California ACA Underwriting Brochure

Plans effective January 1, 2023 and later

For businesses with 1– 100 full-time equivalent employees

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

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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.

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. More information can be found at **https://www.irs.gov/affordable-care-act/employers** and **https://www.irs.gov/pub/irs-tege/epchd704.pdf**.
  - There are 100 or fewer employees in the combined employer businesses. All full-time employees who are a part of a common controlled group along with employees under a common controlled group in other states must be included in the enrollment count.
  - Underwriting reserves the right to final underwriting review and may ask for additional documentation.

Benefit waiting period (BWP)

- 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 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 1st or 15th of the month following: 0 days, 30 days, 60 days, or the day after 90 calendar days has been completed.
- Date of hire BWP is not available.
- One waiting period is available.
- A change to the BWP may only be made on the plan anniversary date.
- No retroactive changes to the BWP will be allowed.
- BWPs must be consistently applied to all employees, including newly hired key employees.

- New hires:
  - The benefit eligibility date will be either the 1st or 15th of the policy month following the benefit waiting period of 0 days, 30 days, 60 days, or the day after 90 calendar days.
  - Policy month refers to the contract effective date of the 1st or 15th.
  - If "90 Days" is selected, the enrollment eligibility date will begin the day after 90 calendar days has been completed.

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	Date of hire: 4/18 Effective date: 7/17 not 8/1 – the day after 90 days is completed	Date of hire: 4/18 Effective date: 7/17 not 8/15 – the day after 90 days is completed

Billing

- ACH debit will be the standard method 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.
- For groups with 20 -100 enrolled, up to 3 billing divisions are allowed.
  - The group must provide the following:
    - > Name of divisions and the divisions addresses; and
    - > Indicate the division each member belongs to on the eList.
    - > Confirm the group wants one bill or separate bills.

- The group should use ebilling to view the bill package premium by division in order to make payments by division.
- Groups can use the auto-draft process if all divisions use the same bank account.

Businesses located outside the United States

- When the parent company is located outside the United States and there is a division inside the country that is seeking coverage, the U.S. location must be a separate legal entity to be considered/counted separate from the rest of the corporation.
  - If it is not a separate legal entity, then all eligible employees from all locations will be counted and the total cannot be more than 100 full-time equivalents (FTE).
- Although a group may be shown as a domestic business corporation, if it is not a separate legal entity, employees located outside the United States are included in the count for the number of employees for the corporation.

Carve outs – excluded class

- Union carve-outs that meet the definition of a Small Employer with a minimum of five enrolled employees who reside within the Aetna California network service area are eligible for coverage.
- Other types of carve outs are not allowed.
- The total size of the group (union and non-union) cannot be more than 100 full-time equivalents (FTE).

Case submission

- 1st of the month effective date – must be received by the 10th of the month after the requested effective date.
- 15th of the month effective date – must be received by the 25th of the month after the requested effective date.
- If the cut-off falls on a weekend or holiday, next available business day will be the cut-off date.
- Incomplete cases will be moved to the next available effective date because we cannot process cases that are missing vital information.
  - Sold groups must submit employee enrollment via the eList Tool. The eList Tool is available on **Producer World**, Small Group.

- The employer keeps a copy of the paper applications on file for auditing purposes.
- Instructions for eList Tool:
  - IMPORTANT: Download a fresh eList Tool from Producer World for every group instead of saving one version to your desktop.
  - 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.
  - Enable the macros prior to entering data.
  - The eList Tool format should not be amended in any manner.
  - 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.
  - The eList Tool must be completed in full.

Census data

- Census data must be provided for all eligible employees, including enrolled, waivers and COBRA/Cal-COBRA.
- Include the date of birth and gender for each employee, spouse and child, date of hire, dependent status and residence ZIP code and employee work location ZIP code.
- COBRA/Cal-COBRA enrollees should be included on the census and noted as COBRA/Cal-COBRA.
- Rates are based on final enrollment.

COBRA and Cal-COBRA

- Federal COBRA is a U.S. law that applies to employers and group health plans that cover 20 or more employees. It lets employees keep their group health plan when their job ends, or hours are cut.
- Cal-COBRA is a California law that applies to employers and group health plans that cover from 1 to 19 employees. It lets employees keep their health coverage for up to 36 months.
- Cal-COBRA is also for people who exhaust their Federal COBRA. When the 18 months of Federal COBRA ends, an individual can keep the health plan up to 18 more months under Cal-COBRA.

Group Health plans	Federal and State COBRA coverage
Small employer	**Cal-COBRA**: Up to 36 months

Group Health plans	Federal and State COBRA coverage
(1 to 19 employees)	
Large employer (20 or more employees)	**Federal COBRA**: 18 or 36 months (depends on the qualifying event) **Cal-COBRA**: If Federal COBRA was 18 months, 18 or more months of Cal-COBRA is available

- Federal COBRA applies to: Group health plans sponsored by 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 the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.
- The COBRA/Cal-COBRA participant must reside in the plan service area. If not, they are only eligible for out-of-network benefits, or urgent/emergency care.
- COBRA/Cal-COBRA eligible enrollees should be included on the census to ensure accurate rates are quoted. The qualifying event, length, start date and end date must be provided in addition to the items noted under the Census Data section above.
- COBRA/Cal-COBRA 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/Cal-COBRA participants can be included for coverage subject to normal underwriting guidelines.
- COBRA participants are not billed separately and are included with the group bill.
- Cal-COBRA premium: A separate check is needed from the member payable to Aetna at the time of the new business case submission.
- For more information visit **California Department of Managed Healthcare** or **California Department of Insurance**.

Deductible and coinsurance (out-of-pocket) credit

- A member's out-of-pocket maximum paid in the same calendar year will be credited to the new plans' out-of-pocket maximum.
- Members who are eligible and want to receive credit for deductibles paid to the prior carrier should submit a copy of the Explanation of Benefits (EOB). The member's Social Security number (SSN) should be included on the EOB; and/or handwrite the SSN on the form to avoid delay.

- EOBs may be submitted at the initial new business case submission or with the member's first claim. Or can be faxed to claims at **1-866-474-4040** no later than 90 days after the effective date.
- For faxes, include "Deductible/Coinsurance (Out of Pocket) Credit Request - ECHS Category: SFRE" in the subject line with the group/control number in order to direct the information to the correct area for processing.
- Deductible carryover not allowed.

Dependent eligibility

- Eligible dependents include:
  - Spouse and domestic partner of employee. If both employee and spouse/domestic partner work for the same company, they may enroll together or separately.
  - Children
    - Children are eligible as defined in plan documents in accordance with applicable state and federal law, for medical and dental coverage 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, children of domestic partners and children subject to legal guardianship.
    - 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.
- Dependents must enroll in the same benefit plan as the employee (participation is not required; however, waivers are required).
- Employees may select coverage for eligible dependents under the dental plan even if they selected single coverage under the medical plan.
- Individuals cannot be covered as an employee and dependent under the same plan.

Effective date

- The effective date must be the 1st or the 15th of the month.
- The effective date requested by the group may be up to 60 days in advance.
- Groups with prior coverage need to coordinate their effective date to ensure they don't have coverage with two carriers at the same time.

Employee eligibility

An eligible employee is:

- Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of an average of 30 hours per week over the course of a month, at the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. This excludes sole proprietors, spouses/domestic partners of sole proprietors, partners of a partnership and spouses/domestic partners of those partners.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse/domestic partner.
- A permanent employee who works at least 20 hours but not more than 29 hours is an eligible employee if all four of the following apply:
  1. The employee otherwise meets the definition of an eligible employee except for the number of hours worked.
  2. The employer offers the employee health coverage under a health benefits plan.
  3. All similarly situated individuals are offered coverage under the health benefits plan.
  4. The employee must have worked at least 20 hours per normal work week for at least 50 percent of the weeks in the previous calendar quarter.

We may request any necessary information to document the hours and time period in question, including, but not limited to payroll records and employee wage and tax filings.

- Employees not eligible for coverage include leased, part time less than 20 hours, temporary, seasonal or substitute employees, 1099 contractors, uncompensated employees, employees making less than equivalent minimum wage, volunteers, retirees, inactive owners, directors, shareholders, outside consultants, managing members who are not active, investors or silent partners.
- Employees are eligible to enroll in the dental plan even if they do not select medical coverage and vice versa.

Employees residing out of California

Medical

- Out-of-state employees who live in an out-of-state network area may enroll if they live in an area with an OA Managed Choice POS network or an Open Choice PPO network and will receive California rates and plans (inclusive of any required extraterritorial benefits).
- HMO plans are not allowed for employees located outside of the CA HMO service area. Dependents enrolled on an HMO Plan have coverage for emergency services only outside of the CA HMO service area.
- Hawaii and Vermont - health coverage is not available.

- 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.
- Massachusetts employees - if the group has any Massachusetts employees, the plan would need to meet Massachusetts Credibility. If the employee/group proceeds with a plan that does not meet Massachusetts Credibility, the MA employee(s) could be subject to fines/penalties associated with Massachusetts Credibility.

Employer contribution

The employer may choose from any of the below contribution amounts:

- At least 50% of the employee-only rate of whichever plan the employee selects; or
- At least $80; or
- Actual cost of the plan

Employer eligibility

Small employer means any person, firm, corporation, partnership, public agency or association that is actively engaged in business or service, on a least 50% of its working days during the previous calendar quarter or previous calendar year, with at least 1, but no more than 100, eligible employees, the majority (51%) of whom were employed within California, that was not formed primarily for purposes of buying insurance, and in which a bona fide employer-employee relationship exists.

- The owner or officer signing the employer group application for the group must be a resident for tax purposes in the state in which the group is applying for medical coverage.
- Employs at least one eligible employee who is not the proprietor or spouse/domestic partner of proprietor but not more than 100 eligible employees; and
- The group has at least 51% of the employees located in CA; and
- In determining whether to apply the calendar-quarter or calendar-year test, we will use the test that ensures eligibility if only one test would establish eligibility.
- In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation, shall be considered one group.
- For the purpose of determining eligibility, the size of a small employer may be determined annually.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse or domestic partner.
- Groups that do not meet the definition of a small employer are not eligible for coverage.

- Groups formed solely for the purpose of obtaining health coverage are not eligible for coverage.
- Groups with no existing health coverage must provide a copy of the most recently filed DE 9C (Quarterly Wage and Tax Statement). This applies to groups that have been in business longer than 3 months.
- Associations, Taft Hartley groups, professional employers' 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 for coverage.
- Groups with prior unpaid premium are eligible for coverage.

Example 1	Example 2
• Two-life group	• Two-life group
• One non-spouse/domestic partner - waiving	• One owner
• One owner - enrolling	• One W-2 enrolling who is not a spouse nor domestic partner of the owner
• Group is not eligible since the employee is not enrolling in the plan	• Group is eligible because there is at least one W-2 employee, who is not a spouse nor domestic partner, enrolling in the plan

Employers leaving a PEO (professional employer organization)

- 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.
- If the PEO has a health plan available to any of their clients (employer businesses), these same employer businesses applying for Aetna small group coverage are not eligible.
- 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 to any of their clients (employer businesses).
- 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 using “payroll services” through a company that itself (or through an affiliate) also offers PEO services are eligible subject to meeting the standard underwriting guidelines for eligibility, participation, etc.
- Underwriting reserves the right to request additional documentation to support eligibility.

Employer’s replacing other group coverage

- Groups should not cancel any existing coverage until they have been notified of approval from the Aetna Underwriting unit.
- Medical - groups with prior coverage can’t have medical coverage with two carriers at the same time. For example, if effective date with prior carrier is the first of the month, then Aetna coverage must be effective the first of the month.

Forms

Enrollment forms are available on **Producer World**.

Guarantee issue – New Business

- Both the Affordable Care Act (ACA) and the federal HIPAA law mandate no small employer or an individual can be turned down by an insurance company for group coverage due to their medical history. This is known in the insurance industry as “guaranteed issue”.

Guarantee renewability - Renewal

- Both the Affordable Care Act (ACA) and the federal HIPAA law mandate no small employer or an individual can be turned down by an insurance company for group coverage due to their medical history. This is known in the insurance industry as “guaranteed issue”.
- A group must be renewed unless one or more of the following exceptions apply:
  - 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.
  - Group no longer meets definition of group under state law.
  - Non-payment of premium

Group size

- Use the "full-time equivalent" (FTE) employee counting method to determine group size. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.
- Group size is calculated using employees who worked in the preceding calendar year. Mid-year fluctuations in the number of employees do not affect a determination of group size.
- 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 on average 30 hours or more a 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 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 nor 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.
  - Employees under a common group in other states
  - Part-time employees who worked on average less than 30 hours per week
  - Union employees
- Don’t include (while these employee types should not be included in the FTE calculation, they may still qualify for coverage)
  - Owners of a sole proprietorship.
  - Partners, Shareholders owning more than 2% of an S corporation, Owners of more than5% of other businesses.
  - Family members or members of the household who qualify as dependents on the individual income tax return of a person listed above, including a spouse, child (or descendant of a child), sibling or step-sibling, and parent (or ancestor of a parent), step parent, niece or nephew, aunt or uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.
  - Seasonal employees working 120 days or less in a year.
  - Independent contractors (form 1099 workers)
  - COBRA
  - 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.
- When the FTE is 100 or fewer it will always be small group 1-100 no matter the number of eligible or enrolling.

Example 1	Full Time Equivalent
15 employees working 30 hours or more	15
5 employees working 20 hours per week	3 (5x20/30)
Total	**18 FTEs - Small group**

Example 2	Full Time Equivalent
85 employees working 30 hours or more	85
30 employees working 25 hours per week	25 (30x25/30)
Total	**110 FTEs - Not small group**

Holding companies

- Holding company - a holding company is a company that owns part, all, or most of other companies' outstanding stock. It usually refers to a company that does not produce goods or services itself; rather its only purpose is to own shares of other companies. Holding companies allow the reduction of risk for the owners and can allow the ownership and control of a number of different companies.
- Parent company - a parent company is a holding company that owns enough voting stock in another firm (subsidiary) to control management and operations by influencing or electing its board of directors. A parent company could simply be a company that wholly owns another company.

Example

  - Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).
  - Bank A (the holding company) has no ownership; it is simply an umbrella company for the three Bank B locations.
  - Bank B has three locations and all under one TIN.
  - Bank A (the holding company) is under a separate TIN.
  - The holding company and banks have no ownership because the owners are all stockholders and bank employees or bank executives.
  - There are no articles of incorporation, only stock certificates.

- Bank B is the only group enrolling. Bank A is listed as an associated company with no employees and the group are not to be enrolled.
- Documentation needed: QWTS for Bank B, which should include all three locations.

Initial premium

- The standard payment method is ACH monthly debit. See Billing section on page 5 for important information.

Late applicants

- An employee or dependent enrolling for coverage more than 31 days from the date first eligible or 60 days from the qualifying event is considered a late enrollee.
- Applicants without a qualifying event (for example, marriage, 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 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 will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days before the anniversary date.

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 employer group being submitted.
- To become appointed with Aetna, go to **Producer World**.

Medicare (MSP) for CMS reporting

- All carriers must report to Centers for Medicare & Medicaid Services (CMS) the number of Medicare Secondary Payer (MSP) groups and the number of employees, each year based on the number of employees provided by the employer.

- Both full and part-time employees are counted based on the number the group employed for at least 20 or more calendar weeks during the current or prior calendar year.
  - Include: full time, part time, seasonal, temporary, union, owners, partners, officers
  - Exclude: self-employed persons, independent contractors (1099), directors, leased employees
- 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.

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. In most counties a municipality is the smallest administrative subdivision to have its own democratically elected officials.

- See Tax Documents section for requirements.
- 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 and must provide a copy of their 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 and participation will be maintained.

Network availability

- The group must be located within the product service area.
- The employee must live or work in the plan service area.
- HMO is not available to employees who live outside of California.
- The COBRA/Cal-COBRA enrollee must reside in the plan service area. If not, they are only eligible for out of network benefits or Urgent/Emergency care.

Newly formed business (in operation less than 3 months)

A newly formed group must meet the following requirements:

- Employs at least one eligible employee who is not the proprietor or spouse/domestic partner of proprietor but not more than 100 eligible employees.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse/domestic partner.
- Entity formation documentation as noted below (only required if owner not on DE 9C or payroll):
  - **Sole Proprietor** – A copy of the business license (not a professional license).
  - **Partnership** or **Limited Liability Partnership** – A copy of the partnership agreement.
  - **Limited Liability Company** – A copy of the articles of organization and the operating agreement to include the signature page(s) of all officers.
  - **Corporation** – A copy of the articles of incorporation.
- All newly formed groups must submit a copy of the most recently filed DE 9C (Quarterly Wage and Tax Statement).
- If a DE 9C is not available, two consecutive weeks of payroll records, which include, for every eligible employee enrolling, taxes withheld, check number and wages earned or other evidence of employment of at least one eligible employee.

Open enrollment (for groups not meeting standard participation or contribution requirements)

- Groups that do not meet Aetna 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 (see Tax Documents section for requirements) and attestation form indicating Aetna is the only carrier offered to the group.
- Standard W-2 rules apply.
- Groups must be complete and have all requirements in by December 15. No exceptions for missing items.
- Ancillary coverage (dental and vision) along with medical may be included during this open enrollment period. Standard participation and contribution requirements apply to ancillary coverage.
- Groups that don't meet our standard participation or contribution requirements will be denied coverage outside of this open enrollment period.

Option sales alongside other carriers

- Groups offering another carrier's HMO or PPO must have:
  - at least 25% participation with Aetna and a minimum of 5 or more CA employees enrolling in an Aetna plan.
  - 60% participation for four or less CA enrolled employees.
- Employees covered by the same employer on another group policy are not considered a valid waiver.

Participation medical

Noncontributory plans (group pays all)

- 100% of eligible employees excluding valid waivers.

Contributory plans

- Groups offering other carrier's HMO or PPO, go to section **Option Sales Alongside Other Carriers** for participation rules.
- For non-option sales, 60% of eligible employees excluding valid waivers, rounded down.
- Valid waivers include spousal group coverage, parental group coverage, individual coverage (on and off exchange), Medicare, Medi-Cal, Champus and TRICARE.
- Employees covered by the same employer on another group policy are not considered a valid waiver, see Option Sales section above.
- All employees waiving coverage must complete the waiver section of the application and be listed as a waiver on the eList Tool.
- If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement.

Pick 10

- Groups should indicate which 10 medical plans they want to offer to employees on the employer application or renewal submission.
- The employer may offer up to 10 plans and we only require enrollment in one plan. Zero-member enrollment plans are allowed.
- The 10 plans include COBRA and out-of-state plans.

Plan changes employee level

- 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 changes employer level

- Groups may change or add plans on the plan anniversary date only.

Product availability medical

- Medical may be written standalone or with ancillary coverages.
- Only non-occupational injuries and disease will be covered. Coverage under the Aetna plans is non-occupational unless it is an owner or employer.
- Employers may choose up to 10 medical plans and we only require enrollment in one plan. Zero-member enrollment plans are allowed.

Rates

- Rates are based on the employer ZIP code and member's date of birth.
- Rates for members enrolling after the effective date or renewal date are based on the age of the person as of the effective date of coverage.
- Member rates will not change until the group's renewal date.

Signature dates

- The Aetna employer application and all employee applications must be signed and dated before and within ninety days of the requested effective date.
- All employee applications must be completed by the employee himself/herself.

Spinoff groups (current Aetna customers leaving an Aetna group only)

Spinoff groups will be considered with the following:

- A letter from the group or broker indicating the group is enrolling as a spinoff. Letter needs to include the name of the group they are spinning off from.
- Ownership documents showing that the spinoff 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.
- Deductible credit does not apply to groups/members moving from one Aetna group to another Aetna group.

Tax documents

- A Quarterly Wage and Tax Statement (QWTS) must be provided for the following groups with:
  - 1 to 5 enrolled employees
  - 6 to 100 enrolled employees with:

    - No current employer group health coverage
    - More than 20% are COBRA/Cal COBRA enrollees
- The above list is not all inclusive. The underwriter may request a QWTS or other documentation and will notify you if needed.
- The QWTS must include the following:
  - 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
- Sole proprietors, partners, and officers not listed on the QWTS are required to submit tax documents.
- In order to satisfy the small employer requirements for proof of eligibility, the most recent IRS tax documents and the entity formation documents are required (if the owner is not on QWTS or payroll). A list of required documents is available, please advise on the entity type (limited liability company, partnership, corporation, etc.) and the entity's formation date.
- The underwriter may request additional documentation, if necessary.
- 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 to verify consistent, continuous employment of eligible employees.

1099 Employees

- 1099 employees are not eligible.

Dental

Dental coverage waiting period

- The coverage waiting period is 12 months.
- If the waiting period applies, the employee must be an enrolled member of the employer's plan for 1 year before becoming eligible for Major and Orthodontic services.
- The group's state, prior dental coverage, plan type (DMO / PPO, non-voluntary / voluntary) and number of eligible employees determine whether or not a waiting period applies.
  - Waiting periods do not apply to Maine based members.
  - Starter groups do not currently have dental coverage.

- Takeover groups currently have dental coverage with another carrier. To qualify as a takeover group:
  - Group's prior coverage must be effective within 90 days prior to the Aetna effective date.
  - Group's prior coverage must be a traditional dental insurance plan.
  - Discount dental and preventive only plans do not qualify as prior coverage.
  - If the group's prior coverage included preventive and basic coverage and/or major services, the group qualifies as having prior coverage for major services.
  - If the group's prior coverage included orthodontic coverage, the group qualifies as having prior coverage for orthodontic services.
- Waiting periods do not apply to DMO plans.
- Waiting periods do not apply to 10+ eligible groups with standard (non-voluntary) PPO and Indemnity plans.
- Waiting periods do apply to PPO and Indemnity plans for major services and if covered, orthodontic services.
- FOC plans follow the DMO and PPO plan rules listed above.
- Non-voluntary PPO/Indemnity, 2 to 9 eligible employees:
  - Starter groups - waiting period applies.
  - Takeover groups – waiting period applies based on qualified prior coverage (major, major + ortho)
- Non-voluntary PPO/Indemnity, 10 to 100 eligible employees:
  - Starter and takeover groups - waiting period does not apply.
- Voluntary PPO/Indemnity, 3 to 100 eligible employees:
  - Starter groups – waiting period applies.
  - Takeover groups – waiting period applies based on qualified prior coverage (major, major + ortho)
    - New dental enrollees without prior coverage, waiting period applies.
    - New dental enrollees at new business who had qualified coverage for the past 12 months, and have not lapsed within the last 90 days, qualify for creditable coverage.
    - Creditable coverage allows for the new dental enrollee to qualify for the same waiting period waiver as existing members of the group.

Dental creditable prior coverage – employer / group

- Complete in full the prior carrier information section of the employer application.
  - Plans that include preventive & basic coverage qualify as having prior coverage of major. These plans do not qualify as having prior coverage of ortho.
  - Only plans that include ortho coverage 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 employer contribution

- Non-voluntary:
  - 2-50 eligible:
    - Employer must contribute at least 25% of the total cost or at least 50% of the cost of employee only coverage for dental plans.
    - For non-contributory plans, the employer pays the entire premium.
  - 51-100 eligible:
    - Employer must contribute any amount of the total cost.
- Voluntary:
  - 3-50 eligible:
    - Employer contributes less than 25% of the total cost or less than 50% of the cost of employee only coverage for dental plans, or if the coverage is 100% paid by the employee.
  - 51-100 eligible:
    - 100% paid by the employee.

Dental ineligible industries

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

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
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

SIC code	Industry
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

Dental late applicants

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.

Dental open enrollment

- 2 to 9 eligible non-voluntary and 2-100 eligible voluntary employees: Open enrollments after the initial one 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.
- Small Group non-voluntary plans with 10 - 100 eligible are allowed open enrollments; open enrollment is available with a qualifying event and at renewal.

Dental participation

- Waivers
  - Waivers are required.
  - The only valid waiver for dental is a spousal waiver.
    - > If an employee is declining coverage because they have dental coverage through their spouse's employer, they are required to provide a spousal waiver.
    - > If an employee is declining coverage for any other reason, this is not considered a valid waiver.
- Non-voluntary
  - 2 to 3 eligible: can be either contributory or non-contributory: 100% participation excluding spousal waivers, with a minimum of 2 enrolled employees.
  - 4 to 50 eligible non-contributory: 100% participation excluding spousal waivers.
  - 4 to 50 eligible contributory: 75% participation excluding spousal waivers and 50% of total eligible employees must enroll

    Example: 20 eligible employees, 8 spousal waivers, 10 employees enrolling

    Step 1: Compute 75% participation

    20 – 8 valid waivers = 12

    12 x 75% = 9 enrolled

    Step 2: Compute 50% of total eligible employees

    20 x 50% = 10 enrolled

    The group meets participation with 10 employees enrolling.
  - 51 to 100 eligible non-contributory: 100% participation excluding spousal waivers
  - 51 to 100 eligible contributory: 30% participation excluding spousal waivers
- Voluntary
  - 3 to 100 eligible contributory only: minimum 30% participation excluding spousal waivers and a minimum of 3 enrolled

- 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 enrollees.
- Change in rates due to census/participation changes
  - Census or participation changes resulting in a +/- 10% change in premium will be rerated.

Dental plan add to existing Aetna product

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

Dental plan availability

1 eligible employee

- Not available

2 eligible employees

- Non-Voluntary available with or without medical
- Voluntary dental not available

3 to 100 eligible employees

- Non-Voluntary and voluntary dental plans are available with or without medical.

Orthodontic coverage

  - 2-9: not available
  - 10-100: available with 10 or more eligible employees with a minimum of five enrolled employees for adults and dependent children for both non-voluntary and voluntary plans.
- Standalone dental has ineligible industries. The dental ineligible industry list does not apply when dental is sold in combination with medical.

Dental plan change employee

- 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.

Dental plan change group

- Changes allowed on plan anniversary date only.

Dental product packaging

- Non-Voluntary Plans (2-9 & 10-100)

    - Dual Option
        - DMO can be either sold standalone or packaged with any PPO Option.
        - PPO can be sold standalone or packaged with the DMO excluding Preventive Plans, and preventative/basic combination.
        - Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold. The only exception would be for out of area/out of state employees not eligible for FOC.
- Voluntary Plans
    - Dual Option:
        - 3-9 - Not available.
        - 10-100 – Same as non-voluntary plans
- Triple option not available.
- PPO plans cannot be packaged together.
- Voluntary and non-voluntary plans cannot be sold together.

Dental rates

- 2-9 eligible employees: ER zip
- 10-50 eligible employees: ER zip
- 51-100 eligible employees: EE zip

Dental replacing coverage

- Must receive a copy of the benefit summary to receive credit for major and orthodontic coverage
- Plans that include preventive & basic coverage 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.

Vision

- Available to groups with two or more eligible employees.
- The employer may only offer one vision plan to all employees.
- No minimum participation or contribution requirements.
- Waivers are not needed as participation is not required.
- Existing groups may only add vision at renewal.

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