Idaho Small Group Underwriting Brochure
Dental & Vision

Plans effective January 1, 2023 and later

For businesses with 2– 50 eligible 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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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. 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.

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 group'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.
- Date of hire BWP is not available.
- Only one BWP is available.
- A reduction of the BWP may only be done on the group's anniversary date. Example: Change from 1st of the month following 3 months to 1st of the month following 1 month.
- An increase in the BWP may be requested once in a 12-month period and may be requested either on or off the anniversary date. Example: Change from 1st of the month following 1 month to 1st of the month following 3 months.
- No retroactive BWP changes will be allowed.
- New Hires: The benefit eligibility date will be the first day 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

Case submission dates

- For 1st of the month effective date, must be received 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.
- Incomplete cases will be moved to the next available effective date.

COBRA

- 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 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 a part-time employee worked divided by the hours an employee must work to be considered full time.
- Companies under common ownership are included in the count.
- 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 3-life group requesting COBRA, Aetna will ask the employer to "validate" the number of employees in the prior calendar year in order to determine the number of employees for COBRA purposes.
- COBRA is not billed separately and is included with the group bill.
- 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.

Dependent eligibility

- Spouse or domestic partner. If the employee and spouse/domestic partner work for the same company, they may enroll together or separately.
- Domestic partners may be covered as an eligible dependent 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 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 eligible for coverage through both parents cannot be covered by both parents under the same plan.
  - 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 benefits as the employee (participation is not required).
- Employees may select coverage for eligible dependents.
- 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 employer may be up to 60 days in advance.

Employee eligibility

- An employee who works on a full-time basis and has a normal work week of 30 or more hours or, by agreement between the employer and the carrier, an employee who works between 20 and 30 hours per week. The term includes a sole proprietor, a partner or a partnership and independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.

- Ineligible employees: part-time, temporary employees, seasonal employees, substitute employees, leased employees, uncompensated employees, employees making less than equivalent minimum wage, volunteers, retirees, inactive owners, directors, stockholders, partners, officers, or other outside consultants who are not active, managing members who are not active, investors, shareholders, and silent partners.
- Retirees are not eligible for any coverage - dental or vision.

Employee enrollment

- Employee enrollment must be submitted via the eList Tool.
- The employer keeps a copy of the paper applications on file for auditing purposes.
- The eList Tool is available on **Producer World**.
- Instructions for the eList Tool:
  - **IMPORTANT:** download a fresh eList Tool 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 the eList Tool.
  - Enable the macros prior to entering data.
  - The eList Tool format should not be amended in any manner.
  - 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 the eList Tool.
  - COBRA/Mini-COBRA participants should be included and noted as COBRA/Mini-COBRA.
  - The eList Tool must be completed in full.

Employer eligibility

- 2-50 eligible employees
- Employer (Companies/Organizations) must not be formed solely for the purpose of obtaining 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.
- 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 on page 12 are ineligible.

Employers replacing other group coverage

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

Forms

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

Holding Companies

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

Example

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

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".

Newly formed businesses (in operation less than 3 months)

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

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:

- 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 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.
- 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.

Tax documents 1 - 50 eligible employees

A Quarterly Wage and Tax Statement (QWTS) containing the names, salaries, etc., of all employees of the employer group must be provided for:

- 2 to 9 eligible employees

- 10+ eligible employees with:
  - no current dental coverage
- Newly hired, terminated, part time, retirees, seasonal, and temporary employees should be noted accordingly on the QWTS.
- Reconciled QWTS should be signed and dated by the employer.
- If a QWTS is not available, explain why and provide a copy of payroll records.
- Sole proprietors, partners, and officers not listed on the QWTS are required to submit tax documents.
- In order to satisfy the small employer requirements for proof of eligibility, the most recent IRS tax documents and the entity formation documents are required. We can provide you a list of required documents if you tell us the entity type (limited liability company, partnership, corporation, etc.) and the entity's formation date.
- The underwriter may request additional documentation, if necessary.
- Seasonal industries, such as lawn and garden services, construction, concrete and paving, golf courses, farm laborers, etc., must provide four consecutive quarters of wage and tax reports to verify consistent, continuous employment of eligible employees.
- Churches must provide Form 941, including a copy of the payroll records with employee names, wages, and hours, which must match the totals on Form 941.

Dental

Dental carve outs - excluded class

- Management carve-outs and other carve-outs are not permitted.
- 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 state, prior dental coverage, plan type (DMO / 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 or FOC plans.
- Waiting periods do not apply to 10+ eligible groups with standard (non-voluntary) PPO and FOC plans.
- Waiting periods do apply to PPO and FOC plans for major services and if covered, orthodontic services.
- FOC plans follow the DMO and PPO plan rules listed above.
- **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

- The following industries are not eligible when dental is sold as 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

- 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 situs

- 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 - municipalities and townships

A township is generally a small unit that has the status and powers of local government.

A municipality is an administrative entity composed of a clearly defined territory and its population, and commonly denotes a city, town, or village. A municipality is typically governed by a mayor and city council, or municipal council.

- Groups must provide a Quarterly Wage and Tax Statement (QWTS)
- W-2: elected or appointed officials and trustees "may" be eligible for group coverage based on the charter or legislation. If so, they may not be on the QWTS; rather, they may be paid via W-2. In that case, provide a copy of their prior year W-2.
- If elected officials are to be covered, provide a copy of the charter or contract indicating which classes or employees are to be covered, the minimum hours

required to work per week to be eligible for coverage, and confirmation that coverage will be offered to all employees meeting the minimum number of required hours and that minimum participation will be maintained.

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 plans must be sold on a full replacement basis.

Dental out-of-area within Idaho

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

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 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 changes 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 changes 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 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.

Vision

- Available to groups of two or more eligible employees.
- The employer may only offer one vision plan to all employees.
- A minimum of 1 enrolling is required.
- Existing groups may only add vision at renewal.
- Vision only is allowed or can be sold with dental.
- Retirees are not eligible.
- 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.

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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 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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