Washington ACA Underwriting Brochure

Plans effective January 1, 2023 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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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 and consistently applied to all employees.
- 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 following the date of hire.
  - 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 BWP 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 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 first of the month, the effective date will be the date of hire.

BWP 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

- Union employees are the only class of employees that may be excluded. 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.

Case submission dates

- 1st of the month effective date - must be received by the 20th 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 because we are unable to process cases that are missing vital information.

COBRA and state continuation

- 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.
- Employers with less than 20 employees (full and part time) are eligible to offer state continuation.

- COBRA applies to group health plans sponsored by employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year.
  - Include: full time, part time, seasonal, temporary, union, owners, partners, officers
  - Exclude: self-employed persons, independent contractors (1099), directors
  - Each part time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part time employee worked divided by the hours an employee must work to be considered full time
- 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 and State Continuation 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 enrollees are required to be included on the census.
- The qualifying event, length, start date and end date must be provided.
- COBRA/state continuation 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/state continuation participants can be included for coverage subject to normal underwriting guidelines.

Counting employees to determine group size in the prior calendar year

- 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 to 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:**
  - 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.
- Illustrative Quote - use TAE count at time of quote.
- Groups with 50 or fewer total average employees based on **previous calendar year** are rated as a small employer.
  - Example: TAE is 45 based on previous calendar year; eligible if 65 - this is a 1-50 group.
- If the TAE is 51-100 based on **previous calendar year** and the eligible is less than 51-100, this is a 51-100 group.
  - Example: 90 TAE based on previous calendar year; 40 eligible - this is a 51-100 group.
- If the TAE is 101+ based on **previous calendar year** and the eligible is less than 101, 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 not allowed.
- Deductible and Coinsurance (Out of Pocket) credit reports may be submitted. Be sure it includes Social Security numbers.

Dependent eligibility

- Spouse or domestic partner.
  - If both employee and spouse/domestic partner work for the same company, they may enroll together or separately.
- Children
  - Children are eligible as defined in plan documents in accordance with applicable state and federal laws, 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.
  - Grandchildren are eligible if court ordered. 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 under the dental plan even if they select 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 employer may be up to 60 days in advance.

Employee eligibility

- We will allow employers to cover employees who work 20 hours or more.
- It includes self-employed individuals, a sole proprietor, or a partner of a partnership if the sole proprietor or partner is included as an employee under a health care insurance plan of a small employer.
- Employees/individuals not eligible for coverage include 1099 contractors, temporary, seasonal, substitute or uncompensated employees, employees making less than

equivalent minimum wage, volunteers, inactive owners, shareholders, officers or managing members who are not active, investors or silent partners.

- Retirees are not eligible for any coverage - medical, 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 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/State Continuation participants should be included and noted as COBRA/State Continuation.
  - The eList Tool must be completed in full.

Employer contribution

Medical

- 75% of the employee cost or 50% of the total cost.
- Groups that do not meet contribution are eligible to enroll during open enrollment, November 15th through December 15th, for a January 1st effective date.

Employer eligibility

- "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than 50 employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise

specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary after the date the small employer no longer meets the requirements of this definition.

- The group must have at least 51% of the eligible employees located in Washington.
- A self-employed individual or sole proprietor who is covered as a group of one must be a common law W-2 employee and:
  - Have been employed by the same small employer or small group for at least twelve months before for small group coverage, and
  - Verify that he or she derived at least 75% of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service (IRS) form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least 51% of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate IRS form 1040, for the previous taxable year.
- 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.
- There must be at least one enrolled common law W-2 employee who is not an owner and not an owner's spouse.
- Partners and LLCs filing as a partnership are eligible even if there are no common law W-2 employees. Owner and spouse groups are not eligible.
- Groups that do not meet the definition of a small employer are not eligible for 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.

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**.

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

- 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 owning 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.

Late applicants

- An employee or dependent enrolling for coverage more than 31 days (60 days for newborns) 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.) 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 (MSP) for CMS reporting

- All carriers must report to Centers for Medicare & Medicaid Services (CMS) the number of Medicare Secondary Payer (MSP) groups and the number of employees, each year based on the number of employees provided by the employer.
- 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.
  - Include: full-time, part-time, seasonal, temporary, union, owners, partners, officers
  - Exclude: self-employed persons, independent contractors (1099), directors, leased employees

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.

Newly formed business (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.

- 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 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.
- 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 along other carriers

Medical

- Participation guidelines must be met for a group to qualify for coverage for all plans. See Participation-Medical section.
- Our option sale participation requirements must be met and are market specific.
- 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-state employees

Medical

- Any active employee who lives in a state other than where the company is domiciled is considered an out-of-state employee.
- Out-of-state employees must be enrolled in a PPO, if available.
- Health coverage is not available in Hawaii or Vermont to any group or resident located in these states.
- Massachusetts employees - 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. For more information on Massachusetts credibility, please contact your CPA or financial advisor.
- 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

Non-contributory plans (employer pays all)

- 100% of eligible employees must enroll, excluding valid waivers

Contributory plans

- 60% of eligible employees must enroll, excluding valid waivers, rounding down

Valid Waivers

- Spousal coverage
- Medicare, Medicaid
- TRICARE/CHAMPUS/CHAMPVA
- Retiree coverage through a previous employer
- Association coverage
- COBRA from previous employer

Invalid waivers will not count towards participation

- Individual coverage (on and off exchange)
- Student health
- Another employer sponsored health plan

All Plans

- The employer must offer coverage to spouse and children. The employer cannot offer employee only plans. However, we do not require/enforce participation for dependents.
- Waivers - all employees waiving coverage must complete the waiver section of the employee application.
- Waivers may be sent in a separate 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.

- 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

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

Rates

Medical

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

Replacing Other Group Coverage

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

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)

We will consider the group with the following:

- A letter from the group or broker indicating the group is enrolling as a spin-off. 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 5 enrolled employees
  - 6 to 50 enrolled employees with no current employer group health coverage
  - 6 to 50 enrolled employees with current prior group health coverage must provide their most recent prior carrier bill including the employee roster in lieu of QWTS.
- 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 must be signed and dated by the employer. Any hand-written comments added must be signed and dated by the employer.
- The underwriter may request payroll in questionable situations.
- 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.
- 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.
- Self-employed individuals, sole proprietor, or corporations considered as group of one, must be employed for last 12 months.
- 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.
- Nonprofit groups may provide payroll documents as long as they also submit the appropriate form detailing their nonprofit status.
- Other documentation may be requested by Aetna Underwriting upon receipt and review of sold case documents.
- Altered legal documentation will not be accepted at any time.

Dental

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, FOC and Indemnity plans.
  - Waiting periods do apply to PPO, FOC and Indemnity 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

- All industries are eligible for dental in Washington.

Dental late applicants

If dental 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 along other carriers

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

Dental out-of-area within Washington

- Employees who reside within Washington 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/Mini-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 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

- Non-Voluntary Plans
  - Dual Option
    - > DMO (if available) can be either sold standalone or packaged with any PPO Option.
    - > PPO can be sold standalone or packaged with the DMO (if available), excluding Preventive Plans, and preventative /basic combination.
    - > Freedom-of-Choice (if available) cannot be packaged with any other option. It must be the only plan sold. The only exception would be for out of area/out of state employees not eligible for FOC.
- Voluntary Plans
  - Dual Option:
    - > 3-9 - Not available
    - > 10-50 – Same as non-voluntary plans
- Triple option not available.
- PPO plans cannot be packaged together.
- 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).

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