Alaska ACA Underwriting Brochure

Plans effective January 1, 2024 and later

For businesses with 1– 50 total average employees written through TBS

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

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Table of Contents

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 50 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.
- BWPs must be consistently applied to all employees, including newly hired key employees.
- The BWP for future employees may be the first of the month following 0 days, 30 days, or 60 days.
    - 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.
- Aetna does not have a date of hire BWP.

- Only one BWP is available.
- A change to the benefit waiting period may only be made on the plan anniversary date.
- No retroactive BWP changes will be allowed.
- New Hires - the benefit eligibility date will be the 1st of the month following the BWP of 0 days, 30 days, or 60 days.
  - If "0" days is selected, and the employee is hired on the 1st of the month, the effective date will be the 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

Carve outs – excluded class

Medical

- Union employees are the only class of employees that may be excluded. However, union employees are included in the total count of eligible employees in determining the case size.
- Management carve-outs and other carve-outs are not allowed.
- Only Union employees can be carved out, no other classes may be excluded.

Case submission dates

- Sold case submissions must be received in Aetna Underwriting as follows:
  - For 1st of the month effective dates, by the 25th of the prior month.
- 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, ACA One Census, QWTS and banking form. Cases that are submitted without these required forms will be moved to the next effective date.

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.
- COBRA coverage will be extended in accordance with federal legislation/regulations.
- Employers with 20 or more employees (full and part time) are eligible to offer COBRA coverage.
- 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 a part time employee worked divided by the hours an employee must work to be considered full time.
- COBRA is an employer directed law. Employers are responsible for notifying eligible plan participants of their COBRA rights upon loss of coverage.
- 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.
- Companies under common ownership are included in the count.
- COBRA participants are not billed separately and are included with the group bill.
- The COBRA participant must reside in the plan service area. If not, they are only eligible for out-of-network benefits, or urgent/emergency care.
- Eligible participants are required to be included on the census.
- Provide the qualifying event, length, start date and end date.
- 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 participants can be included for coverage subject to normal underwriting guidelines.

Counting employees to determine group size

- Total Average Employees (TAE) will be the method used in counting employees for determination of group size eligibility between the 1-50 market and 51-100 market.
- Once the segment size is determined (1-50 or 51-100), we will use the applicable guidelines for product availability, participation, contribution, etc.
- Calculate the average number of employees you employed for the entire previous calendar year. **Here's who you need to include:**
  - 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.
- Illustrative quote - use the TAE count at time of quote.
- New business submission - complete the 'Affordable Care Act (ACA) Medical Loss Ratio Requirement' field on the employer application.
- Groups with 50 or fewer total average employees in the prior calendar year are rated as a small employer no matter the number of eligible or enrolling.
  - Example: TAE is 45 based on the prior calendar year; 65 eligible - this is a 1-50 group.
  - If the TAE is 1-50 in the previous calendar year and the eligible is more than 50, this is a 1-50 group.
- If the TAE is 51-100 in the prior calendar year and the eligible is less than 51-100, this is a 51-100 group.
  - Example: 90 TAE based on the prior calendar year; 40 eligible - this is a 51-100 group.
  - If the TAE is 101+ based on **previous calendar year** and the eligible is 51-100, this is a 51-100 group
  - Example: 110 TAE based on previous calendar year; 57 eligible - this is a 51-100 group.

Deductible and coinsurance (out-of-pocket) credit

- 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 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 faxed to claims at 1-866-474-4040 no later than 90 days after the effective date. If faxed, 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.
- Deductible and Coinsurance (Out of Pocket) carryover is not allowed.
- Deductible and Coinsurance (Out of Pocket) credit reports may be submitted. Be sure it includes Social Security numbers.

Dependent eligibility

- Eligible dependents include:
  - Spouse and domestic partner of employee. If both employee and spouse /partner work for the same company, they may enroll together or separately.
  - Domestic partners (same or opposite sex) and their eligible children may be covered as eligible dependents if the employer elects this designation at contract effective date or renewal date. An affidavit is not required. The plan sponsor is responsible for determining whether the domestic partner is eligible.
  - Children
    - Children are eligible as defined in plan documents in accordance with applicable state and federal law, up to the end of the month when turning age 26, regardless of financial dependency, employment, eligibility of other coverage, student status, marital status, tax dependency or residency. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.
    - 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.
    - Newborns of dependents and grandchildren (if court ordered) are eligible. 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 of the month.
- The effective date requested by the group may be up to 60 days in advance.

Employee eligibility

An eligible employee is:

- A full-time employee who works at least 30 or more hours per week. Aetna will allow employers to cover employees who work 20 hours or more, however, 30 hours is used to determine the size of the group.
- The term eligible employee includes a sole proprietor, a partner of a partnership, or an independent contractor (1099) if the sole proprietor, partner, or contractor is included as an employee under a health care insurance plan of a small employer.
- 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.
- Ineligible employee - employees/individuals not eligible for coverage include temporary employees, seasonal employees, substitute employees, uncompensated employees, volunteers, retirees, inactive owners, officers who are not active, managing members who are not active, investors or shareholders who are not otherwise eligible and silent partners.
- Retirees are not eligible for any coverage – medical, dental, vision.

Employee enrollment

- 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 contribution

Medical

- 50% of the employee-only rate of whichever plan the employee selects.

- Groups that do not meet contribution requirements are eligible to enroll during open enrollment, November 15th through December 15th, for a January 1st effective date.

Employer eligibility

- Small employer is an employer that employed an average of at least 1 but not more than 50 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a health benefit plan year. All persons treated as a single employer under 26 U. S. C. 414(b), (c), (m) or (o) must be treated as one employer.
- 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.
- Groups that do not meet the definition of a small employer are not eligible for coverage.
- Medical plans can be offered to sole proprietorships, partnerships, or corporations.
- Employer (Companies/Organizations) must not be formed solely for the purpose of obtaining health coverage.
- Non-guaranteed 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 for small group coverage.
- There must be at least one enrolled W-2 employee who is not an owner and not the owner's spouse.
- Partners and LLCs filing as a partnership are eligible even if there are no W-2 employees. Owner and spouse groups are not eligible.
- Standalone dental has ineligible industries.

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.

Forms

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

Groups covered under a professional employer organization (PEO)

- Small groups with a PEO master health care plan follow the same underwriting guidelines as groups determined to be ACA.

Guaranteed issue – New Business

- Both the Affordable Care Act (ACA) and the federal HIPAA law mandate no small employer or 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."
  - If a group who was previously terminated for unpaid premium applies for coverage and is otherwise eligible for coverage, the insurer must accept the group.

Guaranteed renewability – Renewal

- Both the Affordable Care Act (ACA) and the federal HIPAA law mandate no small employer or 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."
  - An insurer may term a group for nonpayment of premium.
  - A group cannot be denied coverage based on failure to pay premiums for a prior year's policy.
- 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.

Holding companies

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

Example

- Bank A is the holding company (allows the smaller banks to raise more capital than a traditional bank).

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

Late applicants

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

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

Medical

- Product availability for group benefit offerings is always determined by the ZIP code of the employer.

- Employees enrolled in medical or dental who reside in a PPO or Dental PPO network may enroll in the plan offered by their employer if they live within a 60-mile radius of their work site that is within the service area.
- If the employee resides at a distance farther than the 60-mile radius, exception requests should be directed to Underwriting 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. All correspondence will be mailed to the employee's home address as listed on the application.

Medicare Secondary Payer 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.

Newly formed business

All size groups must provide the following:

- A copy of the Quarterly Wage and Tax statement, if not available, must provide the most recent two consecutive weeks of payroll records, which includes, for every eligible employee: first and last name, hours worked, taxes withheld, check number, wages earned including those Part–time or in the waiting period.
- There must be one enrolled W-2 employee who is not the owner and not the owner's spouse.
- Entity formation documentation as noted below (only required if owner is not on QWTS 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

Open enrollment*

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

Medical

- Participation must be met for a group to qualify for coverage for all plans. See Participation Medical section.
- Employees covered by the same employer on another group policy are not considered a valid waiver.
- Plan design should not promote adverse selection relative to other options being offered.
- Groups that do not meet participation are eligible to enroll during open enrollment, November 15th through December 15th, for a January 1st effective date.

Out of area within Alaska

Medical

- Employees residing outside of an Aetna network service area will be enrolled in the PPO plan.
- If in a non-PPO area, benefits will be paid as out of network.

Out of state employees

Medical

- Out-of-state employees that live/work in an out-of-state network area will receive Alaska rates and products (inclusive of any required extraterritorial benefits).
- Out-of-state employees who reside in an area with a PPO only network must enroll in the Alaska PPO plan.
- Network availability for out-of-state.
- Hawaii or Vermont - health coverage is not available to any group or resident located in these states.
- 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 Massachusetts employee(s) could be subject to fines/penalties associated with Massachusetts credibility.
- 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.

Participation medical

Noncontributory plans (group pays all)

- 100% of eligible employees excluding valid waivers.

Contributory plans

- 60% of eligible employees excluding valid waivers, rounded down.

Valid Waivers

- Any creditable health coverage is a valid waiver. Some examples are:
  - Spousal/parental group coverage
  - Medicare/Medicaid
  - Champus/ChampVA/military coverage
  - Military coverage
  - Retiree coverage
  - Association coverage (for doctors/lawyers covered under an association who want to cover their employees)
  - COBRA from previous employer

All Plans

- Waivers - all employees waiving coverage must complete the waiver section of the employee application.
- Waivers can be submitted via an excel spreadsheet - it must include the employee's name and reason for waiving. Be sure the employer keeps a copy of the paper applications on file for auditing purposes.
- Dependent participation is not required.
- Groups that do not meet participation are eligible to enroll during open enrollment, November 15th through December 15th, for a January 1st effective date.

Pick 5 (medical only)

- Employers may select up to 5 plans and we only require enrollment in one plan. The other 4 plans can have zero-member enrollment.
- The 5 plans include any COBRA and out-of-state plans.
- The same medical plan with different prescription drug plans cannot be offered.

Plan change employee level

Medical

- 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 change group level

Medical

- Changes allowed on plan anniversary date only.

Product availability

Medical

- Plans may be written standalone or with ancillary coverage.
- Pick 5 allows each employee the option to choose their medical product from a selection of product offerings selected by the employer.
- Coverage under this plan is non-occupational if they are an owner, officer, or partner.
- Only non-occupational injuries and disease will be covered.

Rates

- Rates are member level rating based on each member's age and based on final enrollment.

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 (current Aetna customers leaving an Aetna group only)

Spinoff groups will be considered with the following, subject to underwriting approval:

- 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 name of the new spinoff group.
- 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.

Tax documents

- A Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc., of all employees of the employer group must be provided for:
  - 1 to 50 enrolled employees
- Newly hired, terminated, part time, retirees, seasonal, and temporary employees should be noted accordingly on the QWTS/prior carrier bill.
- Reconciled QWTS/prior carrier bill should be signed and dated by the employer. Any hand-written comments added must be signed and dated by the employer.
- If a QWTS is not available, explain why and provide a copy of payroll records.
- The underwriter may request payroll in questionable situations
- Sole proprietors not listed on the QWTS are required to submit tax documents.
- The above list is not all inclusive. The underwriter may request other documentation and will notify you if needed.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages, and hours, which must match the totals on Form 941.

Dental

Dental carve outs – excluded class

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

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 prior dental coverage, plan type (Indemnity / PPO, non-voluntary / voluntary) and number of eligible employees determine whether or not a waiting period applies.
  - Waiting periods do not apply to Maine based members.
  - Starter groups do not currently have dental coverage.

- Takeover groups currently have dental coverage with another carrier. To qualify as a takeover group:
  - Group's prior coverage must be effective within 90 days prior to the Aetna effective date.
  - Group's prior coverage must be a traditional dental insurance plan.
  - Discount dental and preventive only plans do not qualify as prior coverage.
  - If the group's prior coverage included preventive and basic coverage and/or major services, the group qualifies as having prior coverage for major services.
  - If the group's prior coverage included orthodontic coverage, the group qualifies as having prior coverage for orthodontic services.
- Waiting Periods do not apply to DMO.
- Waiting periods do not apply to 10+ eligible groups with standard (non-voluntary) PPO and Indemnity plans.
- **Non-voluntary PPO: 2 to 9 eligible employees:**
  - Starter groups - waiting period applies.
  - Takeover Groups – no waiting period
- **Non-voluntary PPO: 10 to 50 eligible employees:**
  - Starter and takeover groups - no waiting period
- **Voluntary PPO: 3 to 50 eligible employees:**
  - Starter groups – waiting period applies.
  - Takeover groups - waiting periods for major services and ortho, if applicable, are waived based on the prior coverage level for those enrolling at the time of inception of Aetna dental coverage.
    - **New hires:** Waiting period applies. Per dental creditable coverage guidelines, members will have the same waiting period waived as the group if they were covered under a prior dental plan within 90 days of their Aetna dental coverage.

Dental creditable prior coverage – employer / group

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

Dental employer contribution

- Non-voluntary:
  - 2-50 eligible

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

Dental ineligible industries

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

SIC code	Industry
7361	Employment agencies
7363	Personal supply services/help supply services
7911	Dance studios, schools
7922	Theatrical producers (except motion picture) and miscellaneous theatrical services
7929	Bands, orchestras, actors and other entertainers and entertainment groups
7933	Bowling centers
7941	Professional sports clubs & promoter
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

Dental late applicants

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

- An employee or dependent enrolling for coverage more than 31 days from the date first eligible or more than 31 days from the qualifying event is considered a late enrollee.
- Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the late entrant guidelines.
- Voluntary cancellation of coverage is not a qualifying event unless it is done at open enrollment. For example, if a spouse is covered through his/her employer and voluntarily cancels the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open enrollment to be eligible to enroll. However, if each spouse has different open enrollment dates and drops coverage during their annual open enrollment period, the spouse is eligible to enroll.
- Late applicants without a qualifying event (such as marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) will be deferred to the next plan anniversary date of the group and may apply for coverage 30 days before the anniversary date.
  - Late entrant penalty does not apply to Maine based members.
- The dental plan does not cover services and supplies given to a person aged 5 or older if that person did not enroll in the plan during the first 31 days the person is eligible for this coverage.
- The dental late entrant provision does not apply to charges incurred for any of the following:
  - After the person has been covered by the plan for 12 months (24 months for ortho)
  - As a result of injuries sustained while covered by the plan
  - All diagnostic and preventive services.

Dental live/work

- If a subscriber Lives or Works within a specified mileage range of a Plan Network, they are offered the Plan and Rates for that Network.
- 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®.
- If an employee does not qualify for DMO® coverage, they will be offered a PPO or Indemnity plan based on what is available in their market.

Dental open enrollment

- 2 to 9 eligible non-voluntary and 3 to 50 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 to 50 eligible are allowed open enrollments; open enrollment is available with a qualifying event and at renewal.

Dental option sales alongside other carriers

- Not allowed. All dental plans must be sold on a full-replacement basis.

Dental out of area within Alaska

- Employees who reside within Alaska, but outside of a service area may be offered an in-state PPO plan if available.

Dental participation

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

    Example: 20 eligible employees, 8 spousal waivers, 10 employees enrolling
    Step 1: Compute 75% participation
    20 – 8 valid waivers = 12
    12 x 75% = 9 enrolled
    Step 2: Compute 50% of total eligible employees
    20 x 50% = 10 enrolled
    The group meets participation with 10 employees enrolling.
- Voluntary
  - 3 to 50 eligible contributory only: minimum 30% participation excluding spousal waivers and a minimum of 3 enrolled

Census Data

- 2-50: 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/State Continuation enrollees.

Change in rates due to census/participation changes

- Census or participation changes resulting in a +/- 10% change in premium will be rerated.

Dental plan add to existing Aetna product

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

Dental plan change employee level

- Freedom-of-Choice – May change from DMO to PPO and vice versa at any time but must be received in Aetna underwriting by the 15th to be effective the next month.
- Plan changes other than Freedom-of-Choice are only allowed during the plan anniversary date's enrollment period.

Dental plan change group level

- Changes allowed on plan anniversary date only.

Dental product availability

- 1 eligible employee - not available
- 2 eligible employees
  - Non-voluntary
  - Voluntary - not available
- 3 to 50 eligible employees
  - Non-voluntary and voluntary plans
- Orthodontic coverage
  - 2-9: not available
  - 10-50: available with 10 or more eligible employees with a minimum of 5 enrolled

Dental 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, only the PPO plan paired with the selected FOC plan will be provided for those employees. **Note:** The PPO plan will only be available to the applicable employees and is not considered a dual option package.
- A DMO plan can be sold as the only dental plan in all states except in Florida, Maryland, New Jersey, and Virginia.
  - DMO must be packaged with a PPO in Florida, Maryland, New Jersey, and Virginia.
  - For all other states, DMO (if available) can be packaged with any PPO.
  - When offering a DMO and PPO plan together, the below combinations are allowed:
    - Both the DMO and PPO include the ortho benefit ***or***
    - Both the DMO and PPO exclude the ortho benefit ***or***

    - The DMO can include the ortho benefit while the PPO can exclude the ortho benefit.
- A group cannot offer more than two plans, as outlined above.
- PPO 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.
  - Prior approval is required.
- Voluntary and non-voluntary plans cannot be sold together.

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

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 Aetna's 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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