Capital BlueCross and Keystone Health Plan® Central
Underwriting Compliance Guidelines
Effective January 1, 2013

- The guidelines within this document apply to all group health, dental, vision, and prescription drug coverages offered by Capital BlueCross as well as our wholly owned subsidiaries Keystone Health Plan® Central (KHP Central), Capital Advantage Insurance Company® (CAIC), and Capital Advantage Assurance Company® (CAAC).

- For the purpose of this document, all programs offered by Capital BlueCross, CAIC, CAAC, and KHP Central shall be collectively referred to as "Capital." Any guideline(s) specific to KHP Central will be referenced as *HMO*.

- Capital Underwriting Compliance Guidelines specific to our Association, Consortium, and Medicare offerings are available as separate documents to our internal account executives.

- Capital will reject any group that does not meet Underwriting guidelines using the eligibility criteria stated on the initial Group Application. The group will have to reapply with no retroactive effective dates permitted. Eligibility criteria may not be changed merely to meet Underwriting requirements.

- All paperwork for new groups or benefit changes must be received by the deadline stipulated for the requested effective date found within this booklet.

- Small group shall be defined as a group with fewer than 106 contracts enrolled and standard programs offered. Large group shall be defined as a group with more than 105 contracts enrolled. Underwriting Compliance reserves the right to make limited exceptions.

- Capital reserves the right to change these guidelines at any time.

- Capital reserves the right to request additional and/or satisfactory documentation to verify that an applicant and its employees or subscribers meet the eligibility criteria, and to reject an application when such documentation is not provided.

- **The information contained within this communication is considered proprietary and should not be shared with anyone other than the intended recipient.**

- **All questions regarding the information contained within should be directed to the Director of Actuarial Operations.**

Capital BlueCross

Underwriting Compliance Guideline Index

Capital BlueCross

Underwriting Compliance Guideline Index (continued)

I. GROUP ELIGIBILITY

A. Defining an Eligible Group

1. An eligible group is a collection of eligible employees or subscribers who are employed by a single employer. The account must be a legal entity, which has the legal capacity to execute a contract on behalf of its customers. A group cannot be formed for the express purpose of purchasing insurance.

An eligible group must reflect current full-time business activity. Dormant or inactive companies will not be viewed as eligible for group health insurance.

2. Capital reserves the right to deny or cancel any group that does not meet Underwriting guidelines.

An existing group will be given at least 60-days notification of cancellation if found to be noncompliant. A conversion offer will be extended to each subscriber.

B. Location

1. The business must be physically located within Capital's 21-county service area to be eligible for group coverage. If the group is headquartered outside our 21-county service area, Capital can only insure those locations within our territory with notification to the Home Plan. Any group applying for group coverage which is headquartered outside our area must be accompanied by a cede agreement before consideration will be given to the application. If the group is headquartered in our service area, we can insure all locations without BlueCross BlueShield Association (BCBSA) violation concern.

2. Small groups have a residency requirement that at least 25 percent of the enrolled subscribers must reside within our service area with a 30-mile border leniency applied. All *HMO* subscribers must reside within our service territory (30-mile leniency is applied) and they must use an *HMO* network provider in order to receive reimbursement.

C. Common Ownership

In order to combine for rating purposes, one entity or person must own 51 percent or more (controlling majority) of each entity they choose to combine. Family members cannot combine ownership percentages to form "controlling majority." There must be one decision maker legally authorized to make contractual agreements for the entire group population. Capital BlueCross Underwriting Compliance reserves the right to grant final approval on multiple entity groups.

D. Investment Income

Investment-only income will not be considered the basis for group health coverage. Rental-only income groups will not be considered eligible unless ancillary services are provided to multiple units. This is at the discretion of the Underwriting Compliance staff based on tax documentation at the time of application.

E. Employee Class

No management Carve-Out groups will be allowed—coverage must be offered to all employees meeting probationary and weekly work hours criteria. This policy applies to all Capital groups. A union with current bargaining agreement limitations may be considered as an exception to the above statement.

A group may set their probationary period and premium contributions by type or class of employee, provided this is applied uniformly to all employees meeting the same criteria.

A group should be discouraged from offering a different level of required hours per week for eligibility. If a group does offer health coverage to a type or class of employee that varies in hours worked per week to be eligible, the audit and compliance determination will be based on the lesser of the hourly requirements. (Example: Salaried must work 30 hours per week—hourly must work 40 hours per week. The audit and participation results will be determined using 30 hours per week with no exceptions.)

F. Multiple Options

Enrollment Requirements

For Health and *Rx* Lines of Business Sold/Renewed Effective January 1, 2013

Segment is defined as: *PPO*, CMM, *POS*, *HMO*, *Traditional*, *Rx*, *Senior*[SM]
Option mix can contain only one *Rx* program for each medical option offered.
(This includes *MyCoverage Selector* Products)
(Example: Single option = one *PPO*, one *Rx*, one *Senior*
Dual option = one *PPO*, one *HMO*, two *Rx*, one *Senior*)

Market Segment	Options	Option Mix	Option Enrollment Requirements
Small Group (2–9)	Single*	**HSA or HRA program is available to groups of two or more contracts.**	• **Fully Insured groups only. ASO not available.** • At least 75 percent participation.*** • At least 25 percent of enrolled subscribers must reside within our service area. *HMO* residency requirement is 100 percent. A 30-mile border leniency will be applied. • Must be all Capital BlueCross with no other carriers offered. **eBasics[SM] Product Suite** Groups are locked into the eBasics program. Once they are enrolled there are no retro product changes—group cannot drop program until their next renewal. ***PPO* Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Groups may not offer any other medical product along with the *PPO* Choice product. A group may choose to move to a *PPO* Choice product off renewal; however, they would have to wait until their next renewal to select a non-"Choice" product.

Market Segment	Options	Option Mix	Option Enrollment Requirements
Small Group (10–19)	Single, Dual, or Triple**	No more than two products from each product segment may be offered. Each product will count as one option. If an HSA or HRA program is offered, that will count as one option. The HMO *Direct Access* product **can** be offered with our normal *HMO* product.	• **Fully Insured groups only. ASO not available.** • At least 75 percent participation.*** • At least 25 percent of enrolled subscribers must reside within our service area. *HMO* residency requirement is 100 percent. A 30-mile border leniency will be applied. • Must be all Capital BlueCross with no other carriers offered. • A minimum of three contracts enrolled in each option offered. **eBasics Product Suite** Groups are locked into the eBasics program. Once they are enrolled there are no retro product changes—group cannot drop program until their next renewal. ***PPO* Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Groups may not offer any other medical product along with the *PPO* Choice product. A group may choose to move to a *PPO* Choice product off renewal; however, they would have to wait until their next renewal to select a non-"Choice" product.
Small Group (20–105)	Single, Dual, or Triple**	No more than two products from each product segment may be offered. Each product will count as one option. Noncompliance with multiple option guidelines will be addressed at renewal for existing groups. **Note: HSA or HRA program is available to groups of two or more contracts.** Any HSA/HRA offering will count as *one product*. A group may choose to offer two HSAs, two HRAs, or one of each. The HMO *Direct Access* product **can** be offered with our normal *HMO* product. **Note: MCC is not available for small ASO groups.**	• **Can be sold Fully Insured or ASO effective 7/1/2013.** • At least 75 percent participation for both Fully Insured and ASO.*** • At least 25 percent of enrolled subscribers must reside within our service area. *HMO* residency requirement is 100 percent. A 30-mile border leniency will be applied. • A **minimum** of **five contracts** in **EACH** option. **eBasics Product Suite** Groups are locked into the eBasics program. Once they are enrolled there are no retro product changes—group cannot drop program until their next renewal. ***PPO* Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Groups may not offer any other medical product along with the *PPO* Choice product. A group may choose to move to a *PPO* Choice product off renewal; however, they would have to wait until their next renewal to select a non-"Choice" product.

Market Segment	Options	Option Mix	Option Enrollment Requirements
Large Group (106–499)	Single, Dual, or Triple**	No more than two products from each product segment may be offered. Each product will count as one option. **Exceptions must be approved by Case Underwriting through the quote process.** Noncompliance issues will be addressed at renewal for existing groups. **Note: HSA or HRA program is available to groups of two or more contracts.** Any HSA/HRA offering will count as *one product*. A group may choose to offer two HSAs, two HRAs, or one of each. These programs can be offered with Prospective or ASO arrangements only.	• At least 75 percent participation required for Fully Insured groups.*** • At least 25 percent participation required for ASO. • A **minimum** of **10 percent** (of TOTAL) contracts in **EACH** option. A one-year grace period will be granted with at least 10 contracts in each option required at the initial offering. • PPO 1-2-3^{SM} must be offered as a full replacement. (Prospective or ASO only.)
Large Group (500–999)		Any combination of products from any product segment (may offer multiple products from within a segment—each product will count as one option). **Note: HSA or HRA* program is available to groups of two or more contracts.** Any HSA/HRA offering will count as *one product*. A group may choose to offer two HSAs, two HRAs, or one of each. This program can be offered with Prospective or ASO arrangements only.	• At least 75 percent participation required for Fully Insured groups.*** • At least 25 percent participation required for ASO. • A **minimum** of **100 contracts** in **EACH** option. A one-year grace period will be granted with at least 25 contracts in each option required at the initial offering. • PPO 1-2-3^{SM} must be offered as a full replacement. (Prospective or ASO only.)
Large Group (1,000+)		Any combination of products from any product segment (may offer multiple products from within a segment—each product will count as one option). **Note: HSA or HRA* program is available to groups of two or more contracts.** Any HSA/HRA offering will count as *one product*. A group may choose to offer two HSAs, two HRAs, or one of each. This program can be offered with Prospective or ASO arrangements only.	• At least 75 percent participation required for Fully Insured groups.*** • At least 25 percent participation required for ASO. • A minimum of **100 contracts** in **EACH** option. A one-year grace period will be granted with at least 25 contracts in each option required at the initial offering. • PPO 1-2-3^{SM} must be offered as a full replacement. (Prospective or ASO only.)

Market Segment	Options	Option Mix	Option Enrollment Requirements
MyCoverage Selector **20+**		Any grandfathered group, who elects to enroll in the *MyCoverage Selector* product, will lose their grandfathered status. Any combination of *MyCoverage Selector* products can be selected. **Note: MCC is not available.** The minimum monthly defined contribution per employee can be either: *100 percent of the total monthly single-person premium for the lowest priced medical/prescription Plan that the group offers to all eligible employees with no participation requirements needed. *Or less than 100 percent, but then must meet 75 percent participation.	• At least 20 or more enrolled subscribers. • At least 25 percent of enrolled subscribers must reside within our service area. A 30-mile border leniency will be applied. • There is no minimum enrollment needed in each product.
Associations	Single, Dual, or Triple**	Any combination of products from any product segment (may offer multiple products from within a segment—each product will count as one option). Details pertaining to the availability of an HSA/HRA program should be discussed with Underwriting Compliance.	• All associations must adhere to the 75 percent participation guidelines at the member firm level if there are two or more contracts. • Multiple option guidelines are applied at the member firm level using the above stated size guidelines.

***Exceptions must be approved by Underwriting Compliance.**

**If a customer is quoted a multiple option program and fails to meet the minimum enrollment requirements permitted by that enrollment option, the option will be denied and the individual applications selecting that product will be returned to the group. For existing groups renewing a multiple option program falling out of compliance, notification will be sent to the account executive with needed action outlined.

***If the group is offering our *HMO* product(s) ONLY in addition to another carrier, the participation requirement reverts to **25 percent**.

Note—All Capital medical products offered must have the **same funding arrangement**. All products must be self-insured or all products must be fully insured.

Note—All Capital medical products offered must have the **same financial arrangement** (e.g., *PPO*, *Traditional*, *HMO*, and *Rx* must all be Prospective).

G. Calendar Year vs. Benefit Year

A group may elect to move to a Benefit Year program design although our standard is Calendar Year.

This decision should be made after considering all the facts at the time of renewal. The group should consult their account executive and/or producer to understand the impact to their employee's claim payments.

This change can only be made one time. Any group moving to a Benefit Year from Calendar Year will not be able to move back to Calendar Year and vice versa.

II. PARTICIPATION REQUIREMENTS

A. Fully Insured Groups

Seventy-five percent participation is required for all fully insured groups applying for group coverage with Capital.

If a group has 20 or more eligible employees, no more than 50 percent of the total eligible employees may waive coverage.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be deducted from the total eligible count for participation calculation purposes. If an employee does not check a line of business on the waiver, Compliance will not assume they are waiving coverage for that product (e.g., if the employee signs the waiver and checks the "medical" box but not the "dental" box, Compliance will only apply the waiver to the medical participation). Capital may verify true and active coverage during any audit activity.

B. Self-Insured Groups (ASO)

Small Group ASO—Seventy-five percent participation is required for all self-insured small groups (20–105 only) applying for coverage with Capital. Specific stop loss coverage is required for all groups. Proof of active stop loss coverage including aggregate is necessary upon initial enrollment as well as subsequent renewal.

Multi-Coverage Credit (MCC) for dental and vision is not available.

If a group has 20 or more eligible employees, no more than fifty percent of the total eligible employees may waive coverage.

Paperwork to enroll must include all new group paperwork as defined in section VIII of this booklet along with the **signed ASO proposal rate sheet and rate exhibit**.

Large Group ASO—Twenty-five percent participation is required for all self-insured large groups (106+) applying for group coverage with Capital. Specific stop loss coverage is required for groups with fewer than 300 contracts. Proof of active stop loss coverage including aggregate is necessary upon initial enrollment as well as subsequent renewal. This requirement of proof applies only to those groups where stop loss coverage is mandatory and is not provided by Capital or Consolidated Benefits, Inc.

C. 2–19 Contracts

For groups having between 2 and 19 contracts (excluding *Senior* and/or Medicare Advantage contracts), the following participation requirements determine eligibility:

Subtotal Eligible Employees*	Minimum Participation Requirements
1**	1**
2	2
3	3
4	3
5	4
6	5
7	6
8	6
9	7
10	8
11	8
12	9
13	10
14	11
15	11
16	12
17	13
18	14
19	14

***Total eligible employees minus valid employee/spousal waivers.**
****Available to associations only.**

D. *MyCoverage Selector* Groups

Groups with 20 or more enrolled subscribers may apply for the *MyCoverage Selector* product. Every eligible employee will need to log on to Connected Health and either enroll in coverage or waive coverage. Group's sized 20–50 will be required to go to Medpoint. Sales should submit for preliminary rates for these groups.

The group must take at least one of the products offered in the *MyCoverage Selector* product and cannot alter the benefit design in any way. A group may not offer the same medical plan with different *Rx* plans. There will also be no stand-alone or MCC available with the *MyCoverage Selector* products for either dental or vision products. The minimum monthly defined contribution per employee *that elects Capital coverage* must be 100 percent of the total monthly single-person premium for the lowest priced medical/prescription plan that the group offers to all eligible employees in order for the group to not have to meet a participation requirement. If a group should choose not to offer the minimum monthly defined contribution per employee at 100 percent, they have the option to contribute less with the understanding that the group will then be required to meet the 75 percent participation rule. Complete waiver information will be required if a group must meet the 75 percent rule.

Paperwork to enroll must include all new group paperwork as defined in section VIII of this booklet along with the *MyCoverage Selector* setup form and an open enrollment load file of those employees enrolling. Individual paper applications and waivers are not required. **Checks for *MyCoverage Selector* groups will require the medical and *Rx* premium amount, on the lowest tier rate of the least expensive product times the number of eligible employees submitted on the open enrollment file.**

E. Enrollment Minimum

1. All participation guidelines are applied at the employee/subscriber level and not at the dependent level of the contract.

2. If an existing fully insured (both small and large) group or an existing ASO small group falls below the required participation level but exceeds 50 percent participation, a one-year grace period may be given to enable the group's participation level to increase. If the group does not reach the required participation level during the next audit, the group coverage will be canceled with at least 60-days notification.

3. Eligible employees who choose to waive coverage and provide a signed waiver will be deducted from the total eligible employees prior to the calculation of the participation percentage. Capital reserves the right to verify the presence of active coverage with other carriers.

III. EMPLOYEE/EMPLOYER CONTRIBUTION

Capital currently requires that the *employee* contribution for benefits be NO MORE than 15 percent higher than any other competitor offered.

For *MyCoverage Selector* products the *employer* can choose to either offer 100 percent of the total monthly single-person premium for the lowest priced medical/prescription plan that the group offers to all eligible employees or less than 100 percent with the understanding that they are required to meet the 75 percent participation rule.

IV. EMPLOYEE/SUBSCRIBER ELIGIBILITY

A. Group Subscriber Eligibility

1. An eligible employee is defined as one who works a minimum of 20 hours each week for at least nine months a year and receives a regular wage reportable on a W-2. If an employer chooses to stipulate a higher number of hours required for eligibility, we adhere to that number for audit purposes to determine eligibility.

2. All owners are considered to be eligible and are included in the participation calculation.

3. Independent contractors receiving a 1099 form are not eligible for group coverage.

4. Board of Directors cannot be enrolled unless they meet the same criteria as an eligible employee.

5. The spouse of a business owner must have proof of full-time employment via a W-2 to create a group of two in a husband/wife business. The relationship is viewed only as employee/employer when determining eligibility as a subscriber rather than a dependent. If a current W-2 is not available for the spouse of a two-life group, the group will be denied and furnished with a list of possible associations accepting sole proprietors by their account executive or broker.

6. Capital does not acknowledge the continuation of group health insurance coverage as part of a severance agreement or personal agreement made between buyer and seller. Former owners of a business are not eligible to remain on group coverage. Former employees determined not eligible for COBRA and who do not meet the established retiree policy are not eligible to remain enrolled.

7. An existing subscriber found to be ineligible for group enrollment would be given a 60-day notification of cancellation as well as nongroup conversion (provided he/she meets the nongroup underwriting guidelines). It is the group's responsibility to inform the subscriber of this termination.

B. Dependent Eligibility

1. An eligible dependent is the spouse and/or child(ren) of an eligible employee/subscriber. This will include newborn children, children legally placed for adoption, legally adopted children, stepchildren, or children of a legal guardian. A child is eligible and covered until the age limitation specified in the contract. Certain exclusions may apply if a disability is present. Effective October 1, 2010, at renewal, the dependent age will increase to 26 regardless of student status in accordance with health care reform.

2. Divorced/ex-spouses are not eligible to remain on the subscriber's contract, nor are they viewed to be an eligible subscriber unless they are employed by the same group and meet eligibility guidelines.

3. Domestic partnership coverage is available to small and large groups. An affidavit and supporting documentation is required for all small group domestic partner enrollment. Domestic partner coverage must be requested for large groups during the quoting process. An affidavit may be required for large group domestic partner enrollment.

4. Widows/widowers of deceased employees are eligible to remain on the group provided a written policy exists, which is applied uniformly. Such policy may be requested in writing during an audit.

5. Product selections, as well as dependent options, are dictated by the group and the employee. Dependents may select less than the subscriber, but never more.

   The employee may only select products offered by the group. The dependents can only enroll in products selected by the employee.

C. ACT 4

On June 10, 2009, Governor Rendell signed legislation expanding insured group health insurance coverage to adult unmarried children up to age 30. The new Pennsylvania Law (Act 4 of 2009) requires health insurers to continue coverage of unmarried children through age 29 at the option of the employer. This law went into effect for group policies renewing on or beginning January 1, 2010.

To be eligible for coverage under Act 4, the adult dependent must meet the following criteria:

1. Is not married.

2. Has no dependents (see definition) of his or her own (regardless of whether or not the dependent lives with or is claimed on a tax return of the adult dependent).

3. Is a resident of Pennsylvania or enrolled as a full-time student at an institution of higher education.

4. Is not covered under another group or individual health insurance policy or entitled to benefits under any government program.

The employer group should inform Capital, at the time of their contract renewal, if they wish to offer this additional coverage. If so, it is the employer's responsibility to notify Capital when an employee wants to add an eligible dependent to its policy.

Capital will bill the employer a single contract subscriber rate for the coverage of the additional dependent. Since the law states that the employee is responsible for the full cost of the coverage for the dependent, the employer group may wish to collect the cost of the additional premium from the employee.

The dependent must enroll in the same coverage as the employee, except in the case where the employee is over 65.

1. **Note:** Large groups may add this coverage upon request, off-cycle of their renewal date.

2. Small groups can ***only*** add this on their renewal date—**NO EXCEPTIONS WILL BE MADE**.

D. Retirees

1. Retirees are eligible to remain on the group coverage provided the business has an established retiree policy which is applied uniformly to all employees. There are no stipulations as to who must pay the premium. A retiree affidavit may be requested from the employer during an audit. Capital does not endorse any policy set by the employer which is discriminatory in nature.

2. Retirees cannot be used to help satisfy participation requirements.

3. Any group having more than 100 Medicare eligibles enrolled will have some flexibility in their product design and should contact their account executive to obtain information.

4. Any group having more than 20 percent retirees enrolled is subject to review by the Vice President, Actuarial Services. The 20 percent ratio is determined by the total enrolled active employees combined with the number of retirees on the group program.

5. A group cannot be comprised of retirees only with no active contracts enrolled. SeniorBlue® *HMO* and SeniorBlue® *PPO* are the exceptions to this statement. Our Medicare Advantage products can be sold as a stand-alone retiree product with a minimum of two contracts when no active employees are covered through Capital.

6. Medicare Secondary Payer (MSP) rules and guidelines should always be referenced prior to assisting our groups with product selection and eligibility.

7. Neither Medicare Advantage nor the *Senior* products are available for enrollment through the *MyCoverage Selector* platform. Employees needing *Senior* products will be handled outside of the *MyCoverage Selector* platform.

E. COBRA

1. Capital does not administer COBRA and therefore we do not determine COBRA eligibility. The group's legal counsel should advise the group in conjunction with their COBRA administrator. Eligibility for COBRA may be questioned if no qualifying event is evident.

2. A group cannot exceed more than 20 percent COBRA continuants based on total enrollment.

3. COBRA continuants cannot be used to help satisfy participation requirements.

4. A group cannot be comprised of COBRA continuants only with no active contracts enrolled.

5. COBRA is not available for enrollment through the *MyCoverage Selector* platform. Those eleigible for COBRA will be handled outside of the *MyCoverage Selector* platform.

Mini-COBRA Law

The mini-COBRA Law allows eligible employees and dependents to purchase health insurance for a period of nine months after their employment ends. It applies to medical and drug coverage and does not include dental and vision coverage.

Note: The Medicare Secondary Payer (MSP) code on our system will be used to determine whether a group falls into the 2–19 small group classification for existing groups. New group business will have to complete the Group Application in order to provide the information necessary to determine eligibility for mini-COBRA.

V. RATING METHODS

A. Rating Methodology and Limitations

1. **Quotes for new prospect groups should be submitted using the following guidelines:**

   a. Groups expecting to enroll 2–105 contracts should be quoted a demographic rate using small group products.

   b. Groups expecting to enroll 106+ contracts should submit a quote request to Case Underwriting using normal procedures and supplying required documentation.

   c. Underwriting Compliance will have the final determination as to whether a new group will be deemed large or small at the time of the initial audit prior to enrollment.

2. **SIC Code Determination:**

   a. For all new groups, the primary SIC Code shown on the Dunn & Bradstreet website will be used. There are no exceptions to this policy.

Group Termination—Small Group

When a small group voluntarily terminates coverage with Capital and reapplies for coverage **within the same 12-month period**, the census used prior to their termination will be the basis for demographic rating.

A small group cannot terminate coverage and reapply simply to obtain a more favorable demographic rate.

Preliminary Rate Process

Underwriting Compliance will provide preliminary rates for all prospect groups upon receipt of the Service Request. Sales/Producers will be required to collect a group application, individual applications/disclosure forms, a rate sheet/working document, and a broker authorization letter from the group and submit to Compliance when the service request is submitted.

The preliminary rates are provided to group and if accepted, full paperwork and deposit check are required. Once the prospect group is submitted for the final audit, final rates will be based upon actual enrollment.

B. Quoted Rate vs. Actual Rate

The rates presented to a new prospective group will be confirmed through the audit process. The actual enrollment reflected on the individual applications combined with any necessary risk assessment will be the basis for the final rate. If the rate must change, the group will be notified and given two working days to approve or reject the new premium.

Important Note: Effective May 1, 2010, Capital applied “Right Pricing” to all new small group quotes. The rates will be based on the final census using the actual applications submitted. The SIC Code used will always be the primary SIC Code reflected by Dunn & Bradstreet. The group will be notified of the final rates and given two business days to accept or reject the revised rates.

All large group quotes will be quality checked to assure all caveats initially presented to the group are fulfilled.

For small group business, all quoting activity is considered complete once the paperwork is received at Capital. No further changes will be made and the group must reapply if requesting changes to the applications or census used for the quote.

C. Product Change—Off Renewal

1. A small group may choose to change products or add products within the first eight months of their contract period. These product changes will only be considered if moving to a lesser benefit design program (e.g., *PPO* 0/100 to a *PPO* 500/90).

2. No group will be allowed to change to a richer benefit program except on their actual renewal date unless prior written authorization is obtained from the Vice President of Underwriting. This applies to both small and large group business.

3. All product change activity for a small group will be frozen 120 days prior to the renewal date.

4. A small group must be fully paid to date prior to requesting any benefit change or a move to another risk pool (e.g., small group to association).

VI. REPOOLING EXISTING GROUPS

A. Capital Small (2–105) Groups Moving to Experience-Rated (106+)

If the average total enrollment for all health options over a 12-month period is more than 110 contracts, the group is targeted for repooling on their next anniversary date. A large group renewal is generated and delivered to the group at least 60 days prior to their anniversary. No benefit changes are necessary. Unless the group requests a specific financial arrangement, the default is prospective.

B. Experience-Rated (106+) Groups Moving to Small Group (2–105)

If the group's average total enrollment for all health options during the Base Experience Period (BEP) is fewer than 90 contracts when the renewal is calculated, the group is moved to community rating. Benefits must be changed to reflect benefits that are offered to small groups.

C. Groups Changing Risk Pools

Any group changing risk pools that is quoted as a new group will not be accepted. All groups changing risk pools should be quoted using the existing census (e.g., Small direct group moving to LVC or CIT, Fully Insured small group moving to ASO small group). In addition, groups may only change risk pools at the time of their renewal. Requests to move risk pools received off-renewal will be denied. No exceptions will be made.

VII. OTHER UNDERWRITING COMPLIANCE GUIDELINES

A. Audit Selection Criteria

1. The following actions require an audit to be completed:

   a. All new fully insured groups. All products will be audited.

   b. All new 20–105 ASO groups. All products will be audited.

   c. All existing groups falling below two active contracts enrolled.

d. All existing groups moving from one risk pool to another (e.g., small group to association, large rated group to small, fully insured to small group ASO, and vice versa).

e. All new member firms entering an association.

2. The following groups may be subject to an audit:

a. All existing groups with an enrollment variance of 10 percent or more.

b. Any group that is suspected of fraud or activity resulting in noncompliance with underwriting guidelines.

c. All small groups where an audit has not been completed in two years.

d. All large fully insured groups where an audit has not been completed in four years.

e. All association member firms with advance notice to the association.

3. Underwriting Compliance will notify the account executive and/or producer 15 days in advance of any audit taking place for all existing group business. The group will be notified by mail with instructions regarding necessary documentation and the time frame will be clearly communicated to comply with the audit request. Failure to respond to repeated requests for audit documentation may result in termination of group coverage.

4. Underwriting Compliance reserves the right to randomly audit any group to assure continued compliance with our guidelines.

VIII. ENROLLMENT PAPERWORK

A. Group Application—Must be completed in full by the group. Missing information will delay the audit process and may result in a later effective date. In some cases, this document serves as the group contract and as such, must be completed by the Policymaker. All information is required and the group will be contacted to provide any missing information prior to enrollment, ID card issuance, or benefit change activity.

B. Individual Applications—Original applications must be presented and completed entirely by the subscriber. Missing information will delay the enrollment process. Capital does also have an acceptable electronic enrollment template. Please contact the Account Administration department for a copy.

MyCoverage Selector products: Applications not required; however, the Open Enrollment file is required.

C. Waiver Forms—All eligible employees must complete a waiver form if they are choosing not to enroll.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be deducted from the total eligible count for participation calculation purposes. If an employee does not check a line of business on the waiver, Compliance will not assume they are waiving coverage for that product (e.g., if the employee signs the waiver and checks the “medical” box but not the “dental” box, Compliance will only apply the waiver to the medical participation). Capital may verify true and active coverage during any audit activity.

Waiver forms are not necessary for a spouse or children who are not enrolling.

MyCoverage Selector products: Every eligible employee will need to log on to Connected Health and either enroll in coverage or waive coverage. Additionally, paper waiver forms will be required until notice is given that the Connected Health site has been updated to collect waiver information.

D. Sales Paperwork—All required Sales paperwork should be complete and presented as a *packet* with the enrollment/audit documents. Paperwork should NOT be presented in "pieces" to avoid delays and/or loss.

E. Premium Deposit Check (must be received in cash processing)—All new small group applications (2–105) must be accompanied by a one-month premium deposit check. Capital will not accept a postdated check. All deposit checks for small group coverage must be made payable to "*Capital BlueCross*". Underwriting will verify the check has been received in cash processing when they receive the new group paperwork.

***MyCoverage Selector* groups will require the medical and *Rx* premium amount, on the lowest tier rate of the least expensive product times the number of eligible employees submitted on the open enrollment file.**

Capital reserves the right to request additional deposit monies when delinquent payment history exists.

F. Tax Documentation—The most recent tax documentation available must be presented to verify the eligibility of all owners and employees enrolling/enrolled for group coverage. These include but are not limited to:

1. Schedule C.

2. 1065 U.S. Return of Partnership Income (including all K-1s).

3. 1120 U.S. Corporation Income Tax Return.

4. 1120S U.S. Income Tax Return for an S-Corp (including all K-1s).

5. UC-2—most recent unemployment compensation report (should be marked by the group indicating status).

6. Pay stubs for all newly hired employees not yet appearing on the UC-2.

7. Brand new business entities are required to submit the following:

a. SS-4 or PA-100.

b. Letter signed by the Policymaker listing all eligible employees.

c. At least one pay stub for each employee enrolling.

Note: Underwriting Compliance will follow up for the first available UC-2 and/or applicable year-end tax documentation.

G. <u>Ownership Tax Documentation</u>—The most recent tax documentation filed yearly with the Internal Revenue Service must be presented for the following:

1. All groups of 1–19 contracts (a group of one contract is applicable to association business only).

2. All groups choosing to combine multiple business entities for rating purposes, regardless of group size.

3. All groups where the owner(s) is enrolling and does not appear on the UC-2.

Underwriting Compliance reserves the right to request ownership tax documentation for all other group coverage applications when deemed necessary. The necessity will be determined by the manager of Underwriting Compliance.

BlueCross *Dental*SM Enrollment Requirements			
Market Segment (Enrolled Subscribers)	**Minimum Participation Required**	**Product Selection**	**Additional Requirements**
Small Group (2–19)	Refer to 2–19 chart	**Standard products only.**	• Single-option dental only up to 9 enrolled contracts. • Dual option available to 10+ enrolled contracts with a minimum of three enrolled in each option. • Must be all Capital BlueCross with no other carriers offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • Cannot be sold as stand-alone.
Small Group (20–105)	75%	**Standard products only.**	• Single- or dual-option dental is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other dental coverage can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • ASO groups are not eligible for MCC.
Large Group (106+)	75%	Product design can be customized.	• Single- or dual-option dental is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • Eligible employees choosing to waive medical can still enroll in the dental product.
Voluntary (20–105)	25%	Standard product only.	• Cannot be sold as stand-alone. • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as stand-alone.
Stand-Alone	75%	20–105 standard product only. 106+ product can be customized.	• New groups must be 20+ enrolled. • Existing groups that cancel Medical and *Rx* must have at least ten enrolled in Dental to keep as stand-alone. • Single- or dual-option dental is allowed.
***MyCoverage Selector* (20+)**	Waived	Standard products only.	• Not eligible for MCC. • Cannot be sold as stand-alone. • Must meet minimum contribution level for medical or meet 75% participation.
Associations	75% at member firm level	Standard product only.	• Single-option program only for member firms 1–9 enrolled. • Dual-option program available for member firms 10+ enrolled with a minimum of three enrolled in each option. • Must be all Capital BlueCross with no other dental carrier offered. • No dental-only contracts.

Please note, all dental products offered as a dual option must differ by more than simply adding orthodontic or major services.

Underwriting Compliance must approve exceptions.

Note: Existing customers will have two years to meet all dental compliance guidelines.

Dental product changes can be made ONLY at renewal (except at initial purchase of the BlueCross *Dental* product).

Voluntary dental product can only be offered at the group level and billed at the group level.

Voluntary dental cannot be sold as stand-alone.

There will be no SIC Codes excluded.

A group may not split products across risk pools. For example: XYZ Association does not offer dental, but group within XYZ Association wants to enroll directly with BlueCross *Dental*. This would not be allowed. If a group/member firm wants to offer dental, in this case they would have to leave XYZ Association and enroll directly with Capital BlueCross for all products.

Participation chart for 2–19

Subtotal Eligible Employees*	***Non-Voluntary* Minimum Participation Requirements**
2	2
3	3
4	3
5	4
6	5
7	6
8	6
9	7
10	8
11	8
12	9
13	10
14	11
15	11
16	12
17	13
18	14
19	14

***Total eligible employees minus valid employee/spousal waivers.**

BlueCross *Vision*SM Enrollment Requirements			
Market Segment (Enrolled Subscribers)	**Minimum Participation Required**	**Product Selection**	**Additional Requirements**
Small Group (2–19)	Refer to 2–19 chart	**Standard products only.**	• Single-option vision only up to 9 enrolled subscribers. • Dual option available to 10+ enrolled contracts with a minimum of three enrolled in each option. • Must be all Capital BlueCross with no other carriers offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • Cannot be sold as stand-alone.
Small Group (20–105)	75%	**Standard products only.**	• Single- or dual-option vision is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other vision coverage can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • ASO groups are not eligible for MCC.
Large Group (106+)	75%	Product design can be customized.	• Single- or dual-option vision is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • Eligible employees choosing to waive medical can still enroll in the vision product.
Voluntary (20–105)	25%	Standard product only.	• Cannot be sold as stand-alone (i.e., can only be sold in conjunction with medical). • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as stand-alone (i.e., can only be sold in conjunction with medical).
Stand-Alone	75%	20–105 standard product only. 106+ product can be customized.	• Single- or dual-option vision is allowed. • New group must have 20+ enrolled. • Existing groups that cancel Medical and *Rx* must have at least ten enrolled in Vision to keep as stand-alone.
MyCoverage Selector **(20+)**	Waived	Standard products only.	• Not eligible for MCC. • Cannot be sold as stand-alone. • Must meet minimum contribution level for medical or have 75% participation.
Associations	75% at member firm level	Standard product only.	• Single-option program only for member firms 1–9 enrolled. • Dual-option program available for member firms 10+ enrolled with a minimum of three enrolled in each option. • Must be all Capital BlueCross with no other vision carrier offered. • No vision-only contracts.

Underwriting Compliance must approve exceptions.

Note: Existing customers will have two years to meet all vision compliance guidelines.

Vision product changes can be made ONLY at renewal (except at initial purchase of the BlueCross *Vision* product).

Voluntary vision product can only be offered at the group level and billed at the group level.

Voluntary vision cannot be sold as stand-alone.

A group may not split products across risk pools. For example: XYZ Association does not offer vision, but group within XYZ Association wants to enroll directly with BlueCross *Vision*. This would not be allowed. If a group/member firm wants to offer vision, in this case they would have to leave XYZ Association and enroll directly with Capital BlueCross for all products.

Participation chart for 2–19

Subtotal Eligible Employees*	*Non-Voluntary* Minimum Participation Requirements
2	2
3	3
4	3
5	4
6	5
7	6
8	6
9	7
10	8
11	8
12	9
13	10
14	11
15	11
16	12
17	13
18	14
19	14

***Total eligible employees minus valid employee/spousal waivers.**

Paperwork Due Dates

Effective Date	*30 Days—Late Letter	**15-Day Due Date
01/01/2013	11/30/2012	12/17/2012
01/15/2013	12/14/2012	12/31/2012
02/01/2013	12/31/2012	01/15/2013
02/15/2013	01/15/2013	02/01/2013
03/01/2013	01/30/2013	02/15/2013
03/15/2013	02/15/2013	03/01/2013
04/01/2013	03/01/2013	03/15/2013
04/15/2013	03/15/2013	04/01/2013
05/01/2013	04/01/2013	04/15/2013
05/15/2013	04/15/2013	05/01/2013
06/01/2013	05/01/2013	05/15/2013
06/15/2013	05/15/2013	05/31/2013
07/01/2013	05/31/2013	06/14/2013
07/15/2013	06/14/2013	07/01/2013
08/01/2013	07/01/2013	07/15/2013
08/15/2013	07/15/2013	08/01/2013
09/01/2013	08/01/2013	08/15/2013
09/15/2013	08/15/2013	09/03/2013
10/01/2013	09/03/2013	09/16/2013
10/15/2013	09/16/2013	10/01/2013
11/01/2013	10/01/2013	10/15/2013
11/15/2013	10/15/2013	11/01/2013
12/01/2013	11/01/2013	11/15/2013
12/15/2013	11/15/2013	12/02/2013

15th of the month effective dates are not available to Associations.

*A late letter signed by the group is required if paperwork is received after these dates.

**Paperwork is due in to Sales Services by this date—any groups requesting exceptions for after this date will need approved by the Sr. Director of Producer Relations and/or Director of Actuarial Operations.

Frequently Asked Questions

What if I do not have all the paperwork needed? Can I submit what I have?

No, Underwriting Compliance cannot complete an audit unless all the needed documentation is submitted.

How long will the audit process take for a new group?

If all necessary paperwork is received, the audit for a new group will be completed in five business days or less.

How does the group get enrolled?

Underwriting Compliance forwards all new group paperwork and applications to Account Administration where the group is enrolled and ID cards are generated. Certain large groups may have electronic enrollment capabilities and will not require paper applications. The need for hard copy individual enrollment applications for any group activity is determined by our Account Administration department.

What if the group does not complete all fields on the Application for Group Benefits?

The paperwork will be returned to the sales representative or broker for completion. All the information requested on the group application is imperative to the processing of the group paperwork.

Which employees should be entered into the census to obtain a community demographic quote?

All active employees should be entered into the census, as well as all COBRA contracts. Retirees should be entered into the census using the Medicare primary indicator.

Dependents through 29 will be enrolled as a single contract; however, they should NOT be included in the census for quoting.

It is important to note that the census used to produce a quote very often varies from the actual enrollment. As a result, the rates will often change; however, the group will always have the opportunity to reject the new rates and pull the application prior to actual enrollment.

What if an incorrect SIC Code was used for a community renewal?

For all existing Capital BlueCross business, if an SIC Code is identified by the customer to be inaccurate, it will be changed provided **both** a written explanation is furnished as well as a document proving the change occurred with Dunn & Bradstreet.

For all NEW group applications, the primary SIC Code reflected on the D&B website will be the SIC Code used with no exceptions.

Why does Underwriting Compliance contact a group directly to ask questions?

Capital BlueCross' contract is with the group and, specifically, the Policymaker. Underwriting Compliance very often has the need to verify information or obtain more clarity surrounding notations found on tax documentation, etc. The account executive and broker will be informed when this has occurred, but the audit process will not be delayed to gain "permission." This would only result in further delays to the enrollment process.

Who is responsible for indicating eligibility on the UC-2?

This function can and should ONLY be done by the Policymaker or someone with specific knowledge concerning employee status at the group. The information pertaining to eligibility which is marked on the UC-2 is vital to the audit process and that information must be credible.

The UC-2 should be clearly marked with notations for each employee listed stating eligible, terminated, not eligible, waiving, etc. This will be used for audit purposes and in some cases could impact the approval or denial of the group application. Account executives and/or brokers should never assume responsibility for this task.

Why was a group canceled for only having one contract when another employee was added and they now have two contracts?

When Underwriting Compliance terminates a group which has fallen to only one contract, that action is taken at least 60 days in advance and the group is notified via a certified letter. If the group adds another employee during that time, unless the application and proof of employment are sent to Underwriting Compliance directly, the cancellation cannot be reversed. It is important that the group is aware that before this cancellation can be reversed, the additional employee's eligibility must be established.

Who can be the Policymaker of a group?

The role of Policymaker should always be clearly defined to a potential new group customer. The Policymaker **must** be an individual directly employed by the group who has the legal authority to sign a contract as well as make health program decisions on behalf of the employees at that location. The Policymaker may designate a "group leader" who will handle the daily operation and employee issues of a group program.

Tax documents contain confidential information. How can I be sure this will not be shared?

Capital BlueCross has very strict Human Resource policies concerning the confidentiality of our customer information. Capital is also very aware of the need for compliance with all Health Insurance Portability and Accountability (HIPAA) regulations.

Although a group's tax documentation is **always** required to prove eligibility and compliance, these documents never leave the Underwriting Compliance file. The files within this department are locked at all times. At Capital we take our customer's privacy very seriously.