Aetna Funding Advantage

Underwriting Guidelines

Plans effective January 1, 2025

AZ, FL, MA, MD, TX:

For businesses with 2 - 100 enrolled full-time employees

All other states:

For businesses with 2 enrolled – 100 eligible full-time employees

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). Aetna Funding Advantage (AFA) plans are self-funded, meaning the benefits coverage is offered by the employer. Aetna Life Insurance Company only provides administrative services and offers stop loss insurance coverage to the employer.

This material is intended for brokers and agents and is for informational purposes only.
AFA (09/2021)

Aetna.com

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Introduction — underwriting guidelines

This material is for informational purposes only and is not intended to be all inclusive. These guidelines in part are established in support of state requirements regulating Aetna Funding Advantage's (AFAs) stop loss coverage component. Other policies and guidelines may apply.

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

All underwriting guidelines are subject to change without notice.

Definition of a group

- Small group — Small employer means any person, firm, corporation, limited liability company or partnership actively engaged in business or self-employed for at least 3 consecutive months who, on at least 50 percent of its working days during the current 12 months, employed at least 2, but no more than 50 eligible employees*; and covers at least 2 employees* on the first day of the plan year. Refer to the segment definition grid for specific state counting methodology and size requirements.
- Small employer definition includes a self-employed individual/sole proprietor who wholly owns the business if there is at least one full-time eligible common-law/W-2 employee, enrolling or waiving, who is not the owner's spouse/domestic partner.
  - For CA & CO domiciled eligible groups, the small employer definition extends through 100 eligible full-time employees.
- Large group — Large employer means any person, firm, corporation, limited liability company or partnership actively engaged in business or self-employed for at least 3 consecutive months who, on at least 50 percent of its working days during the current 12 months, employed at least 51 employees on the first day of the plan year, but no more than 100 enrolling employees*.
- For the purposes of determining the number of eligible employees:
  - Organizations must not be formed solely for the purpose of obtaining health coverage.
  - An employer with only an owner and the owner's spouse/domestic partner is not an eligible employer.
  - Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation, shall be considered one employer.
  - Union employees are included in the total count of eligible employees in determining case size, except if the union is covered under a collective bargaining agreement.
    - > If covered under a collective bargaining agreement, union employees, as a class, may be excluded by a self-funded employer as not being eligible for coverage.
  - Employees covered through the employer by health insurance plans, or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act, shall not be counted.
  - Employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits or other applicable laws, shall **not be** counted.
  - To be counted, each employee must meet the normal work week hours rule of 30 hours a week.
  - The employer definition shall continue until the plan anniversary date following the date the employer no longer meets the requirements of this definition.

*COBRA/State continuation participants do not count towards the number of enrolled employees to determine

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employer eligibility for the AFA product.

Counting methodology

The following describes the counting methodologies known as the Total Average Employee (TAE) Counting Methodology, Full-time Equivalent (FTE) Counting Methodology, and Eligible Employees Counting Methodology. The counting methodologies are used to determine a rating segment for the stop loss product.

TAE Counting Methodology:

- Calculate the average number of employees you employed for the entire previous calendar year. Here's who you need to include:
  - Employees in the calendar year prior to your policy effective date
  - All employees – they do not need to be eligible for insurance coverage
  - All employees for whom the company issues a W-2. This includes full-time, part-time, temporary, seasonal, salaried, and hourly workers
  - If you have multiple locations, include employees in all company locations
  - If you have multiple corporate entities, include employees in all entities that are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m) or (o))
- How to calculate:
  1. Count the number of employees for each month
  2. Add each month's total to get an annual total
  3. Divide the annual total by 12 (or divide by the number of months you had employees).
  4. Round up or down to the nearest whole number (examples: 24.6 = 25 or 24.4 = 24)
  5. Newly formed business - calculate the prior year average using only those months the group was in business; or use reasonable expected total employees if the group was not in business the prior year.
- Groups with 50 or fewer total average employees in the **previous calendar year** are rated as a small employer no matter the number of eligible or enrolling.
  - If the TAE is 2 to 50 in the **previous calendar year** and the eligible is more than 50, this is a 2 to 50 group.
  - If the TAE is 51 or more in the previous calendar year and the eligible is less than 101, this is a 51 to 100 group.

  Examples: 45 TAE based on previous calendar year; 65 eligible – this is a 2 to 50 group. 115 TAE based on previous calendar year; 45 eligible – this is a 51 to 100 group.

FTE Counting Methodology:

- Group size is only determined on issuance and at the time of renewal based on the **prior calendar year**. Mid-year fluctuations in the number of employees do not affect a determination of group size. Because employers average their number of employees across months in the year, fluctuations are taken into account ahead of time.
- A business not in existence the prior year should calculate the group size based on the "average number of employees the employer is reasonably expected to employ on business days in the current calendar year."
- Full-time employees are those who worked, 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
  - Part-time employees who worked, on average, less than 30 hours per week
  - Union employees
- Don't include (while these employee types should not be included in the FTE calculation, they may still qualify for coverage):

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- Owners of a sole proprietorship
- Partners, shareholders owning more than 2 percent of an S corporation, and owners of more than 5 percent of other businesses; it is possible they could be included if they meet the definition of a common-law employee and would need to provide documentation as a common-law employee
- Family members or members of the household who qualify as dependents on the individual income tax return of a person listed in the bullets above, including a spouse, child (or descendant of a child), sibling or 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 workers working 120 days or less in a year; there is a limited exception to counting seasonal workers if counting them is what triggered the employer to be large rather than small only because of their employment for 120 days or fewer; only then should they not be counted
- Independent contractors (Form 1099 workers) who are not common-law employees
- COBRA/State continuation unless there is a permitted exception under 42 USC 300gg-91 (d) (5)
- Retired enrollees

• How to calculate:

- Full-time employees that work at least 30 hours per week in any month are counted as one full-time employee. This amount is added to the number of part-time employees.
- Part-time employees are counted by taking the hours worked by all part-time employees in a week and dividing that amount by 30.
- Seasonal employees working up to 120 days in a year are not counted in the calculation.

Example 1:

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

Example 2:

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

- When the FTE in the **prior calendar year** is 50 or fewer, it will always be small group 2 to 50 no matter the number of eligible or enrolling.

Examples:

45 FTE in the prior calendar year; 60 eligible — this is a 2 to 50 group.
75 FTE in the prior calendar year; 49 eligible – this is a 51 to 100 group.
115 FTE in the prior calendar year; 45 eligible – this is a 51 to 100 group.

Eligible Employee Counting Methodology:

• Current eligible employees will be used as the counting methodology to determine case size for all other states not using the TAE or FTE counting methodology. Refer to the Employee Eligibility section for the definition and criteria of an **eligible employee**.

• COBRA/State continuation participants do not count towards the number of enrolled employees to determine employer eligibility for the AFA product.

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Segment definition

State	AFA counting method	Segment size (minimum enrolled), maximum eligible	State	AFA counting method	Segment size (minimum enrolled), maximum eligible
AZ[1]	Eligible	2 – 100	MO	Eligible	2 - 100
CA	FTE	10 - 100	MS	Eligible	2 – 100
CO	Eligible	2 - 100	NC[3]	FTE	4 -100
CT	FTE	2 - 100	NE	Eligible	2 - 100
DE[2]	Eligible	5 - 100	NJ	FTE	2 - 100
FL[1]	Eligible	2 – 100	NV	Eligible	2 - 50
GA	Eligible	2 - 100	OH	Eligible	2 - 100
IA	Eligible	2 - 100	OK	Eligible	2 - 100
ID	Eligible	2 - 50	PA	Eligible	2 - 100
IL	Eligible	2 - 100	RI	Eligible	10 - 100
KS	Eligible	2 - 100	SC	Eligible	2 - 100
KY	Eligible	5 - 100	TN	Eligible	2 - 100
LA	Eligible	2 - 100	TX[1]	Eligible	2 - 100
MA[1]	Eligible	2 - 100	UT	Eligible	2 – 50
MD[1]	FTE	2 - 100	VA	Eligible	2 - 100
ME	Eligible	11 - 100	WI	TAE	2 - 50
MI	Eligible	2 – 100	WV	Eligible	2 - 100
MN	Eligible	2 - 50	WY	Eligible	2 - 50
Refer to specific group size segment guidelines					

[1] AZ, FL, MA, MD, TX Segment size - maximum enrolled 100.

[2] DE domiciled employer must have at least six eligible employees. The majority of employees (51 percent or more) must work in Delaware for the group to be eligible for the AFA product.

[3] NC must have at least 12 eligible employees.

Participation requirements

Non-contributory plans (self-funded employer pays all plan contributions)

- 100 percent of total eligible employees

Contributory plans (plan contributions are paid by both the self-funded employer and enrolled employees)

- A subscriber whose spouse/domestic partner is also a subscriber of the same employer may enroll as two separate subscribers or Employee + Spouse.

2-50 eligible employees

- 30 percent of total eligible employees, with a minimum of 2 enrolled; refer to **segment definition grid** for specific state information.

51-100 eligible employees

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- 20 percent of total eligible employees; refer to **segment definition grid** for specific state information.

Waivers

- All employees waiving coverage must complete the waiver section of the AFA Individual Medical Questionnaire (AFA Enrollment/Change Request Form).
- Dependent participation is not required.

Product availability

- The AFA product may be offered on a standalone basis or with fully insured ancillary coverage. Refer to the Fully Insured Underwriting Guidelines for ancillary products.
- Religious Accommodations and Religious Exemptions will not be approved under the AFA product.
- For 5+ enrolled, an employer may select up to four AFA medical plans.
- For 2–4 enrolled groups, an employer may select up to two AFA medical plans.
- Groups may change or add plans on the renewal/plan anniversary date only.
- It is at Aetna's discretion whether a renewal is offered to a group on the AFA product. The product is not guaranteed renewable.
  - For CA groups, AFA plans are guaranteed renewable except for nonpayment of premium, fraud or intentional misrepresentation of material facts, and discontinuation of the AFA product.

Billing

- Monthly costs are funded via an ACH Debit. Payment via check is not allowed with this product.
- Bills will be available around the 25th of the month and the ACH Debit takes place the second business day of the next month.
- No separate bank account required.
- For groups with 20+ enrolled, we allow up to 3 classes or divisions. These groups may not be administered on Springboard.

Carve-out

- Management carve-outs and other carve-outs are not permitted.

COBRA/State continuation

- COBRA applies to employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year. The COBRA/State continuation calculation is based on the following:
  - Includes: full-time, part-time, seasonal, temporary, union, owners, partners, and officers
  - Excludes: self-employed persons, independent contractors (1099) and directors
  - Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time
- With Aetna's consent, state continuation/mini-COBRA/spousal continuation beneficiaries are eligible to enroll with the AFA product. The employer is responsible for complying with the state-specific laws regarding any such coverage offered.
- Because COBRA is directed at employers, the decision to comply with COBRA should be made by the employer. In situations where it may appear the employer is not subject to COBRA — for example, a group of five enrolled employees requesting COBRA — we will ask the self-funded 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.

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- COBRA/State continuation beneficiaries are not billed separately and are included with the self-funded employer's bill.
- If the COBRA/State continuation beneficiary does not reside in an Aetna service area, they are only eligible for out-of-network benefits or urgent/emergency care.
- COBRA/State continuation-eligible beneficiaries are required to be included on the census.
- The COBRA/State continuation qualifying event, length, start date and end date must be provided.
- COBRA/State continuation beneficiaries are not to be included for the purpose of counting employees to determine the size of the case. Once the size of the case has been determined according to the law applicable to the employer, COBRA/State continuation beneficiaries can be included for coverage subject to normal underwriting guidelines.
- Aetna reserves the right to revise the service fees and stop loss premium rates or withdraw the quote if the total number of COBRA/State continuation enrollees exceeds 10 percent of the total eligible employees.

Coordination of benefits

- This stop loss policy offered in connection with AFA assumes that the plan administered will always pay medical claims secondary to no-fault automobile insurance personal injury protection coverage.

Dependent eligibility

- Spouse of employee, domestic partners (same and opposite sex) — If both employee and spouse/domestic partner work for the same company, they may enroll together or separately. If enrolling together, the group must still meet the minimum number of enrolling employees as stated in the Employer Eligibility section.
- Children
  - Children are eligible as defined by the self-funded employer in accordance with applicable federal laws, up to the end of the month the dependent turns age 26 except as noted below for Florida medical coverage, 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.
  - Florida based groups and subscribers with medical coverage: Dependent children are covered until the end of the month when the dependent turns 30.
  - Children can only be covered under one parent's plan when both parents work for the same company.
  - When the eligible 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. If enrolling together, the group must still meet the minimum number of enrolling employees as stated in the Employer Eligibility section.
  - Grandchildren are eligible if court ordered to cover the grandchild under the plan. A copy of the court order must be submitted.
  - Incapacitated child — Attainment of limiting age will not terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or spouse/domestic partner for support and maintenance. Proof of incapacity and dependency shall be furnished to Aetna within 31 days of the child's attainment of the limiting age and subsequently as we may require it, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
- Dependents must enroll in the same benefits as the employee.
- COBRA/State continuation dependent beneficiaries should be included and noted as COBRA/State continuation in enrollment submission.

Domiciled state

- The domiciled state is considered where the permanent legal company headquarters reside.
- If no eligible employees are located in the domiciled state where the business is located, the group would not be eligible for the AFA product, unless an exception is warranted by a unique situation and granted by Aetna Underwriting management.

Effective date

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

Employee eligibility

- Eligible employees include the partners of a partnership but do not include an employee who works on a seasonal, temporary or substitute basis. An eligible employee shall include any employee who is not actively at work but is covered under the small employer's health insurance plan pursuant to workers' compensation and COBRA/ State continuation.
- Eligible employees are those who work a normal work week of at least 30 hours. Employees who work a normal work week of less than 30 hours are not eligible unless Aetna provides an exception.
- Coverage must be extended to all employees meeting the above conditions unless:
  - They belong to a union class excluded as the result of a collective bargaining arrangement
  - Employees in the benefit waiting period when the waiting period is not waived during open enrollment, or the waiting period has not been met by the contract plan effective date
- Employees not eligible for coverage include independent contractors (1099); leased, part-time, temporary, seasonal or substitute employees; uncompensated employees; employees making less than equivalent minimum wage; volunteers, inactive owners, directors, shareholders, officers, outside consultants; managing individuals who are not active; investors or silent partners.
- Groups with more than 10 percent retirees, retirees will be excluded from the quote.
- The retiree must be covered currently with present carrier (must be shown on the bill roster or provide a copy of the ID card).
- If there were no retirees covered by the prior carrier, the employee must be covered as an employee on the bill roster.
- Provide the census for retirees.
- Retirees are not to be included for purpose of counting employees in determining the size of the group.

Employee enrollment

- Employee enrollment may be submitted via AFA One Census or the AFA Enrollment/ Change Request Form paper enrollment form.
- All enrollments are required when the case is submitted. Once AFA One Census has been submitted, there will be no additional changes or enrollments permitted.
- The employer should keep a copy of the paper enrollment/waiver forms on file for auditing purposes.
- If a group satisfies participation requirements based on the business eligibility section of the employer application, waivers are not needed for AFA One Census.
- Employees in the benefit waiting period for groups not waiving the benefit waiting period should not be included.
- COBRA/State continuation beneficiaries should be included and noted as COBRA/State continuation.
- All enrollments, including COBRA/State continuation enrollments, must be completed prior to the group's effective date or renewal/plan anniversary date.
- At the time of sale, Individual Medical Questionnaires are required for any COBRA/State Continuation enrollee not

included on the initial underwritten quote. Once a group has been issued or renewed, the open enrollment period is closed. Late enrollments are not permitted.

Employer contribution

- We require the employer pay 50 percent of the total contributions for the cost of coverage of the lowest cost plan option selection; or
- 50 percent of employee-only contributions for the cost of coverage of the lowest cost plan option selection.

ERISA requirement under employer eligibility

- To be eligible for AFA, the health plan must be governed under the Employee Retirement Income Security Act of 1974 (ERISA). In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

Ineligible industries

- Associations; Taft-Hartley groups; employee leasing firms; groups with the SIC Code of 7361 (Employment Agencies) and 7363 (Help Supply Services); closed groups (groups that restrict eligibility through criteria other than employment); and groups where no employer/employee relationship exists are not eligible.
- Flowering industries are defined as businesses that work in General Cannabis, Medicinal Chemicals, and Botanical Products. Plan sponsors in flowering industries with contracts sitused in certain states are eligible for AFA coverage. Contact underwriting for eligible states.
- Below is a listing of ineligible industries, which is not all inclusive.

AFA ineligible SIC codes / industries due to non-ERISA only in CA, FL, GA, IL, ME, and MO	
43xx	U.S. Postal Service
82xx	Educational Services
8661	Churches, temples, and shrines and non-church religious organizations (convent, monastery, religious instruction)
91xx	Executive, Legislative, and General Government, Except Finance
92xx	Justice, Public Order, and Safety
93xx	Public Finance, Taxation, and Monetary Policy
94xx	Administration of Human Resource Programs
95xx	Administration of Environmental Quality and Housing Programs
96xx	Administration of Economic Programs
97xx	National Security and International Affairs
AFA ineligible SIC codes / industries for staffing	
7361	Employment Agencies
7363	Help Supply Services

Late applicants

- An employee or dependent requesting to enroll for coverage after the effective date or renewal/plan anniversary date is considered a late applicant.
- Voluntary termination of coverage is not a qualifying life event unless it is done at open enrollment. For example, if a spouse is covered through his/her employer and voluntarily terminates the coverage, it is not a qualifying event to be added to the other spouse's plan. The spouse who cancelled the coverage must wait until the next open

enrollment to be eligible to enroll. However, if each spouse has different open enrollment dates and drops coverage during their annual open enrollment period, the spouse is eligible to enroll.

- Late applicants without a qualifying life event (e.g., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are not allowed and will be deferred to the next agreement and stop loss policy renewal date of the plan and must reapply for coverage 30 days before the plan's renewal date.

Licensed and appointed producers

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

Medical underwriting

- Refer to the grid on the next page for the state-specific minimum enrolling employee Individual Medical Questionnaire (IMQ)/member level census requirements. The preferred IMQ submission method is the Online IMQ portal. The tool and instructions are available on Producer World. **https://www.aetna.com/producer/SmallGroup/afa.html**
- Currently self-funded groups and groups with a PEO master health care plan must provide:
  - Current carrier documented renewal which includes current rates and renewal rates for each plan
  - Benefit summary for each plan
  - The most current existing carrier's claim experience reports (currently self-funded groups only)
- Underwriting reserves the right to request IMQs in certain situations as the member level census may be deemed insufficient.
- Employers with 2 to 50 enrolled and no current medical coverage are required to complete the AFA Individual Medical Questionnaire(AFA IMQ).
- Full disclosure of all claims in excess of $25,000 is required at time of quote with copies of existing carrier's/administrator's source reports.
- For cases requiring IMQs, 100 percent of all enrolling employee and dependents must submit an IMQ.
- For cases that are currently covered by Staff Model or Mix Model Health Maintenance Organizations, IMQs will be required for Underwriting review/decision.
- Groups coming from Kaiser Health will follow our normal IMQ guidelines by state/funding type.
- Medical conditions of COBRA/State continuation beneficiaries are included in the monthly cost calculation. Medical claims may be reviewed for any individuals who had prior Aetna coverage and used along with the health information included on the AFA IMQ, all of which will be included in the overall medical assessment of the case.
- At the time of sale, IMQs are required for any COBRA/State Continuation enrollee not included on the initial underwritten quote.

State-specific IMQ requirements

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

Size Segment by Enrolled		
State	ACA Incumbent [1]	Non-ACA Incumbent [2]
AZ	2-9	2-4
CA [3]	Not required	Not required
CO	2-24	2-4
CT	2-9	2-4
DE [4]	5-14	Not required
FL	2-9	2-4
GA	2-9	2-4
IA	2-24	2-4
ID	2-24	2-4
IL	2-9	2-4
KS	2-9	2-4
KY [5]	5-24	Not required
LA [6]	2-9	2-4
MA	2-9	2-4
MD	2-4	2-4
ME [7]	Not required	Not required
MI	2-14	2-4
MN	2-14	2-4
MO	2-9	2-4
MS	2-24	2-4
NC [8]	4-9	Not required
NE	2-24	2-4
NJ	2-4	2-4
NV	2-9	2-4
OH	2-24	2-4
OK	2-24	2-4
PA	2-14	2-4
RI [9]	Not required	Not required
SC	2-24	2-4
TN	2-24	2-4
TX [10]	2-24	2-4
UT	2-24	2-4
VA	2-14	2-4
WI	2-24	2-4
WV	2-14	2-4
WY	2-24	2-4

[1] Off-cycle renewals follow the ACA incumbent rules for the state.

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(2) No IMQs are required for 5-50 enrolled in these states if current on-cycle renewal, at least 8 months of claims data (if coming from a level funded incumbent outside of a MEWA or PEO), member level census, and prior carrier/funding type provided. If it doesn't meet these requirements follow the ACA incumbent rules for the state.
(3) CA domiciled employers must have at least 10 enrolled employees.
(4) DE domiciled employers must have at least six eligible employees. The majority of the employees (51 percent or more) must work in Delaware for the group to be eligible for the AFA product.
(5) KY domiciled employers must have at least five enrolled employees.
(6) LA domiciled employers with 10-50 enrolling employees that are currently fully-insured must provide member level census, renewal, and claims data. IMQs will be required if the claims data is not provided.
(7) ME domiciled employers must have at least 11 enrolled employees.
(8) NC domiciled employers must have at least 12 eligible employees.
(9) RI domiciled employers must have at least 10 enrolled employees.
(10) TX domiciled employers with 25-50 enrolling employees that are currently fully-insured must provide HB2015 claims reporting from current policy period including detailed large claim report (Tier I & Tier II). IMQs will be required if the HB2015 claims reporting is not provided.

Medicare secondary payer

- Each year, all self-funded employers must report to Centers for Medicare & Medicaid Services (CMS) the number of Medicare Secondary Payer (MSP) employees, based on the number of employees covered by the plan.
- MSP is the term used by Medicare when Medicare is not responsible for paying first. This is generally when the plan would pay primary to Medicare for active employees and would pay first when there are 20 or more total employees (full- and part-time) for 20 or more weeks during this calendar year or the prior calendar year. The Medicare Secondary Payer calculation is based on the following:
  - Includes: full-time, part-time, seasonal, temporary, union, owners, partners, and officers
  - Excludes: self-employed persons, independent contractors (1099), directors and leased employees

Monthly costs information

- Monthly costs are based on final enrollment and require that:
  - No portion of the participant's cost sharing, including but not limited to, copayments, deductibles and/or coinsurance balances, will be subsidized or funded by the employer, with the exception of a federally qualified Health Reimbursement Account (HRA) or Health Savings Account (HSA), whether insured or self-funded, including but not limited to a partially self-funded Section 105 wraparound, now or in the future; **and**
  - An employer should not fund the deductible of the quoted health plan through an HRA or HSA at more than 50 percent annually.
- All quotes are subject to change based on additional information that becomes available during the quoting process and/or during case submission/installation, including any change in census.
- All monthly costs will be quoted on a four-tier structure: employee; employee + spouse; employee + child(ren); and family.
- For cases underwritten via member level census, the monthly costs may be revised if enrollment changes by more than +/- 10 percent from the initial quote enrollment projection.
- For cases underwritten with IMQs, the monthly costs may be revised if there are any enrollment changes from the initial quote enrollment projection.
- If any of the information we receive is determined to be incomplete or incorrect, we reserve the right to adjust the quoted monthly costs.
- Aetna may adjust the monthly costs if census changes occur from the quote to sold case.
- Aetna reserves the right to revise the service fees and stop loss premium rates or withdraw the quote if:
  - The total number of COBRA/State continuation enrollees exceeds 10 percent of the total eligible employees

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- The total number of indemnity enrollees exceeds 10 percent of the total eligible employees

Newly formed business

- A company must have been in business for a minimum of three months prior to the requested effective date to be eligible for an AFA quote.

Open enrollment

- Annual Group Open Enrollment may last up to 30 days and must end prior to the renewal/plan anniversary date.
- Annual Group Open Enrollment does not apply to new business.

Option sales

- All medical plans must be offered on a full-replacement basis.
- No other employer-sponsored medical plan can be offered.

Out-of-state (OOS) employees

- Out-of-state participants residing outside of the Choice POS II Network may enroll in the AFA indemnity plan.
- Aetna reserves the right to revise the service fees and stop loss premium rates or withdraw the quote if the total number of indemnity enrollees exceeds 10 percent of the total eligible employees.

Plan change benefit level

- Plan changes can be made on the agreement anniversary date only.

Plan change participant level

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

Prior Aetna coverage

- AFA groups that we have terminated for non-payment must pay all premiums still owed on the prior Aetna plan before the new AFA agreement will be issued.

Professional employer organization (PEO)/co-employer groups

- Small groups with a PEO master health care plan follow the same underwriting guidelines as groups currently on a self-funded plan with one exception – we do not require prior carrier claims experience. To receive a quote, we require:
  - Renewal (including current and renewal rates)
  - Benefit summary

Replacing other group coverage

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

Signature dates

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

Stop Loss

State	Aggregate stop-loss	Individual stop-loss
AZ, DE, GA, IA, ID, IL, LA (51–100), MA, MI, MN, MS, NC (51–100), NE, NJ (51 –100)[1], OH, OK, PA, SC, TX, UT, VA, WI, WV, and WY	110% of expected claims	$20,000
KY	110% of expected claims	$30,000
CO, KS (2-50), LA (2–50), MO (2-50), RI, and TN	120% of expected claims	$20,000
KS (51-100)[2] and MO (51-100)[2]	110% of expected claims	$20,000
MD, ME	120% of expected claims	$30,000
NC (12–50)	Greater of 120% of expected claims or $26,000	$30,000
CT (2-50)	Greater of 120% of expected claims or $4,000 per employee	$20,000
CT (51-100)[2]	Greater of 110% of expected claims or $4,000 per employee	$20,000
FL (2-50)	Greatest of $2,000 per employee, 120% of expected claims or $20,000	$20,000
FL (51-100)[2]	Greatest of $2,000 per employee, 110% of expected claims or $20,000	$20,000
NJ (2–50)[1]	125% of expected claims	$20,000
NV (2-50)	Greater of 120% of expected claims or $20,000	$50,000
CA (10-100)	Greatest of $5,000 per member, 120% of expected claims, or $40,000	$100,000

[1]NJ Aetna Funding Advantage Stop Loss contracts cannot be written for longer than a 12-month policy period.

[2]CT, FL, KS and MO If a group grows to 51-100 at renewal and prefers to maintain an Aggregate Stop Loss of 120% of expected claims, underwriting can override to allow that flexibility.

Two or more companies or common ownership

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

Waiting period

- The benefit waiting period (BWP), sometimes known as the probationary period, is the time that a member must be employed by the plan sponsor before they are eligible to enroll for benefits.
- At initial submission of the case, the BWP may be waived for current employees upon the self-funded employer's request. This must be indicated on the employer application.
- The BWP for future employees may be the first of the calendar month following 0 days, 30 days, 60 days, or the day after 90 calendar days has been completed including the date of hire.
  - CA groups – the waiting period cannot exceed 60 days.
- Date of hire BWP is not available.
- One BWP may be selected.
- A change to the BWP may only be made on the renewal/plan anniversary date.
- No retroactive changes will be allowed.
- BWP must be consistently applied to all plan participants, including newly hired key employees.

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- A rehired employee is an employee who was previously employed by the same employer, but lost coverage due to termination of employment or reduction of hours.
  - If the employee is rehired within one year from the termination date, the employee does not have to serve the BWP, unless otherwise specified in the plan sponsor contract.
  - If the employee is rehired after one year from the termination date, the BWP must be met.
- For new hires, the benefit eligibility date will be the first day of the calendar month following the BWP of 0 days, 30 days, 60 days, or the day after 90 calendar days including the date of hire. Calendar month refers to the Plan Year effective date of the first.
  - If "0" days is selected, and the plan has a first of the month bill cycle, and the employee is hired on the first of the month, the effective date will be the date of hire.
  - If "90" days is selected, the enrollment eligibility date will begin the day after 90 calendar days has been completed including the date of hire.

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

Specific guidelines for Allina HealthAetna Funding Advantage

Employer eligibility

- The employer must be headquartered in one of the counties within the service counties and there must be at least one eligible employee enrolling in Minnesota to be eligible for Allina Health|Aetna Funding Advantage (AHAFA).

Service counties (SC) Counties			
Anoka	Carver	Rice	Ramsey
Chisago	Hennepin	Nicollet	Washington
Brown	Isanti	Scott	Wright
Dakota			

Live/work

- Employees are eligible for the AHAFA plans when they live or work in the SCs listed above.

Product availability

- Product availability will vary by location. Refer to the grid below.

Employee location	Network service area
Live/work in SC	AHAFA Performance or Broad Network
Live/work in MN, but outside of SC	AHAFA Broad Network
Live/work outside of MN	AFA MN OOS CPOSII Network/AFA MN OOS Indemnity

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Specific guidelines for Banner Aetna Funding Advantage

Banner | aetna™

Employer eligibility

- The employer must be headquartered and there must be at least one eligible employee enrolling in Arizona in order to be eligible for Banner|Aetna Funding Advantage (BAFA).

Live/work

- Employees are eligible for the BAFA plans when they live or work within 60 miles of the BAFA-eligible Arizona employer headquarters for the Broad Network and live or work in the service area for the BAFA Performance Network.

Product availability

- Employers meeting the enrollment requirement for a BAFA proposal can choose to offer the Performance Network (BAFA Perf Open POS II Plans) alongside BAFA Broad Network (BAFA Broad Open POS II Plans) or as a standalone offering.
- Product availability will vary by location. Refer to the grid below.

Employee location	Network service area
Arizona – Coconino, Maricopa, Pima and Pinal counties	BAFA Performance Network
Arizona – All counties	BAFA Broad Network
Located outside of AZ	AFA AZ OOS CPOSII Network/AFA AZ OOS Indemnity

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Specific guidelines for Innovation Health Funding Advantage

Employer eligibility

- The employer must be headquartered within one of the following Northern Virginia counties/cities and there must be at least one eligible employee enrolling within VA, MD, or DC to be eligible for Innovation Health Funding Advantage (IHFA).

Counties			Cities	
Arlington	Frederick	Shenandoah	Alexandria	Manassas
Clarke	Loudoun	Spotsylvania	Fairfax	Manassas Park
Fairfax	Page	Stafford	Falls Church	Winchester
Fauquier	Prince William	Warren	Fredericksburg	

Live/work

- Employees are eligible for the IHFA plans when they live or work within 60 miles of the IHFA service areas listed above.

Product availability

- Product availability will vary by location. Refer to the grid below.

Employee location	Network service area
IHFA regions – DC, MD, and VA	IHFA Broad Network only
Located outside of IHFA regions	AFA CPOSII Network/AFA Indemnity

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