employer must contribute any amount. Excludes employee pay all plans.
- **Voluntary:**
  - 51-100 with medical or standalone — 100 percent paid by the employee

## Late entrant rule

If dental or vision is being sold along with medical, follow the medical underwriting guidelines for this topic.

- An employee or dependent enrolling for coverage more than 31 days from the date first eligible or more than 31 days from the qualifying event is considered a late enrollee.
- Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the late entrant guidelines.
- 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 to be 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 drops coverage during their annual open enrollment period, the spouse is eligible to enroll.
- Late applicants without a qualifying event (such as 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.
  - Late entrant penalty does not apply to Maine based members.
  - The dental plan does not cover services and supplies given to a person aged 5 or older if that person did not enroll in the plan during the first 31 days the person is eligible for this coverage.
  - The dental late entrant provision does not apply to charges incurred for any of the following:
    > After the person has been covered by the plan for 12 months (24 months for ortho)
    > As a result of injuries sustained while covered by the plan
    > All diagnostic and preventive services.

## Live/Work

- Employees in AZ, CA, GA, MA, MD, MO, NC, NJ, and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO.
- If an employee does not qualify for DMO coverage, they will be offered a PPO or Indemnity plan based on what is available in their market.

## Open enrollment

- Small Group non-voluntary plans with 51-100 lives are allowed open enrollments; open enrollment is available with a qualifying event and at renewal.
- Voluntary plans: Open enrollments after the initial effective date will not be allowed. Employees and dependent must enroll when initially eligible. If enrollment outside open enrollment or life qualifying event date, the member would be subject to the "Late Entrant" Provision. No exceptions.

## Out-of-area within state

- Employees who reside within state but outside of a service area may be offered an in-state PPO plan, if available; otherwise, an indemnity plan can be offered.

## Participation

- **Non-voluntary**
  **51-100 with medical or standalone**
  - 51-100 non-contributory: 100 percent, excluding spousal waivers
  - 51-100 contributory: 30 percent, excluding spousal waivers
- **Voluntary**
  **51-100 with medical or standalone (round to the nearest whole number)**
  - 51-100 contributory: Minimum 30 percent participation, excluding spousal waivers and a minimum of three enrolled
- **Census data**
  - 51-100: Census data must be provided, which includes age/date of birth, gender, dependent status, residence and work ZIP Codes of all eligible employees and COBRA/State Continuation enrollees.
- **Change in rates due to census/participation changes**
  - 51-100: Census or participation changes resulting in a +/- change in premium will be rerated.

## Plan change employee level

- 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.
- Plan changes other than Freedom-of-Choice are only allowed during the plan anniversary date's enrollment period.

## Adding dental to existing Aetna product

- The future renewal date of the change will match the current Aetna plan anniversary date of the existing product.
- Dental plans must be requested prior to the desired effective date.

## Product availability

- 51-100 eligible employees
  - Non-voluntary and voluntary plans
    > All industries are eligible if sold with medical.
    > See **Industry Eligibility** section for list of ineligible industries if dental is standalone.
  - Orthodontic coverage available with a minimum of five enrolled.

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## Product packaging

- Dental can be sold as standalone without medical.
- Freedom-of-Choice, where available, cannot be packaged with any other option. It must be the only plan sold.
    - If Freedom-of-Choice is not available where an employee lives, only the PPO plan paired with the selected FOC plan will be provided for those employees. Note: The PPO plan will only be available to the applicable employees and is not considered a dual option package.
- A DMO plan can be sold as the only dental plan in all states except in Florida, Maryland, New Jersey, and Virginia.
- DMO must be packaged with a PPO in Florida, Maryland, New Jersey, and Virginia.
- For all other states where 51-100 dental is sold, DMO (if available) can be packaged with any PPO.
- When offering a DMO and PPO plan together, the below combinations are allowed:
    - Both the DMO and PPO include the ortho benefit *or*
    - Both the DMO and PPO exclude the ortho benefit *or*
    - The DMO can include the ortho benefit while the PPO can exclude the ortho benefit.
- A group cannot offer more than two plans, as outlined above.
- PPO plans cannot be packaged together except in the following scenario:
    - Group must have 51+ eligible employees.
    - Group must have Aetna medical.
    - Dental plans must cover the same service categories (preventive, basic, major and ortho).
    - Plan benefits must have a minimum of 10% differential for basic and major services.
    - Prior approval is required.
- Voluntary and non-voluntary plans cannot be sold together.

## Industry eligibility

All industries are eligible if sold with medical.

The following industries are not eligible when dental is sold standalone.

**Ineligible industry SIC code list when dental is sold standalone**

**State list**

| | | | | | |
|---|---|---|---|---|---|
| Arizona | Georgia | Louisiana | Missouri | Oklahoma | Virginia |
| Connecticut | Illinois | Maine | Nebraska | Pennsylvania | West Virginia |
| Delaware | Iowa | Maryland | New Jersey | South Carolina | |
| DC | Kansas | Massachusetts | North Carolina | Tennessee | |
| Florida | Kentucky | Michigan | Ohio | Texas | |

| SIC code | Industry |
|---|---|
| 7361 | Employment agencies |
| 7363 | Personal supply services/help supply services |
| 7911 | Dance studios, schools |
| 7922 | Theatrical producers (except motion picture) and miscellaneous theatrical services |
| 7929 | Bands, orchestras, actors and other entertainers and entertainment groups |
| 7933 | Bowling centers |
| 7941 | Professional sports clubs & promoters |

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| SIC code | Industry |
|---|---|
| 7948 | Racing, including track operation |
| 7991 | Physical fitness facilities |
| 7992 | Public golf courses |
| 7993 | Coin-operated amusement devices |
| 7996 | Amusement parks |
| 7997 | Membership sports & recreation clubs |
| 7999 | Amusement and recreation services, not elsewhere classified |
| 8611 | Business associations |
| 8621 | Professional member organizations |
| 8631 | Labor unions and similar labor organizations |
| 8641 | Civic social and fraternal organizations |
| 8651 | Political organizations |
| 8661 | Religious organizations |
| 8699 | Membership organizations, not elsewhere classified |
| 8811 | Private households |
| 8999 | Miscellaneous services, not elsewhere classified |

# Specific guidelines for 51-100 Vision*

***Effective February 1, 2023, refer to Producer World for Ancillary (Vision) underwriting guidelines for the following states: CA, CT, DE, FL, GA, MD, MI, NC, NJ, OH, PA, TX and VA.**

## Guidelines

- No minimum participation or contribution.
- The employer may only offer one vision plan to all employees.
- Waivers are not needed as participation is not required.
- Existing groups may add vision at renewal only.
- Retirees can comprise no more than 10 percent of the group.
- Vision only is allowed or can be sold with medical and dental.
- Late enrollments (more than 31 days from the date first eligible or more than 31 days from a qualifying event) are not permitted. Enrollment must be deferred to the next plan anniversary date.

If a specific guideline is not referenced in this section, refer to the Medical section for guidance.

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