



Associated Employers Trust Minimum Quote Requirements & Quote Assumptions and Conditions

Wells Fargo Insurance Services

Minimum Quote Requirements and Disclaimers

Below is a list of the minimum information requirements to receive a quote. If a quote request is received without any of the following information, a single request will be made for the missing information within 24 hours of receiving the quote. If that information is not received within 2 business days, or our office is not informed of pending follow up, the quote will be declined due to incomplete information after 5 business days from receipt of initial request.

Groups 5-99 Currently Fully Insured

1. **Broker/Agent Information:**
 - a. Broker/Agent Name, Phone/Fax and E-mail
2. **UHC Representation Name/Office if through UHC representative.**
3. **Company Profile:**
 - a. Full Company Name
 - b. Address of Company (Street/City/State/Zip)
 - c. Standard Industry Code (SIC) or North American Industry Classification System (NAICS)[†].
 - d. Renewal Date
 - e. Requested Effective Date[†]
 - f. Years in business
4. **Employer Contribution**
 - a. % level of Individual rate[‡]
 - b. % level of Family rate[§]
5. **Company Census in Microsoft Excel and include for each employee:**
 - a. All company employees must be included
 - i. **Our office will assume the submitted census includes all employees to determine participation requirements unless otherwise noted. Employees listed as "Waiving Coverage" are assumed to have valid waivers; therefore the assumed participation level is 100%. NOTE: THIS MAY EFFECT FINAL RATING BASED ON INFORMATION PROVIDED AT GROUP ENROLLMENT.**
 - ii. **ALSO NOTE: New groups will be required to submit a copy of the latest Quarterly Wage and Tax Report (5208) or the current two week payroll statement (all pages, including grand totals) in lieu of the 5208. In addition, owner only groups will require proof of ownership/tax documentation for all owners/officers/partners enrolling. Please see the NEW GROUP SUBMISSION CHECKLIST FOR ADDITIONAL INFORMATION.**
 - b. Current Plan the employee is enrolled on and the dependent tier (i.e. EE, ES, ESC or EC).
 - c. Date of Birth (MM/DD/YYYY)
 - d. Gender
 - e. Active/COBRA Status
 - f. Home Zip Code^{**}
 - g. Please add employees who are waiving coverage and note if for other coverage or simply waiving.
6. **Summary of Current and Renewal Benefits: (include listing of co-pays, coinsurance, deductibles and Pharmacy co-pays for each plan)**
7. **Rate History:**
 - a. Current name & how long with carrier^{††}
 - b. If less than 3 yrs, list prior carrier
 - c. Current Rates
 - d. Renewal Rates
 - i. Off anniversary quoting: Current rates and prior year's rates are required for quoting.
8. **Completed and signed AET HRQ**

[†] SIC is a direct factor in rating. If this information is not provided, our office will assume, if possible, based on research. NOTE: THIS MAY EFFECT FINAL RATING BASED ON INFO PROVIDED AT GROUP ENROLLMENT.

[‡] Quotes are valid for the month noted on the original RFP. Please inquire with our office for quote effective date extension.

[‡] If this information is not provided, the minimum quote assumption of 50% employee contribution will be used. NOTE: THIS MAY EFFECT FINAL RATING BASED ON INFO PROVIDED AT GROUP ENROLLMENT.

[§] If this information is not provided, the minimum quote assumption of 0% dependent contribution will be used. NOTE: THIS MAY EFFECT FINAL RATING BASED ON INFO PROVIDED AT GROUP ENROLLMENT.

^{**} If this information is not provided, our office will assume all employees share the zip code of the company. NOTE: THIS MAY EFFECT FINAL RATING BASED ON INFORMATION PROVIDED AT GROUP ENROLLMENT.

^{††} Years with previous carrier is a direct factor in rating. If no information is provided, our office will assume group had insurance with incumbent for only 1 year.

Self-Insured (all group sizes) or Fully Insured (groups over 100 employees)

1. All information listed for groups 5-99. Please also include the following.
2. Most recent 24 months of paid claim experience and earned premium listed monthly along with eligibility.
3. Claimant Large Loss Information: (include diagnosis if applicable and current status of the claim)
4. If group is self-funded, please also provide:
 - a. Stop Loss Levels and Fees
 - b. Administrative Fees
 - c. Attachment Point & Corridor Amount

Quoting Assumptions & Conditions

- Employer must be an active member (in good standing) of Associated Industries or an endorsed sponsor to be eligible for coverage. However, quotes can be released without membership.
- Group must be headquartered in Washington; at least 51% of eligible employees must be located in Washington. Group may have a location or subsidiary located outside the State of Washington as long as at least 51% of all eligible employees – in and out of state - are located in the State of Washington or work at an employer site located in Washington State.
- Quotes are only valid for the effective date quoted. Please contact Wells Fargo Insurance Services if you would like to change the effective date of the quote.
- Quotes are valid only for effective date shown on the proposal and are based on the information provided; however, this proposal may be invalidated if the information provided has been misrepresented. Final rates as verified and approved by the Program Manager of AET are guaranteed for 12 months beginning on the first day of the policy. The Trust reserves the right to recalculate rates at any time during the employer's contract year if the enrollment of the participating employer changes by more than 10%
- Proposed rates are based on the census provided. Final rates are based on actual enrollment, pending verification and approval by the Program Manager of the Trust.
- An AET Group Health Risk Questionnaire is required. The Trust reserves the right to re-rate the participating employer if the completed questionnaire is not received before the quote is prepared. If the Group Health Risk Questionnaire is more than 3 months old on the effective date of the new participating employer, the agent will be required to request an updated questionnaire from the participating employer.
- Available only to employers with 5 or more enrolling employees.
- A true Employer/employee relationship must exist and be verifiable.
- Eligible employees are permanent employees who work at least 30 hours in a normal work week. An employer may elect to reduce the eligibility requirement to 20 hours per week, provided it is non-discriminatory, as long as there are at least two employees in the group who work 30 hours a week or more.
- The maximum waiting period for newly hired employees to become eligible for medical benefits is 12 months.
- Employer may elect to waive their selected employee waiting period at the time of initial case issue only, but have the option to change their waiting period once a year at case renewal.
- 100% of eligible employees must have workers' compensation coverage, except those legally not required to be covered by workers' compensation coverage.
- New employer coverage will be effective the first of the month.
- A group will not be eligible for coverage if they have been with more than 3 carriers in the last 5 years (exceptions are considered if the carrier left the market).
- Employees and dependents that elected not to enroll when first eligible due to other group health coverage, will be allowed to enroll if they involuntarily lost the coverage. Proof of loss of other group coverage will be required. Coverage under this Association Health plan will be effective on the first day of the month following the termination of the other group Health plan coverage.
- Employees who decline coverage without other insurance may not enroll until the renewal date of their employer.
- Carrier age limits for dependent children: End of the month following the 26th birthday.
- Re-certification is required on any disabled or handicapped dependent over the limiting age.
- The program is offered to full-time employees and their dependents only. "Full-time" means an employee who regularly works at least 20 hours per week or more at his/her employer's place of business and has satisfied the employment probationary period set by the employer.
- AET does not provide coverage for retirees.
- Coverage for Domestic Partners must be indicated on the Group Master Application and an approved Affidavit of Domestic Partnership must be submitted for each such covered partner.
- Quote is based on only one classification of employees and one probationary period for all employees unless otherwise clearly specified in the request for proposal. Participating employers with less than 10 employees are not eligible for multiple classifications and/or probationary periods. Multiple employee classifications must be non-discriminatory and preclude individual selection by the employer or the employees.
- All rates (excluding-HSA) assume that none of the deductible, coinsurance, or co-payments are self-insured.
- AET will only accept Group Master Applications from one legal entity in which a true employer/employee relationship exists with all eligible employees. Documentation substantiating this relationship may be requested.

- Standard benefits, contractual and administrative practices of UnitedHealthCare Insurance Company shall apply. Participating employer's prior plan shall not be duplicated.
- This quote does not provide coverage for early/Medicare eligible retirees.
- This quote is contingent upon the condition that UnitedHealthCare is the only carrier of medical coverage offered.
- Off-anniversary Group Specific benefit, rate and risk level changes are not allowed.
- All claims incurred prior to the effective date will be the liability of the prior carrier.
- This quote assumes that we will not be subject to extraterritorial mandates (i.e., not subject to the benefits or the administrative mandates of a state outside of the state the contract is issued in.). This quote may be subject to underwriting review in the event an extraterritorial mandates applies.
- Contribution/Participation Assumptions:
 - Employer must contribute at least 50% of the cost for employees; contributions are not required for dependent coverage. At least 75% of eligible employees must be enrolled. Employees who are able to provide evidence of other group coverage may be excluded from the eligibility requirement.
 - Employer may elect to contribute a higher amount. If coverage is contributory (employer pays less than 100%), minimum participation remains at 75%. If coverage is noncontributory (employer pays 100%), all eligible members must be enrolled. Employees who are able to provide evidence of other group coverage may be excluded from the eligibility requirement.
 - New groups will be required to submit a copy of the latest Quarterly Wage and Tax Report (5208) or the current two week payroll statement (all pages, including grand totals) in lieu of the 5208. In addition, owner only groups will require proof of ownership/tax documentation for all owners/officers/partners enrolling. Please see the NEW GROUP SUBMISSION CHECKLIST FOR ADDITIONAL INFORMATION.
- Quote Assumptions pertaining to CDHP Plans:
 - The employer must contribute an equal percentage (a minimum of 50%) of the employee cost for both the CDHP and non-CDHP Plans.
 - The employer contribution to the CDHP fund cannot exceed 50% of the CDHP Plan deductible.
 - If the CDHP Plan fully replaces other plans (total replacement), all other standard underwriting rules apply.
 - If a group currently has more than one non-CDHP plan, the rules above will apply to the plan with the highest deductible.
 - We will not offer a non-CDHP plan against another carrier's CDHP plan.
- Rates are guaranteed for 12 months for initial policy and also at renewal.
- Rating is based on employer's location.
- Quotes issued are not a guarantee of plan coverage, risk classification or eligibility.
- COBRA and/or State Continuation Coverage employees added after the initial group enrollment may subject the group to re-rating.
- Medical Plan Selection
 - Groups with 5+ enrolled active employees may select one UnitedHealthcare plan
 - HRA Plans: The Employer may contribute up to 50% of the employee deductible and may not contribute toward the coinsurance.
 - Groups enrolling 10+ active employees may select up to two plans (see Dual Option Grid in Appendices)
 - HSA plans require prescription plan choice (H9) as does the Choice Plus HRA \$3000/\$3000 (WBK).
 - Select one of six prescription plan choices for all other plan pairings (K5, K6, G4, P9, V0, and H9).

If any of the above terms are not met, then UnitedHealthcare Insurance Company reserves the right to immediately change rating components or void the AET proposal.