California ACA Underwriting Brochure

Medical Plans effective January 1, 2025 and later

For businesses with 1– 100 full-time equivalent employees

aetna®

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

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

Underwriting Guidelines

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

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

All underwriting guidelines are subject to change without notice.

Affiliated, associated, multiple companies, common ownership

- All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. More information can be found at **https://www.irs.gov/affordable-care-act/employers** and **https://www.irs.gov/pub/irs-tege/epchd704.pdf**.
  - There are 100 or fewer employees in the combined employer businesses. All full-time employees who are a part of a common controlled group along with employees under a common controlled group in other states must be included in the enrollment count.
  - Underwriting reserves the right to final underwriting review and may ask for additional documentation.

Benefit waiting period (BWP)

- The benefit waiting period (BWP), sometimes known as the probationary period, is the time that a member must be employed by the plan sponsor before they are eligible to enroll for benefits.
- At initial submission of the group, the BWP may be waived upon the employer's request. This should be checked on the employer application.
- The BWP for future employees may be 1st or 15th of the month following: 0 days, 30 days, 60 days, or the day after 90 calendar days has been completed.
  - 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.
- Date of hire BWP is not available.

- One waiting period is available.
- A change to the BWP may only be made on the plan anniversary date.
- No retroactive changes to the BWP will be allowed.
- BWPs must be consistently applied to all employees, including newly hired key employees.
- New hires:
  - The benefit eligibility date will be either the 1st or 15th of the policy month following the benefit waiting period of 0 days, 30 days, 60 days, or the day after 90 calendar days.
  - Policy month refers to the contract effective date of the 1st or 15th.
  - If "90 Days" is selected, the enrollment eligibility date will begin the day after 90 calendar days has been completed.

Examples	1st of the month following the BWP	15th of the month following the BWP
0 days	Date of hire: 4/1 Effective date: 4/1	Date of hire: 4/1 Effective date: 4/15
0 days	Date of hire: 4/18 Effective date: 5/1	Date of hire: 4/18 Effective date: 5/15
30 days	Date of hire: 4/18 Effective date: 6/1	Date of hire: 4/18 Effective date: 6/15
60 days	Date of hire: 4/18 Effective date: 7/1	Date of hire: 4/18 Effective date: 7/15
90 days	Date of hire: 4/18 Effective date: 7/17 not 8/1 – the day after 90 days is completed	Date of hire: 4/18 Effective date: 7/17 not 8/15 – the day after 90 days is completed

Billing

- The ACH banking agreement is the most efficient way to pay the premium, other options are available.
- ACH debit will be the standard method for premium payments. The group will provide a banking consent form which will allow monthly ACH Debit withdrawal. The customer will have the flexibility to choose from one of the following:
  - Due date which is the 1st of the month, or the 15th of the month based on effective date
  - 2nd through the 28th of the month
  - The last banking day of the month
- Banking only occurs Monday - Friday. If selected date falls on a weekend or holiday, the draft will occur on the preceding banking day.
- Premiums will be withdrawn each month via ACH Debit withdrawal.

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- 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.
- For groups with 20 -100 enrolled, up to 3 billing divisions are allowed.
  - The group must provide the following:
    - Name of divisions and the divisions addresses; and
    - Indicate the division each member belongs to on ACA One Census.
    - Confirm the group wants one bill or separate bills.
  - The group should use ebilling to view the bill package premium by division to make payments by division.
  - Groups can use the auto-draft process if all divisions use the same bank account.

Businesses located outside the United States

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

Carve outs – excluded class

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

Case submission

- 1st of the month effective date – must be received by the effective date.
- 15th of the month effective date – must be received by the effective date.
- If the cut-off falls on a weekend or holiday, next available business day will be the cut-off date.

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- 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, ACA One Census, QWTS and banking form. Cases that are submitted without these required forms will be moved to the next effective date.
- Sold groups must submit employee enrollment via ACA One Census. ACA One Census is available on **Producer World**, Small Group.
  - The employer keeps a copy of the paper applications on file for auditing purposes.
    - IMPORTANT: Download a fresh ACA One Census from Producer World for every group instead of saving one version to your desktop.
    - > When ACA One Census is used, the employee enrollment forms do not need to be included in the sold case submission. All the required information must be entered into 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.

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.

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- 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

- Federal COBRA applies to: Group health plans sponsored by employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.
  - Include: full time, part time, seasonal, temporary, union, owners, partners, officers.
  - Exclude: self-employed persons, independent contractors (1099), directors.
  - Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.
- The COBRA/Cal-COBRA participant must reside in the plan service area. If not, they are only eligible for out-of-network benefits, or urgent/emergency care.
- COBRA/Cal-COBRA eligible enrollees should be included on the census to ensure accurate rates are quoted. The qualifying event, length, start date and end date must be provided in addition to the items noted under the Census Data section above.
- COBRA/Cal-COBRA participants are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined according to the law applicable to the group, COBRA/Cal-COBRA participants can be included for coverage subject to normal underwriting guidelines.
- COBRA participants are not billed separately and are included with the group bill.
- Cal-COBRA premium: A separate check is needed from the member payable to Aetna at the time of the new business case submission.
- For more information visit **California Department of Managed Healthcare** or **California Department of Insurance**.

Deductible and coinsurance (out-of-pocket) credit

- A member's out-of-pocket maximum paid in the same calendar year will be credited to the new plans' out-of-pocket maximum.

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- 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 to direct the information to the correct area for processing.
- Deductible credit does not apply to groups coming from a PEO.
- Deductible carryover not allowed.

Dependent eligibility

- Eligible dependents include:
  - Spouse and domestic partner of employee. If both employee and spouse/domestic partner work for the same company, they may enroll together or separately.
  - Children
    - Children are eligible as defined in plan documents in accordance with applicable state and federal law, for medical and dental coverage up to the end of the month when turning age 26, regardless of financial dependency, employment, eligibility of other coverage, student status, marital status, tax dependency or residency. This requirement applies to natural and adopted children, stepchildren, children of domestic partners and children subject to legal guardianship.
    - Children can only be covered under one parent's plan when both parents work for the same company.
    - Grandchildren are eligible if court ordered. A copy of the court order must be submitted.
- Dependents must enroll in the same benefit plan as the employee (participation is not required; however, waivers are required).
- Employees may select coverage for eligible dependents under the dental plan even if they selected single coverage under the medical plan.
- Individuals cannot be covered as an employee and dependent under the same plan.

Effective date

- The effective date must be the 1st or the 15th of the month.
- The effective date requested by the group may be up to 60 days in advance.

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- Groups with prior coverage need to coordinate their effective date to ensure they don't have coverage with two carriers at the same time.

Employee eligibility

An eligible employee is:

- Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal work week of an average of 30 hours per week over the course of a month, at the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements (subject to withholding on a W-2 form); ***or***
- Employee is a sole proprietor, spouse/domestic partner of sole proprietor, corporate officer, partner of a partnership, or the spouse or domestic partner of a partner of a partnership engaged on a full-time basis an average of 30 hours per week, in the employer's regular places of business and the group meets all small employer eligibility requirements.
- Employee works at least 20 hours, but not more than 29 hours per week in the employer's business on a permanent, year-round basis and meets the individual employee criteria, as defined within California Health and Safety Code for an eligible part-time employee:
  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

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- Out-of-state employees who live in an out-of-state network area may enroll if they live in an area with an OA Managed Choice POS network or an Open Choice PPO network and will receive California rates and plans (inclusive of any required extraterritorial benefits).
- HMO plans are not allowed for employees located outside of the CA HMO service area. Dependents enrolled on an HMO Plan have coverage for emergency services only outside of the CA HMO service area.
- Hawaii and Vermont - health coverage is not available.
- Guam, Puerto Rico, and U.S. Virgin Islands – health coverage is not available.
- Employees residing in Idaho, Missouri, Montana, and Wyoming are not eligible for enrollment in Managed Choice or Open Access Managed Choice medical plans. They are eligible for the PPO plan, if available.
- Massachusetts employees - if the group has any Massachusetts employees, the plan needs 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

The group must quality as a 'small employer' as defined by the California Insurance Code Sections 10700, 10752, and 10755, and the California Health and Safety Code Section 1357.500, and the federal Patient Protection and Affordable Care Act (ACA) as follows:

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

- The owner or officer signing the employer group application for the group must be a resident for tax purposes in the state in which the group is applying for medical coverage.
- Employs at least one full time, (working an average of 30 hours or more per week), W-2 employee who is also an 'eligible employee'.

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- Sole proprietors and their spouses or domestic partners, and partners or a partnership and their spouses or domestic partners are employees for purposes of determining whether an employer has one employee.
- The group has at least 51% of the employees located in CA.
- In determining whether to apply the calendar-quarter or calendar-year test, we will use the test that ensures eligibility if only one test would establish eligibility.
- In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation, shall be considered one group.
- For the purpose of determining eligibility, the size of a small employer may be determined annually.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse or domestic partner.
- Groups that do not meet the definition of a small employer are not eligible for coverage.
- Groups formed solely for the purpose of obtaining health coverage are not eligible for coverage.
- Groups with no existing health coverage must provide a copy of the most recently filed DE 9C (Quarterly Wage and Tax Statement). This applies to groups that have been in business longer than 3 months.
- Associations, Taft Hartley groups, professional employers' organizations (PEO)/employee leasing firms and closed groups (groups that restrict eligibility through criteria other than employment) and groups where no employer/employee relationship exists are not eligible for coverage.
- Groups with prior unpaid premium are eligible for coverage.

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

Employers leaving a PEO (professional employer organization)

- Groups that use the services of a PEO generally do not meet the definition of a small employer as the transfer of employees to the PEO in effect ends/severs the

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employer/employee relationship. The employees become part of the large PEO group, are considered employees of the PEO, and are paid by the PEO.

- If the PEO has a health plan available to any of their clients (employer businesses), these same employer businesses applying for Aetna small group coverage are not eligible.
- Groups currently with a PEO who indicate health coverage is not available through the PEO must provide a letter from the PEO indicating health coverage is not available to any of their clients (employer businesses).
- Groups that indicate they are with a PEO when sent in as a sold group and subsequently indicate they have terminated their PEO contract must provide a copy of the contract termination letter sent from the PEO to the client (employer) business. This letter must verify the cancellation of the leasing arrangement as well as the cancellation date.
- Groups using "payroll services" through a company that itself (or through an affiliate) also offers PEO services are eligible subject to meeting the standard underwriting guidelines for eligibility, participation, etc.
- A group must choose one coverage option and may not offer different coverage arrangements (e.g., both as a large and small employer) at the same time.
- Underwriting reserves the right to request additional documentation to support eligibility.

Employer's replacing other group coverage

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

Forms

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

Guarantee issue – New Business

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

Guarantee renewability - Renewal

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- Both the Affordable Care Act (ACA) and the federal HIPAA law mandate no small employer, or an individual can be turned down by an insurance company for group coverage due to their medical history. This is known in the insurance industry as “guaranteed issue”.
- A group must be renewed unless one or more of the following exceptions apply:
  - Fraud or intentional misrepresentation of material facts.
  - Failure to comply with participation or contribution requirements.
  - For network plans, failure to meet an insurer’s service area requirements if no enrollee lives, works, or resides in service area.
  - Membership by a participating group in the association ceases if association group coverage.
  - Insurer discontinues a particular type of coverage or discontinues all coverage from the market.
  - Group no longer meets definition of group under state law.
  - Non-payment of premium

Group size

- Use the "full-time equivalent" (FTE) employee counting method to determine group size. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.
- Group size is calculated using employees who worked in the preceding calendar year. Mid-year fluctuations in the number of employees do not affect a determination of group size.
- Business not in existence the prior year should calculate the group size based on the “average number of employees the employer is reasonably expected to employ on business days in the current calendar year.”
- Full-time employees are those who worked on average 30 hours or more a week for more than 120 days in a year (even if they are not enrolling for health coverage); or the number of employees the employer expects to work these hours. If the total number of employees isn’t a whole number, round it down to the nearest whole number.
- Include in the count (even if they are not eligible nor enrolling for health coverage):
  - All full-time employees of a group if the business is affiliated with another employer, under common ownership, or a part of a controlled group.
  - Employees under a common group in other states
  - Part-time employees who worked on average less than 30 hours per week
  - Union employees

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- 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.

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- Parent company - a parent company is a holding company that owns enough voting stock in another firm (subsidiary) to control management and operations by influencing or electing its board of directors. A parent company could simply be a company that wholly owns another company.

Example

  - Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).
  - Bank A (the holding company) has no ownership; it is simply an umbrella company for the three Bank B locations.
  - Bank B has three locations and all under one TIN.
  - Bank A (the holding company) is under a separate TIN.
  - The holding company and banks have no ownership because the owners are all stockholders and bank employees or bank executives.
  - There are no articles of incorporation, only stock certificates.
  - Bank B is the only group enrolling. Bank A is listed as an associated company with no employees and the group are not to be enrolled.
  - Documentation needed: QWTS for Bank B, which should include all three locations.

Initial premium

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

Late applicants

- An employee or dependent enrolling for coverage more than 31 days from the date first eligible or 60 days from the qualifying event is considered a late enrollee.
- Applicants without a qualifying event (for example, marriage, newborn child, adoption, loss of spousal coverage, etc.) are subject to the late entrant guidelines as noted below.
- Voluntary cancellation of coverage is not a qualifying event unless it is done at open enrollment.
- For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open enrollment to be eligible to enroll. However, if each spouse has different open enrollment dates and drops coverage during their annual open enrollment period, the spouse is eligible to enroll.

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- Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days before the anniversary date.

Licensed, appointed producers

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

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.

Network availability

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

Newly formed business (in operation less than 3 months)

A newly formed group must meet the following requirements:

- Employs at least one eligible employee who is not the proprietor or spouse/domestic partner of proprietor but not more than 100 eligible employees.

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

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

- Groups that do not meet Aetna standard participation or contribution requirements are eligible to enroll for medical coverage during an annual open enrollment period.
- Groups must be submitted between November 15 and December 15 of each year for a January 1 effective date.
- Other Underwriting Guidelines still apply for all coverages including Medical.
- Groups must provide the quarterly wage and tax statement (see Tax Documents section for requirements) and attestation form indicating Aetna is the only carrier offered to the group.
- Standard W-2 rules apply.
- Groups must be complete and have all requirements in by December 15. No exceptions for missing items.
- Ancillary coverage (dental and vision) along with medical may be included during this open enrollment period. Standard participation and contribution requirements apply to ancillary coverage.
- Groups that don't meet our standard participation or contribution requirements will be denied coverage outside of this open enrollment period.

Option sales alongside other carriers

- Groups offering another carrier's HMO or PPO must have:

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  - at least 25% participation with Aetna and a minimum of 5 or more CA employees enrolling in an Aetna plan.
  - 60% participation for four or less CA enrolled employees.
  - Only Aetna and one other carrier is allowed.
- Employees covered by the same employer on another group policy are not considered a valid waiver.

Participation medical

Noncontributory plans (group pays all)

- 100% of eligible employees excluding valid waivers.

Contributory plans

- Groups offering other carrier's HMO or PPO, go to section **Option Sales Alongside Other Carriers** for participation rules.
- For non-option sales, 25% with Aetna and a minimum of 5 or more CA employees enrolling in an Aetna plan. If not a minimum of 5 or more CA employees, participation must be 60%:
  - of eligible employees excluding valid waivers, rounded down.
  - Valid waivers include spousal group coverage, parental group coverage, individual coverage (on and off exchange), Medicare, Medi-Cal, Champus, and TRICARE.
- Employees covered by the same employer on another group policy are not considered a valid waiver, see Option Sales section above.
- All employees waiving coverage must complete the waiver section of the application and be listed as a waiver on ACA One Census.
- If the coverage is not from a qualifying group plan, the employee may not be considered a valid waiver and will count toward the minimum participation requirement.

Pick 10

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

Plan changes employee level

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- Employees are not eligible to change plans until the group's open enrollment period, which is upon their annual renewal (except for qualified special enrollment events).

Plan changes employer level

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

Product availability medical

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

Rates

- Rates are based on the employer ZIP code and member's date of birth.
- Rates for members enrolling after the effective date or renewal date are based on the age of the person as of the effective date of coverage.
- Member rates will not change until the group's renewal date.
  - We do not change rates/plans mid policy based upon a group's address change. Rates will be adjusted for groups moving to another rating area at next renewal.

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 time in business up to a maximum of six consecutive weeks.

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- 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 4 enrolled employees
  - 5 to 100 enrolled employees with no current employer group health coverage.
- 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 not listed on the QWTS are required to submit the most recent IRS tax documents and the entity formation documents.
- The underwriter may request additional documentation, if necessary.

1099 Employees

- 1099 employees are not eligible.

Dental

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

Vision

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

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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. For more information about Aetna plans, refer to www.aetna.com.

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