Ancillary underwriting brochure

For businesses with up to 100 employees *

(*Refer to page 3 for a list of applicable states and group sizes)

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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 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.

If in the future, an ancillary standalone group adds a medical product, some guidelines may change. Refer to the associated medical underwriting guidelines for the topic.

The following set of ancillary guidelines will apply to employers based on the eligible lives for their state per the below grid.

Small Group 2-50 eligible lives	**Small Group 2-100 eligible lives**	
50 or fewer eligible employees in the combined employer businesses	100 or fewer eligible employees in the combined employer businesses	
• District of Columbia (2-50 eff 10/1/2024) • Idaho • Minnesota • Nevada • Utah • Washington • Wyoming	• Arizona • California • Colorado • Connecticut • Delaware • Florida • Georgia • Illinois • Kansas • Kentucky • Louisiana • Maine • Maryland • Michigan	• Missouri • Nebraska • New Jersey • New York • North Carolina • Ohio • Oklahoma • Pennsylvania • South Carolina • Tennessee • Texas • Virginia • West Virginia

Benefit waiting period (BWP)

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

For standalone dental and/or vision, the following applies:

- The benefit waiting period (BWP), sometimes known as the probationary period, is the period of time that a member must be employed by the plan sponsor before they are eligible to enroll for benefits.
- Only one BWP is available.
- A change to the BWP may only be made on the plan anniversary date.
- No retroactive BWP changes will be allowed.
- BWPs must be consistently applied to all employees, including newly hired key employees.
- At initial submission of the group, the BWP may be waived upon the group's request by checking the associated field on the employer application.
- For new hires, the benefit eligibility date will be either the 1st or 15th of the policy month following the BWP of 0 days, 30 days, 60 days, or the day after 90 calendar days has been completed.

  Policy month refers to the contract effective date of the 1st or 15th.

  - If "0" days is selected and the group has a 1st of the month bill cycle, and the employee is hired on the first of the month, the effective date will be the date of hire.
  - If "0" days is selected and the group has a 15th of the month bill cycle, and the employee is hired on the 15th of the month, the effective date will be the date of hire.
  - If "90 Days" is selected, the enrollment eligibility date begins 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

- A rehired employee is an employee who was previously employed by the same employer, but lost coverage due to termination of employment or reduction of hours.
    - If the employee is rehired within one year from the termination date, the employee does not have to serve the waiting period, unless otherwise specified in the plan sponsor contract.
    - If the employee is rehired after one year from the termination date, the waiting period must be met.

Billing

- The ACH banking agreement is the most efficient way to pay the premium, other options are available.
- ACH debit is the standard method for premium payments.
- If the group elects monthly ACH debit withdrawal, the group will provide a completed banking consent form.
- The customer will choose from one of the following billing due dates:
    - Either 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.
- If ACH is not desired, please complete the ACA Banking Consent Form with the group name and select the option 'Additional payment options requested'. Plan Sponsor Services will contact the group regarding these payment options.

Carve outs/excluded classes of employees

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and / or vision, the following applies:

- Only union employees can be carved out, no other classes may be excluded.

Case submission dates

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and/or vision, the following applies:

- **California**: Sold case submissions must be received in Aetna Underwriting as follows:
    - 1st of the month effective dates - must be received by the effective date.
    - 15th of the month effective dates - must be received by the effective date.

- Any state not noted above: Sold case submissions must be received in Aetna Underwriting as follows:
    - 1st of the month effective dates – must be received by 25th of the prior month.
    - 15th of the month effective dates* - must be received by 10th of the month.

    *Note: 15th of the month effective dates are not available in: AK, ID, WA and MD SHOP.
- If the cut-off falls on a weekend or holiday, next available business day will be the cut-off.
- All required forms must be received upon initial case submission. Your case submission is not considered as complete until the following items are received: Employer application, One Census – ACA, and banking form. Cases that are submitted without these required forms will be moved to the next effective date.

COBRA

- COBRA coverage will be extended in accordance with the federal/state legislation/regulations.
- COBRA is an employer directed law. Employers are responsible for notifying eligible plan participants of their COBRA rights upon loss of coverage.
- COBRA applies to employers with 20 or more employees on more than 50% 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 the part time employee worked divided by the hours an employee must work to be considered full time.
- Because COBRA is directed at employers, the decision to comply with COBRA should be made by the employer. In situations where it may appear the employer is not subject to COBRA, for example a three-life group requesting COBRA, we will ask the employer to "validate" the number of employees in the prior calendar year to determine the number of employees for COBRA purposes.
- If the COBRA enrollee does not reside in an Aetna service area, they are only eligible for urgent/emergency care.
- Provide the qualifying event, length, start and end.
- COBRA participants are not billed separately and are included with the group bill.
- COBRA participants are required to be included on the census.
- COBRA participants are not to be included for purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law applies to the group, retirees and COBRA participants can be included for coverage subject to normal underwriting guidelines.

Dependent eligibility

For dental and/or vision, the following applies:

- Spouse: If both employee and spouse work for the same company, they may enroll together or separately.

- Domestic partner: Coverage is available upon request except as noted below.
  - The following states mandate domestic partner coverage: California and Washington.
  - In Louisiana, domestic partners are not eligible for coverage.
- Dependent children:
  - Children are eligible as defined in plan documents in accordance with applicable state and federal laws, up to the end of the month the dependent turns age 26 except as noted below for Connecticut and Florida, 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.
  - Connecticut based groups: Dependent children are covered until the end of the policy year when the dependent turns 26.
  - Florida based groups and subscribers: Dependent children are covered until the end of the calendar year when the dependent turns 26.
  - 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 papers must be submitted.
  - Incapacitated Child: Attainment of limiting age will not terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance.
- Proof of incapacity and dependency shall be furnished to Aetna by the employee or the member within 31 days of the child's attainment of the limiting age and subsequently as we may require it, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
- Dependents must enroll in the same benefit option as the employee (participation is not required).
- Individuals cannot be covered as an employee and dependent under the same plan.

Effective date

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and/or vision, the following applies:

- The effective date must be the 1st or the 15th of the month.
- Dental benefits are administered on a calendar year basis (regardless of medical).

Employee eligibility

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and/or vision, the following applies:

- Retirees are not eligible for standalone vision coverage.

- An eligible employee is one who works 30 hours or more per week and meets the state and federal definition of employee.
- Coverage must be extended to all employees who meet the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement. While they must be included in the count in determining whether the group is a small employer, the employer may carve out union employees as an excluded class.
- For 2-50 eligible groups, retirees are not eligible for dental coverage.
- For 51-100 eligible groups dental coverage:
    - Retirees cannot comprise more than 10% of the group.
    - The total number of COBRA enrollees cannot comprise more than 10% of the total eligible employees.
- Ineligible employees include leased, part-time, temporary, seasonal or substitute employees, 1099 (independent contractors), uncompensated employees, employees making less than equivalent minimum wage, volunteers, inactive owners, directors, shareholders, officers, outside consultants, managing members who are not active, investors or silent partners.

Employee enrollment

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and/or vision, the following applies:

- Employee enrollment must be submitted via ACA One Census.
- The employer keeps a copy of the paper applications on file for auditing purposes.
- ACA One Census is available on **Producer World.**
- IMPORTANT: download a fresh ACA One Census from Producer World for every group instead of saving one version to your desktop.
    - The employee enrollment forms do not need to be included in the sold case submission. All the required information must be entered into ACA One Census.
    - 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 ACA One Census.
    - COBRA/State continuation participants should be included and noted as COBRA/state continuation.
    - ACA One Census must be completed in full.

Employer eligibility

If dental or vision is sold along with medical, follow the medical underwriting guidelines for this topic. For standalone dental and/or vision, the following applies:

- Groups must consist of at least one enrolled W-2 employee who is not an owner and not an owner's spouse.
- Organizations must not be formed solely for the purpose of obtaining coverage.
- Associations, Taft Hartley groups, 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.
- Upon renewal, groups may be required to complete an employer verification form.

- When dental is sold or renewed without medical (aka standalone dental), the standard industrial classification codes (SICs) listed below are ineligible for all states except Washington.

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
8621	Professional member organizations
8631	Labor unions and similar labor organizations
8641	Civic social and fraternal associations
8651	Political organizations
8661	Religious organizations
8699	Membership organizations, not elsewhere classified
8811	Private households
8999	Miscellaneous services, not elsewhere classified

Employers replacing other group coverage

- The employer should not cancel any existing coverage until they have been notified of approval from the Aetna Underwriting unit.

Forms

- Links to enrollment forms are available on **Aetna.com under employer forms.**

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** and click "Register Now."

Live/work

This topic does not apply to vision.

For dental, the following applies:

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

Plan changes group level

- Changes allowed on plan anniversary date only.

Signature dates

- The Aetna employer application and all employee applications must be signed and dated before and within ninety (90) days of the requested effective date.
- All employee applications must be completed by the employee himself/herself.
- Electronic signatures are acceptable.

Spinoff groups

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 and the new spinoff group.
- Ownership documents showing that the spinoff company is a newly formed separate entity.
- A minimum of two weeks payroll.
- For dental, a spinoff group may qualify as a takeover group, if the group they spun off from has prior dental coverage for major services or a preventive + basic coverage plan.
    - Please see more details about takeover group qualifications under the "Dental Coverage waiting period section"

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/DNO, PPO/PDN, non-voluntary/voluntary) and number of eligible employees determine whether a waiting period applies.
    - **Maine:** Waiting periods do not apply to Maine based employer groups or members.
    - **Ohio and Texas:** Waiting periods do not apply to 10+ eligible groups enrolling in Ohio or Texas state voluntary plans only. Waiting periods do apply if these groups enroll in National voluntary plans.
    - 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.
    - Starter groups do not currently have dental coverage.
    - Waiting periods do not apply to DMO/DNO plans.
    - Waiting periods do not apply to 10+ eligible groups with standard (non-voluntary) PPO/PDN and Indemnity plans.
    - Freedom-of-choice (FOC) plans follow the respective DMO/DNO and PPO/PDN plan rules listed above.
    - Non-voluntary PPO/PDN, Indemnity, 2 to 9 eligible employees:
        - Starter groups: Waiting period applies.
        - Takeover groups: No waiting period based on qualified prior group coverage (major, major + ortho).
    - Non-voluntary PPO/PDN, Indemnity, 10 to 100 eligible employees:
        - Starter or takeover groups: No waiting period.
    - Voluntary PPO/PDN, Indemnity, 2 to 100 eligible employees:
        - Starter groups: Waiting period applies.
        - Takeover groups: No waiting period based on qualified prior group coverage (major, major + ortho).

Creditable prior coverage – employer/group

- Complete in full the prior carrier information section of the employer application.
    - Plans that include preventive and basic coverage DO qualify as having prior coverage of major services.
    - 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.

Employer contribution

- **Non-voluntary:**
    - 2-50 eligible: Employer must contribute at least 25 percent of the total cost or 50 percent or higher of the cost of employee only coverage for dental plans.
    - 51-100 eligible: Employer must contribute any amount of the total cost.
    - For non-contributory plans, the employer pays the entire premium.
- **Voluntary:**
    - 2-50 eligible: Employer contributes less than 25 percent of the total cost or 50 percent or lower of the cost of employee only coverage for dental plans, or if the coverage is 100 percent paid by the employee.
    - 51-100 eligible: 100 percent paid by the employee.
- If employer contribution is 50%, assume non-voluntary plan if not otherwise indicated.

Late applicants

If dental is 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, 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 rule (does not apply to Maine-based employer groups or members): 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 Aetna

- 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
    - Diagnostic and preventive services such as exams, cleanings, fluoride, and images (excludes services related to orthodontia).

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.

Participation

- **New York:** Regulatory minimum participation is the lesser of 50% of eligibles or 5 enrollees.

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, it is not considered a valid waiver.

Non-voluntary

- 2 to 3 eligible: Can be either contributory or non-contributory, 100 percent participation excluding spousal waivers, with a minimum of 2 enrolled employees.
- 4 to 50 eligible:
    - Non-contributory: 100 percent participation excluding spousal waivers.
    - Contributory: 75 percent participation excluding spousal waivers and 50 percent of total eligible employees must enroll
- 51 to 100 eligible
    - Non-contributory: 100 percent participation excluding spousal waivers
    - Contributory: 30 percent participation excluding spousal waivers

Voluntary

- 2 to 100 eligible: contributory only; minimum 30 percent participation excluding spousal waivers and a minimum of 2 enrolled

  Example: 20 eligible employees, 8 spousal waivers, 10 employees enrolling
  Step 1: Compute 75 percent participation
  20 – 8 valid waivers = 12
  12 x 75% = 9 enrolled
  Step 2: Compute 50 percent of total eligible employees
  20 x 50% = 10 enrolled
  The group meets participation with 10 employees enrolling.

- **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 percent change in premium will be rerated.

Plan changes employee level

- Freedom-of-Choice: May change from DMO/DNO to PPO/PDN and vice versa at any time but must notify Aetna by the 15th of the current month to be effective for the next month.
- Plan changes other than Freedom-of-Choice are only allowed during the plan anniversary date's enrollment period.

Product availability

- 1 eligible employee: dental products are not available
- 2 – 100 eligible
  - Non-voluntary and voluntary plans are available.
  - Orthodontic coverage:
    - 2-9 eligible: available
    - 10-100 eligible: available, a minimum of 5 must be enrolled.

Product packaging

- Dental can be sold as standalone without medical.
- Freedom-of-Choice, where available, cannot be packaged with any other option. It must be the only plan sold.
  - If Freedom-of-Choice is not available where an employee lives, a default PPO/PDN plan will be provided for those employees. **Note:** The PPO/PDN plan will only be available to the applicable employees and is not considered a dual option package.
- A DMO/DNO plan can be sold as the only dental plan in all states except in Florida, Maryland, New Jersey, and Virginia.
- DMO/DNO must be packaged with a PPO/PDN in Florida, Maryland, New Jersey, Virginia.

- For all other states, DMO/DNO (if available) can be packaged with any PPO/PDN.
- When offering a DMO/DNO and PPO/PDN plan together, the below combinations are allowed:
  - Both the DMO/DNO and PPO/PDN include the ortho benefit ***or***
  - Both the DMO/DNO and PPO/PDN exclude the ortho benefit ***or***
  - The DMO/DNO can include the ortho benefit while the PPO/PDN can exclude the ortho benefit.
- A group cannot offer more than two plans, as outlined above.
- PPO/PDN plans cannot be packaged together except in the following scenario:
  - Group must have 51+ eligible employees.
  - Group must have Aetna medical.
  - Dental plans must cover the same service categories (preventive, basic, major and ortho).
  - Plan benefits must have a minimum of 10% differential for basic and major services.
- Voluntary and non-voluntary plans cannot be sold together.

In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

In Virginia, Aetna DMO® is called Aetna DNO. It is not an HMO. To receive maximum benefits, members must choose a participating primary care dentist to coordinate their care with in-network providers.

Vision

- Available to groups of 2 or more eligible employees.
- A minimum of 1 enrolling employee is required.
- The employer may only offer one vision plan to all employees.
- Existing groups may only add vision at renewal.
- Late enrollments (more than 31 days from the date first eligible or more than 31 days from a qualifying event) are not permitted. Enrollment must be deferred to the next plan anniversary date.
- If purchasing only Vision, the Employer Application only needs the following:
  - Group Contact information: Contact name, Phone number, Fax number, Email address
  - Benefit waiting period information (if classes of employees, need each employee labeled)
  - Employer signature
  - Broker information: Broker name (both agent and agency), Tax ID number/SSN, Broker mailing/physical address, Broker email address

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This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits may vary by location. Health/dental benefits, health/dental insurance plans/policies contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Plan features and availability may vary by location and group size. Investment services are independently offered through PayFlex, Inc. Aetna HealthFund HRAs are subject to employer defined use and forfeiture rules and are unfunded liabilities of your employer. Fund balances are not vested benefits. Providers are independent contractors and not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health and dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. The Aetna Personal Health Record should not be used as the sole source of information about the member's medical history. Information is believed to be accurate as of the production date however it is subject to change. Go to **Aetna.com** for more information about Aetna plans.

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