Aetna Fully-Insured

Small-Mid Size Business

Medical 51+ Underwriting Guidelines

Plans effective January 1, 2027 and later

- Aetna Medical – AZ, CA, CO, CT, DC, DE, FL, GA, IA, IL, KS, MA, ME, MI, MD, MO, NC, NE, NV, NJ, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, WA and WV
- Banner|Aetna – AZ

The following guidelines apply only to the states listed above.

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

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

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

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

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

Aetna.com

©2021 Aetna Inc.
5991450-27-01 (9/26)

aetna®

Table of Contents

Introduction — underwriting guidelines 3
51+ employer definition 3
Carve-outs/Excluded class 3
COBRA/State continuation 3
Coordination of benefits 4
Counting employees to determine case size 4
Deductible and coinsurance (out-of-pocket) credit (101-200 enrolled groups) 7
Dependent eligibility (medical only) 7
Domiciled state 8
Effective date 9
Employee eligibility 9
Employee enrollment 9
Employer contribution 9
Employer deductible funding 9
Employer eligibility 9
Late applicants 10
Licensed and appointed producers 10
Live/Work situs 10
Medical underwriting 11
Medicare secondary payer for CMS reporting 11
Newly formed business 12
Open enrollment 12
Option sales 12
Out-of-state (OOS) employees 12
Participation Medical 12
Plan change benefit level 13
Plan change participant level 13
Premium/Billing 13
Prior Aetna Coverage 13
Product availability 13
Professional employer organization (PEO)/co-employer groups 13
Rating information 14
Replacing other group coverage 14
Signature dates 14
Tax documents 14
Two or more companies affiliated, associated, multiple companies or common ownership 14
Waiting period 14
Specific guidelines for Banner|Aetna 16
Enrollment 16
Banner|Aetna plan availability 16
Licensed and appointed producers 16
Live/Work 16
Pick five 16
Quoting 16
2+ Dental 17
2+ Vision 17

Introduction — underwriting guidelines

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

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

All underwriting guidelines are subject to change without notice.

51+ employer definition

- A 51+ employer means any person, firm, corporation, limited liability company or partnership actively engaged in business or self-employed, on at least 50 percent of its working days during the current 12 months, employed at least 51 employees on the first day of the plan year.
  - No more than 200 enrolled employees*
- If the employer has not been in existence for at least three consecutive months, underwriting management approval is required because more documentation is required.
- For the purpose of determining the number of eligible employees under this subdivision:
  - Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation shall be considered one employer, unless contrary to state law/restriction.
  - Employees covered through the employer by health insurance plans, or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act, shall not be counted.
  - Employees who are not actively at work but are covered under the employer's health insurance plan pursuant to workers' compensation, continuation of benefits or other applicable laws shall not be counted.
  - A 51+ employer will continue as a 51+ group until the plan anniversary date following the date the employer no longer meets the requirements of this definition, may be offered different plans as required by the law.

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

Carve-outs/Excluded class

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

COBRA/State continuation

- COBRA applies to employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.
  - Include: Full-time, part-time, seasonal, temporary, union, owners, partners, officers.
  - Exclude: Self-employed persons, independent contractors (1099), directors.
  - Each part-time employee counts as a fraction of an employee, with the fraction equal to number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time.
- The employer must inform Aetna of any State Continuation/Mini-COBRA/Spousal Continuation beneficiaries. Aetna will allow these beneficiaries to enroll as required by law.

Table of contents

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

Coordination of benefits

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

Counting employees to determine case size

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

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

Table of contents

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

Total average employee counting methodology

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

To determine case size

- Illustrative Quote: Use the TAE count at the time of the quote.
- Groups with 50 or fewer total average employees in the prior calendar year are rated as a 1-50 employer no matter what the number of enrolling employees is.
  - If the TAE is 1-50 in the previous calendar year and the eligible is more than 50, this is a 1-50 group. Example: 45 TAE based on previous calendar year; 65 eligible - this is a 1-50 group.
- Groups with 51 or more total average employees in the previous calendar year are rated as a 51+ employer.
  - If the TAE is 51+ in the prior calendar year and the number eligible is less than 51, this is a 51+ group.Example: 60 TAE based on prior calendar year; 45 eligible – this is a 51+ group.
  - If the TAE is 200+ in the prior calendar year and the number eligible is less than 201, this is a 51+ group. Example: 215 TAE based on prior calendar year; 45 eligible – this is a 51+ group.

Full-time equivalent counting methodology

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

Table of contents

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

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

Example 1:

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

Example 2:

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

- When the FTE in the **prior calendar year** is 51 or more and the eligible count is 200 or less it will always be 51+.

Examples: 60 FTE in the prior calendar year; 40 eligible – this is a 51+ group. 215 FTE in the prior calendar year; 45 eligible – this is a 51+ group.

Table of contents

Eligible employee counting methodology

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

Deductible and coinsurance (out-of-pocket) credit (101-200 enrolled groups)

- Deductible credit and Coinsurance (Out of Pocket) credit applies to calendar–year plans for group–to–group takeover for individuals on the prior group plan, for overlapping benefit periods. Not available on plan–year plans.
- 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 Deductible and Coinsurance (Out of Pocket) paid under the prior carrier should submit a copy of the member's Explanation of Benefits (EOBs) to us no later than 90 days after the effective date. Be sure the member's Social Security number (SSN) is on the EOB and/or handwrite the SSN on the form to avoid delay.
- EOBs may be submitted with the initial submission, with the first claim, or can be emailed to SGDeductiblecredits@aetna.com no later than 90 days after the effective date. Please include "Deductible/Coinsurance (Out of Pocket) Credit Request – ECHS Category: SFRE" in the subject line with the Group/Control Number to direct the information to the correct area for processing. Once submitted, please allow approximately 7-10 business days for processing.
- Deductible and Coinsurance (Out of Pocket) carryover is not allowed.
- Deductible and Coinsurance (Out of Pocket) credit reports may be submitted. Be sure to include Social Security numbers.

Dependent eligibility (medical only)

- Spouse of employee, domestic partners (same and/or opposite sex) – If employee and spouse/domestic partner work for the same company, they may enroll together or separately. If enrolling together, the group must still meet the minimum number of enrolling employees as stated in the **Employer Eligibility section**.
- Children
  - Children are eligible as defined in accordance with applicable federal and state law, up to the end of the month that the dependent turns age 26, according to state legislation. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.
    - **CT:** Children are eligible up to the end of the policy year when turning 26.
    - **FL & GA:** Children are eligible up to the end of the calendar year when turning 26.
  - Children over the age limit may request to continue medical coverage, depending on eligibility criteria, as noted below for the following states:
    - **FL:** At the election of an employer offering group medical coverage, or the subscriber, a dependent child between the ages of 26 and 30 may request to continue medical coverage as a dependent up to the end of the year when turning age 30, on his or her parent's group coverage even after the child reaches the limiting age under the terms of the policy if he or she is:
      - Not yet 30 years of age; is unmarried; has no dependents of his or her own; is a resident of FL, or if not a resident of FL, is a full-time or part-time student; is not eligible for Medicare; and is not actually covered under another group, blanket, or individual health plan. The Florida Supplemental Dependent Enrollment Form must be completed.
    - **IA:** Unmarried dependents age 26 and over are eligible if they are a full-time student at an accredited post-secondary institution. Each eligible dependent must confirm eligibility annually before their birthday. The IA Young Adult Enrollment Form must be completed.
    - **IL:** Eligible dependents who are military personnel to the age of 30, if the policy provides for dependent coverage

and the insured chooses to elect dependent coverage. The dependent must:

- Reside in Illinois; have served as an active or reserve member of the United States Armed Forces; and be discharged or released from duty for reasons other than a dishonorable discharge. The IL Supplemental Dependent Enrollment Form must be completed.

> **NE:** Medical coverage for dependents may be extended beyond age 26 to age 30. The dependent:

- Must be unmarried; reside in Nebraska or be enrolled on a full-time basis in any college, university, or trade school; and not eligible for coverage under another plan, either fully insured or self-funded. The Nebraska Young Adult Enrollment Form must be completed.

> **NJ:** At the election of the employer, dependents beyond age 26 may remain on their parent's New Jersey fully insured medical plan through age 30, until their 31st birthday. To be eligible, the parents of the over-age dependent must be actively covered under a New Jersey–issued group health contract. This does not apply to small-mid size business situs in another state, regardless of where the employee resides. Eligible dependents must be the insured's child (by blood or by law) and must meet the following criteria:

- Is younger than 31 years of age; unmarried; has no dependents; is a New Jersey resident or is enrolled as a full-time student; is not provided coverage as a named subscriber, enrollee, or covered person under any other health plan (cannot be entitled to Medicare); elects coverage before his or her 30th birthday; and the employee completes the New Jersey mandated form to enroll dependents up to age 31. The HINT Supplemental Enrollment Information Form must be completed.

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

- Is not married; has no dependents; is a Pennsylvania resident or is enrolled as a full-time student at an institution of higher education; and is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group or individual health insurance policy or enrolled in or entitled to benefits under any government health care benefits program. The Pennsylvania DU30 Supplemental Enrollment Form must be completed.

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

- Parent or Stepparent

> **IL:** medical coverage may be available to the parent or stepparent of the insured if the parent or stepparent meets the definition of a qualifying relative and lives or resides within the service area.

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

Domiciled state

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

Effective date

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

Employee eligibility

- Eligible employees include the partners of a partnership but do not include an employee who works on a seasonal, temporary or substitute basis. An eligible employee shall include any employee who is not actively at work but is covered under the small-mid size employer health insurance plan pursuant to workers' compensation and COBRA/State Continuation.
- To be an eligible employee, each employee must meet the eligibility guidelines to be counted under the normal work week hours rule of 25 hours or more.
- Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement.
- Employees not eligible for coverage include independent contractors (1099s) unless mandated by state law, leased, part-time (working less than 25 hours), temporary, seasonal or substitute employees, uncompensated employees, employees making less than equivalent minimum wage, volunteers, inactive owners, directors, shareholders, officers, outside consultants, managing individuals who are not active, investors or silent partners.
- Groups with more than 10 percent retirees will receive a Non-Quote Notification (NQN) letter.
- The retiree must be covered currently with present carrier (must be shown on the bill roster or provide a copy of the ID card).
- If there were no retirees covered by the prior carrier, the employee must be covered as an employee on the bill roster.
- Provide a census for retirees.
- Retirees are not to be included for purpose of counting employees in determining the size of the group.

Employee enrollment

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

Employer contribution

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

Employer deductible funding

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

Employer eligibility

Table of contents

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

Late applicants

- An employee or dependent requesting to enroll for coverage after the effective date or renewal/plan anniversary date is considered a late applicant unless they have a qualifying life event.
- Voluntary termination of coverage is not a qualifying life event unless it is done at open enrollment. For example, if a spouse is covered through his/her employer and voluntarily terminates the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open enrollment period to be eligible to enroll. However, if each spouse has different open enrollment dates and drops coverage during their annual open enrollment period, the spouse is eligible to enroll.
- Late applicants without a qualifying life event (e.g., marriage, divorce, newborn child, adoption, loss of spousal coverage) are not allowed and will be deferred to the next Agreement Renewal Date of the plan and must reapply for coverage 30 days before the plan's renewal date.
- Does not apply to 101+ groups with a CA contract.

Licensed and appointed producers

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

Live/Work situs

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

Group headquarters state	States within situs region
Connecticut	No situs
Delaware	CT, DC, DE, MD, NJ, NY, PA, VA
District of Columbia	CT, DC, DE, MD, NJ, NY, PA, VA
Illinois	IN
Maryland	CT, DC, DE, MD, NJ, NY, PA, VA
New Jersey	CT, DC, DE, MD, NJ, NY, PA, VA

Table of contents

New York (up to 100 eligible)	CT, NJ
Pennsylvania	CT, DC, DE, MD, NJ, NY, PA, VA
Virginia	CT, DC, DE, MD, NJ, NY, PA, VA

Medical underwriting

- The submitted census must include all waivers as well as first and last names.
- We allow slice business of Aetna with Kaiser Health groups if the Aetna population meets 20% minimum participation.
- Claims experience for the last 12 months and large claims report for groups domiciled in Maine, Oklahoma, or Texas.
- 101-200 enrolled groups, currently self-funded groups, groups leaving a Captive Insurer, and groups with a PEO master health care plan must provide:
  - Current carrier documented renewal which includes current rates and renewal rates for each plan
  - Benefit summary for each plan
  - The most current existing carrier's claim experience reports (101-200 enrolled groups, currently self-funded groups, and Captive Insurer groups only)
- Underwriting reserves the right to request Individual Medical Questionnaires (IMQs) in certain situations as the member level census may be deemed insufficient.
- Full disclosure of all claims in excess of $25,000 is required at time of quote, along with copies of existing carrier's/administrator's source reports.
- Medical conditions of COBRA/State Continuation beneficiaries are included in the premium.
- At the time of sale, Individual Medical Questionnaires are required for any COBRA/State Continuation enrollee not included on the initial underwritten quote.
- Medical claims may be reviewed for any individuals who had prior Aetna Fully Insured coverage and used along with the health information included on the 51+ Fully Insured Individual Medical Questionnaire and included in the overall medical assessment of the case.
- If the above items are not available, please contact your Account Executive.

State-specific IMQ requirements

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

Size Segment by Enrolled		
State	ACA Incumbent[1]	Non-ACA Incumbent
AZ, CA, CO, CT, DC, DE, FL, GA, IA, IL, KS, MA, MD, MI, MO, NE, NJ, NV, NY, OH, OK, OR, PA, SC, TN, TX[2], VA, WA, WV	2-4	2-4
NC	3-4	3-4
ME, UT	Not required	Not required

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

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

Table of contents

Medicare secondary payer for CMS reporting

- Each year, all employers must provide the Centers for Medicare & Medicaid Services (CMS) with the number of Medicare secondary payer (MSP) employees, based on the number of employees covered by the plan.
- MSP is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the plan would pay primary to Medicare for active employees and would pay first when there are 20 or more total employees (full and part-time) for 20 or more weeks during this calendar year or the prior calendar year.
  - Include: Full-time, part-time, seasonal, temporary, union, owners, partners, and officers
  - Exclude: Self-employed persons, independent contractors (1099), directors and leased employees

Newly formed business

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

Open enrollment

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

Option sales

- All medical plans must be offered on a full-replacement basis.
- No other employer-sponsored medical plan can be offered.
  - Exception: we allow slice business of Aetna with Kaiser Health groups if the Aetna population meets 20% minimum participation.

Out-of-state (OOS) employees

- Out-of-state participants residing outside of the network may enroll in the Aetna Fully Insured PPO, OAEPO, OAMC or Indemnity plan, depending on availability.
- Health coverage is not available in Hawaii to any group or resident located in this state.
- Health coverage is not available in Vermont to any group located in this state. Out of state employers wishing to add employees/dependents who both live and work in Vermont may do so only if the total number of Vermont certificate holders is under 25. These Vermont residents may be enrolled in a PPO or OAMC plan.
- Massachusetts employees – if the employee/group proceeds with a plan that does not meet Massachusetts credibility, the Massachusetts employee(s) could be subject to fines/penalties associated with Massachusetts credibility. For more information on Massachusetts credibility, please contact your CPA or financial advisor.
- Employees residing in Idaho, Missouri, Montana, and Wyoming are not eligible for enrollment in Managed Choice or Open Access Managed Choice medical plans. They are eligible for the PPO plan, if available.
- Aetna reserves the right to revise the rates or issue a Non-Quote Notification (NQN) if:
  - The total number of Indemnity enrollees exceeds 10 percent of the total eligible employees.

Participation Medical

Non-contributory plans (employer pays all plan contributions)

- 100 percent of total eligible employees

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

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

Waivers

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

Plan change benefit level

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

Plan change participant level

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

Premium/Billing

- ACH debit is available for premium payments.
  - The group will provide a banking consent form which will allow monthly ACH Debit withdrawal. The customer will have the flexibility to choose from one of the following:
    > Due date which is the 1st of the month, based on effective date
    > 2nd through the 28th of the month
    > The last banking day of the month
  - Banking only occurs Monday - Friday. If selected date falls on a weekend or holiday, the draft will occur on the preceding banking day.
  - Premiums will be withdrawn each month via ACH Debit withdrawal.
  - Other forms of payment are available. Plan Sponsor Services will contact the group regarding these payment options.
- Customers can also pay by check, electronic funds transfer (EFT), or by calling our automated phone system at **1-877-404-7115**. When using the automated phone system, be sure to have the checking account and routing numbers available. There is no extra charge for this service.
- Billing invoices will be provided 10 days prior to the due date.
- Up to three billing divisions are allowed.

Prior Aetna Coverage

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

Product availability

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

Professional employer organization (PEO)/co-employer groups

Small-mid size business with a PEO master health care plan follow the same underwriting guidelines as groups currently on a self-funded plan with one exception – we do not require prior carrier claims experience, unless the group has 101-200 enrolled. To receive a quote, we require:

- Renewal (including current and renewal rates)

- Benefit summary

Rating information

- Rates are based on final enrollment and require that:
  - No portion of the member's cost sharing — including but not limited to copayments, deductibles and/or coinsurance balances — will be subsidized or funded by the employer except a federally qualified Health Reimbursement Account (HRA) or Health Savings Account (HSA), whether insured or self-funded — including but not limited to a partially self-funded Section 105 wraparound, now or in the future.
- All quotes are subject to change based on additional information that becomes available in the quoting process and during case submission/installation, including any change in the census.
- All rates will be quoted on a four-tier structure: employee; employee + spouse; employee + child(ren); and family.
- For cases underwritten via member level census, groups may be re-rated if enrollment changes by more than +/- 20 percent from the initial quote enrollment projection.
- For cases requiring Individual Medical Questionnaires, 100 percent of all enrolling employees and dependents must submit an IMQ. Any census changes from the quote to sold case will impact the rates.
- For cases underwritten with IMQs, Aetna may revise the rates if census changes occur from the quote to sold case.
- Aetna reserves the right to revise the rates or issue a Non-Quote Notification (NQN) if the following are true:
  - Any of the information received is determined to be incomplete or incorrect.
  - The total number of COBRA/State Continuation enrollees exceeds 10 percent of the total eligible employees.
  - The total number of indemnity enrollees exceeds 10 percent of the total eligible employees.

Replacing other group coverage

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

Signature dates

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

Tax documents

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

Two or more companies affiliated, associated, multiple companies or common ownership

- All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 may be treated as one employer. More information can be found at https://www.irs.gov/affordable-care-act/employers and https://www.irs.gov/pub/irs-tege/epchd704.pdf.
  - The underwriter may request a QWTS or other documentation and will notify you if needed.
  - Underwriting reserves the right to final underwriting review.
  - If a common ownership group wishes to be rated together, we only will produce quotes rating the common ownership group together.
  - If a common ownership group wishes to be rated separately, we only will produce separate quotes breaking the common ownership group apart.

Waiting period

- The benefit waiting period (BWP), sometimes known as the probationary period, is the time that a member must be employed by the plan sponsor before they are eligible to enroll for benefits.
- At initial submission of the case, the BWP may be waived for current employees upon the employer's request. This

must be indicated on the employer application.

- The BWP for future employees for groups with 2-14 enrolled may be the 1st of the month following 0 days, 30 days, 60 days, or the day after 90 calendar days has been completed including the date of hire.
- The BWP for future employees for groups with 15+ enrolled may be the date of hire.
- Date of hire BWP is not available for groups with 2-14 enrolled.
- Date of hire BWP is available for groups with 15+ enrolled.
- One or two BWPs may be selected and must be consistently applied within a class of employees as defined by the employer, such as management versus non-management, hourly versus salaried, etc.
- A change to the BWP may only be made on the renewal/plan anniversary date.
- No retroactive changes will be allowed.
- BWP must be consistently applied to all plan participants, including newly hired key employees.
- A rehired employee is an employee who was previously employed by the same employer, but lost coverage due to termination of employment or reduction of hours.
  - If the employee is rehired within one year from the termination date, the employee does not have to serve the waiting period, unless otherwise specified in the plan sponsor contract.
- For new hires for groups with 2-14 enrolled, the benefit eligibility date will be the 1st of the policy month following the BWP of 0 days, 30 days, 60 days, or the day after 90 days including date of hire. Policy month refers to the contract effective date of the 1st.
  - If 0 days is selected, and the plan has a 1st of the month bill cycle, and the employee is hired on the 1st of the month, the effective date will be the date of hire.
  - If 90 Days is selected, the enrollment eligibility date will begin the day after 90 calendar days have been completed including date of hire.

Examples	1st of the month following the BWP
0 days	Date of hire: 4/1 Effective date: 4/1
0 days	Date of hire: 4/18 Effective date: 5/1
30 days	Date of hire: 4/18 Effective date: 6/1
60 days	Date of hire: 4/18 Effective date: 7/1
90 days	Date of hire: 4/18 Effective date: 7/17 not 8/1 – The day after 90 days is completed including date of hire.

- For new hires for groups with 15+ enrolled, the benefit eligibility date may be the date of hire.

Specific guidelines for Banner | Aetna

Enrollment

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

Banner | Aetna plan availability

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

Licensed and appointed producers

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

Live/Work

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

Pick five

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

Quoting

New business

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

2+ Dental

Refer to Producer World for Ancillary (Dental and Vision) underwriting guidelines.

2+ Vision

Refer to Producer World for Ancillary (Dental and Vision) underwriting guidelines.

Aetna.com

©2021 Aetna Inc.
5991450-27-01 (9/26)