California ACA underwriting brochure

Pending Regulatory Review

Plans effective January 1, 2019

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.

14.02.061.1-CA I (10/18)

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.
- Groups who have more than one business with different tax identification numbers (TIN) may be eligible to enroll as one group if the following are met:
  - One owner has controlling interest of all businesses to be included; or
  - Companies that are affiliated and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer.
  - All groups filed under one combined tax return are considered one group.
  - There are 100 or fewer employees in the combined groups.
  - Businesses with equal controlling interest may be considered, if the owners of the company designate an individual to act on behalf of all the groups.
  - A completed Common Ownership form must be submitted.
  - Underwriting reserves the right to final underwriting review and may consider common ownership on a case-by-case underwriting exception.

Example

One owner has controlling interest of all businesses to be included:

- Company 1 - Jim owns 75% and Jack owns 25%
- Company 2 - Jim owns 55% and Jack owns 45%

Both businesses must be written as one group since Jim has controlling interest in both businesses.

Benefit waiting period (BWP)

- 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 exactly 90 days after the date of hire.
- 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 eligibility date will be the first day of the policy month following the waiting period, not to exceed 90 calendar days from the date of hire.
  - Policy month refers to the contract effective date of the 1st or 15th.
  - If "Exactly 90 Days" is selected, the enrollment eligibility date will begin 90 calendar days from the date of hire.

Examples	1st of the month following the BWP	15th of the month following the BWP
0 days	Date of hire: 4/1 Effective date: 4/1	Date of hire: 4/1 Effective date: 4/15
0 days	Date of hire: 4/18 Effective date: 5/1	Date of hire: 4/18 Effective date: 5/15
30 days	Date of hire: 4/18 Effective date: 6/1	Date of hire: 4/18 Effective date: 6/15
60 days	Date of hire: 4/18 Effective date: 7/1	Date of hire: 4/18 Effective date: 7/15
90 days exact	Date of hire: 4/18 Effective date: 7/16 – exactly 90 days from the date of hire	Date of hire: 4/18 Effective date: 7/16 – exactly 90 days from the date of hire

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

- 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 20th of the prior month.
- 15th of the month effective date – must be received by the 5th of the month.
- 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 may submit enrollment via the eList Tool (completed in full).
  - The eList Tool is available on Producer World, under forms.
  - Do not amend eList Tool format in any manner.
  - When you use the Tool, do not send the employee enrollment forms. All the required information must be entered into the eList Tool.

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 (1 to 19 employees)	**Cal-COBRA**: Up to 36 months
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

For more information visit **California Department of Managed Healthcare**.

- 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.

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 husband and wife/partner work for the same company, they may enroll together or separately.
  - Children - medical and dental coverage
    - o 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, and children subject to legal guardianship.
    - o Children can only be covered under one parent's plan when both parents work for the same company.
    - o 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 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.

Electronic funds transfer (EFT)/ACH

- Payment for the first month's premium at new business can be processed via an Electronic Funds Transfer/ACH.

- Once the group is issued, the group can pay their monthly premiums online or by calling **1-866-350-7644**, using their checking account and routing number, with no extra charge

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 at least 30 hours, in the small employer's regular place of business, who has met applicable waiting period requirements. This excludes sole proprietors, spouses of sole proprietors, partners of a partnership and spouses of those partners.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse.
- 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 will receive California rates and products (inclusive of any required extraterritorial benefits).
- Out-of-state employees who live in an area with a OA Managed Choice POS network must enroll in the California OA Managed Choice plan.
- Effective 1/1/19, the Open Choice PPO plan is no longer available for employees that don't reside in an OA Managed Choice POS network area.

- 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, Missouri and Vermont - health coverage is not 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.
- The employee can't be the owner(s) of the business
- The employee can't be the spouse of the owner(s)
- The employee may be a domestic partner
- Employs at least one eligible employee who is not the proprietor or spouse 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.

- 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.

Example 1	Example 2
• Two-life group • One non-spouse - waiving • One owner - enrolling	• Two-life group • One owner • One domestic partner of the owner enrolling
• Group is not eligible since the employee is not enrolling in the plan	• Group is eligible because a domestic partner is not considered a spouse for the purpose of determining whether there is at least one employee enrolling in the plan

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 of proprietor but not more than 100 eligible employees.
- Groups with no existing health coverage must provide a copy of the most recently filed DE 9C
- This material is intended for brokers and agents and is for informational purposes only.
- (Quarterly Wage and Tax Statement).
- Groups with 1 to 19 enrolled employees (with or without existing health coverage) 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.

Employer's 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.

- Groups currently with a PEO that offers health coverage through the PEO to any members are not eligible for coverage with Aetna.
- Groups currently with a PEO who indicate health coverage is not available through the PEO must provide a letter from the PEO indicating health coverage is not available.
- Groups that indicate they are with a PEO when sent in as a sold group and subsequently indicate they have terminated their PEO contract must provide a copy of the contract termination letter sent from the PEO to the client (employer) business. This letter must verify the cancellation of the leasing arrangement as well as the cancellation date.
- Groups only using “payroll services” are eligible subject to meeting the standard underwriting guidelines for eligibility, participation, etc. The most recent Quarterly Wage and Tax statement(QWTS) filed for the group is required.

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**.

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 is not to be enrolled.
- Documentation needed: QWTS for Bank B, which should include all three locations.

Initial premium

- The initial premium payment is not a binder check and does not bind Aetna to provide coverage.
- EFT option is available for the initial premium payment. If the EFT method is selected, the initial premium will be withdrawn from the checking account when the group is approved. This is a one-time authorization for the first month's premium only. When an ACH form is submitted, the form must be fully completed including the amount of the premium.
- If a copy of the check is provided, once coverage is approved, you will be notified to send the check to the bank lockbox. If the check is not submitted within 5 days, coverage will terminate retroactive to the case effective date.
- If the initial premium payment is returned for nonsufficient funds, the standard termination process will be followed.
- If the request for coverage is withdrawn or denied due to business ineligibility the premium will be returned to the group.

- If the group is currently with Aetna and adding medical, dental and/or vision coverage, no premium payment is required at the time of enrollment.
- Cal-COBRA premium: A separate check is needed from the member payable to Aetna at the time of the new business case submission.

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 **www.aetna.com/insurance-producer/index.html** and click "Get Started".

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.

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

- Groups that do not meet Aetna's 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 (life, disability, 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 other carrier's HMO must have at least 40% participation with Aetna and minimum of 5 CA employees enrolling in an Aetna plan.
- 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

- 60% of eligible employees excluding valid waivers, rounded down.
- Groups offering other carrier's HMO must have at least 40% participation and a minimum of five employees enrolling in an Aetna plan.
- Valid waivers include spousal group coverage, parental group coverage, Medicare, Media-Cal, Campus and TRICARE.
- 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 5

- Groups should indicate which 5 medical plans they want to offer to employees on the employer application or renewal submission.
- The employer may offer up to 5 plans and we only require enrollment in one plan. The other 4 plans can have zero-member enrollment.
- The 5 plans include any COBRA and out-of-state plans.
- Pick-A-Plan is no longer available to new or renewing groups.

Plan changes employees

- 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

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

Prior Aetna coverage

- Groups that have terminated health coverage with Aetna in the past 12 months are not eligible.
- If group owes monies to Aetna for prior period, monies would need to be paid before Aetna plan can be issued.

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.
- Groups may choose up to 5 medical plans they wish to allow their employees to enroll into.

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 19 enrolled employees
  - 20 to 100 employees with no current health coverage
  - More than 10% of the employees are located outside of California
  - More than 20% are COBRA/Cal COBRA enrollees
  - Associated, affiliated, multiple companies
- 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. We can provide you a list of required documents if you tell us 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.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages and hours, which must match the totals on Form 941.

1099 Employees

- 1099 employees are not eligible.

Vision

- Available to groups with two or more enrolled employees.
- Group may only offer one vision plan to all employees.
- To enroll, submit a list of employees and dependents with vision plan indicated.
- Premium can be included with payment for medical, dental or life, or can be separate.
- No minimum participation or contribution requirements.
- Waivers are not needed as participation is not required.

Dental

Plan availability

1 eligible employee

- Not available.

2- 9 eligible employees

- Non-Voluntary
- Voluntary dental not available
- Orthodontic coverage not available

3 to 100 eligible employees

- Non-Voluntary and voluntary dental plans are available with or without medical.
- Standalone available.
- Standalone dental has ineligible industries.

Orthodontic coverage

- 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. See footnotes in the dental benefit grid for adult orthodontic availability.

Coverage waiting period

- Must be an enrolled member of the employer's plan for 1 year before becoming eligible for Major and Orthodontic services (if applicable).
- Waiting Periods do not apply to DMO.
- **Non-voluntary PPO: 2 to 9 eligible employees:**
    - Virgin Groups - waiting period applies.
    - Takeover Groups (Prior coverage) – waiting period does not apply.
- **Non-voluntary PPO: 10 to 100 eligible employees**:

    - Waiting period does not apply.
- **Voluntary PPO: 3 to 100 eligible employees**:
    - Virgin groups – waiting period applies.
    - Takeover groups - waiting period waived based on the prior coverage level for members covered under the prior carrier at the time of takeover.
    - New Hires – waiting period applies.
- Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires must be covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage.
- Discount dental and preventive only plans do not apply.
- Takeover/Replacement cases (prior coverage) need a copy of the last billing statement and schedule of benefits in order to provide credit. If a group's prior coverage did not lapse more than 90 days, the waiting periods are waived.
- In order for the waiting period to be waived, the group must have had a dental plan in place that covered Major (and Ortho, if applicable) immediately preceding our takeover of the business.
- The prior carrier plan does not have to have been in force for 12 months to be considered takeover. As long as the group had prior coverage for ortho and/or major services before the Aetna plan, the waiting period is waived.

Example:

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

Creditable prior coverage

Voluntary plans

- Plans that cover preventive and basic services will satisfy our requirements for having prior creditable coverage as long as the member was covered for 12 months under a dental plan within the last 90 days that included both preventive and basic coverage. You must provide a copy of the schedule of benefits to receive credit.
- Preventive only or discount plans do not meet the requirements for having prior creditable coverage. These groups will continue to be written as having no prior coverage.

Employer contribution

Non-Voluntary

- 2-50 with medical or standalone - employer must contribute at least 25% of the total cost or50% of the cost of employee only coverage for Dental plans.

- 51-100 with medical or standalone - employer must contribute any amount. Excludes employee pay all plans.

Voluntary

- 3-50 with medical or standalone - employer contributes less than 25% of the total cost or50% of the cost of employee only coverage, or if the coverage is 100% paid by the employee.
- 51 - 100 with medical or standalone - 100% paid by the employee.
- 51 – 100 if the employer pays any amount the group is not eligible for a voluntary plan and would get a standard plan.

Ineligible industries

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

SIC code	Industry
7319-7319	Advertising, Miscellaneous
7800-7999	Amusement, Recreation & Entertainment
8600-8699	Associations & Trusts
5511-5599	Auto Dealerships
7231-7241	Beauty & Barber Shops
7331-7338	Direct Mailing, Secretarial
7361-7363	Employment Agencies
8700-8799	Engineering & Mgmt. Services
7000-7099	Hotels
9721-9721	International Affairs
3911-3915	Jewelry Manufacturing
8100-8199	Legal
8000-8059	Medical Groups
8071-8099	Medical Groups
7389-7389	Miscellaneous Business SVCS.
7379-7379	Miscellaneous Computer Services
8999-8999	Miscellaneous Services
5271-5271	Mobile Home Dealers
4111-4121	Passenger Transportation
7221-7221	Photo Studios
7384-7384	Photofinishing Labs
6500-6799	Real Estate
7251-7299	Repairs, Cleaning, Personal Svc
5800-5899	Restaurants
8211-8299	Schools, Libraries, Education
0761-0783	Seasonal Employees

SIC code	Industry
7381-7382	Security Sys, Armored Cars
8800-8899	Service-Private Households
8300-8499	Social Services - Museums, Art Galleries Botanical Gardens
7631-7631	Watch, Clock & Jewelry repair

Late entrant

- The plan does not cover services and supplies given to a person age 5 or older if that person did not enroll in the plan during one of the following:
  - The first 31 days the person is eligible for this coverage or
  - Any period of open enrollment agreed to by the employer and us
- This 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
- For services listed as visits and exams, images and pathology in the schedule of benefits.

Open enrollment

- Small Group non-voluntary plans with 10 - 100 eligible are allowed open enrollments after the initial period. Employees/dependents that do not enroll when initially eligible are now eligible to enroll during a subsequent open enrollment period without being subject to the late entrant provision. This exception does not apply to voluntary Dental plans.
- If the Employer's enrollment policy permits enrollment outside open enrollment or life qualifying event date, the member would be subject to the "Late Entrant" Provision.
- 2 to 9 eligible employees and 2-50/100 voluntary: No exceptions will be made for Small group. Open enrollments after the initial one will not be allowed. Employees and dependent must enroll when initially eligible. An open enrollment is a period when any employee can elect to join the dental plan without penalty, regardless if they previously declined coverage during the first 31 days of initial eligibility.

Participation

Non-Voluntary

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

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

51 to 100 with medical or standalone

- 51 to 100 non-contributory: 100% excluding valid waivers
- 51 to 100 contributory: 30% excluding valid waivers.

Voluntary

3-100 with medical or standalone (round to the nearest whole number)

- 3 to 100 eligible employees with medical or standalone: minimum 30% excluding valid waivers and a minimum of 3 enrolled

Valid Waivers

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

Change in rates due to number of Employees

- 2-9: Not allowed.
- 10-100: An employer with a change in the total base of eligible and/or enrolled employees resulting in a 10% change in premium will be reviewed for a possible rerate.

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 change group

- Dental plans must be requested 5 days prior to the desired effective date.
- The future renewal date of the change will be the same as the medical plan anniversary date.

Product packaging

- Standard Non-Voluntary Plans (2-9 & 10-100)
  - DMO can be either sold standalone or packaged with any PPO Option as a Dual Option with a minimum of 2 enrolled.

- PPO can be sold standalone or packaged with the DMO as a Dual Option with a minimum of 2 enrolled.
- Freedom-of-Choice cannot be packaged with any other option. It must be the only plan sold.
- Triple option not available.

- **Voluntary Plans**
  - Dual Option:
    - 3-9 - Not available for voluntary.
    - 10-100 – Same as standard non-voluntary plans.

Rates

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

Reinstatement (voluntary plans only)

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

Replacing dental coverage

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

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