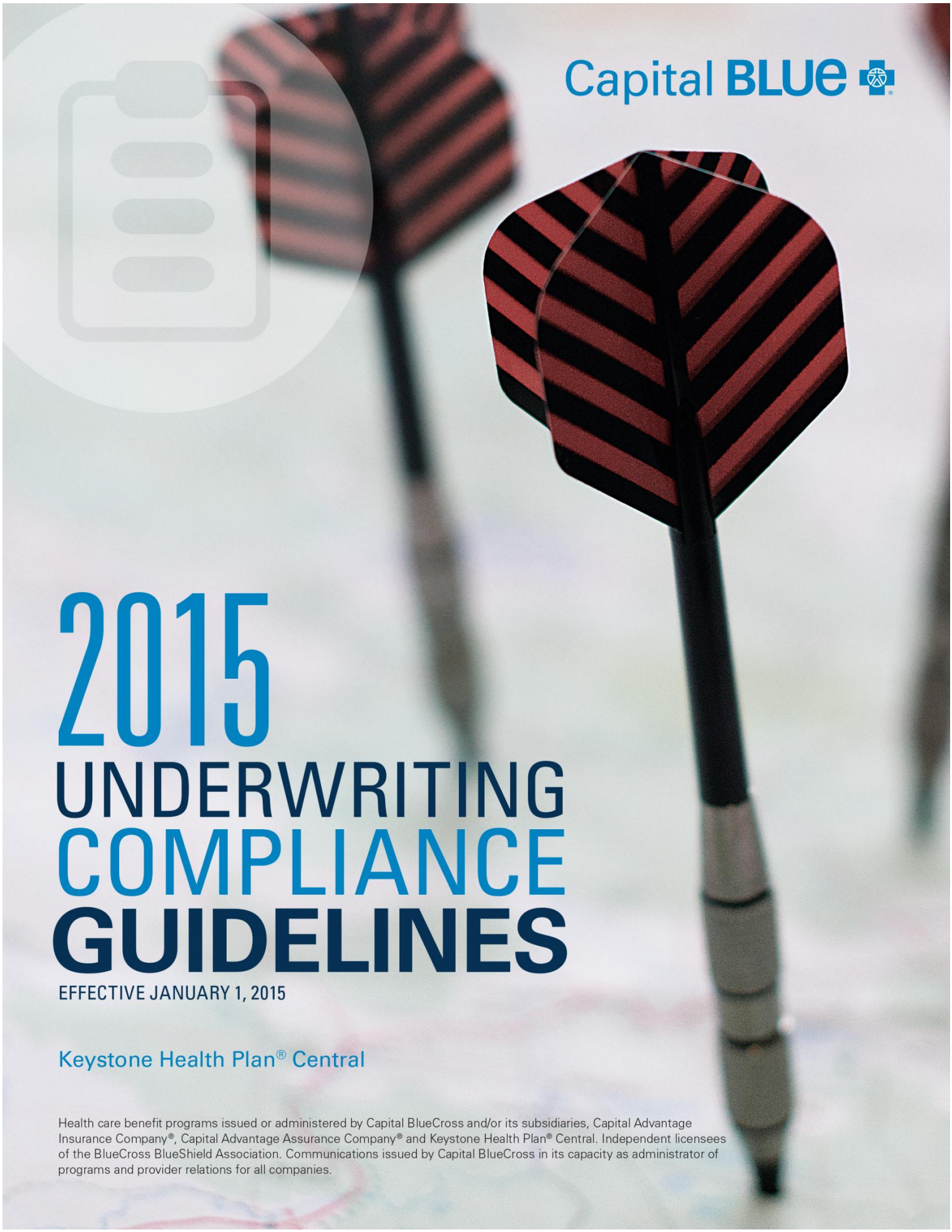

Capital BLUE

2015 UNDERWRITING COMPLIANCE GUIDELINES

EFFECTIVE JANUARY 1, 2015

Keystone Health Plan® Central

Capital BlueCross and Keystone Health Plan® Central Group Underwriting Compliance Guidelines Effective January 1, 2015

- 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 consortium and Medicare offerings are available as separate documents to our internal Account Executives.

- Capital may reject or adjust the rates for 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. (See additional details throughout these guidelines for differences in market segments.)

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

- For definition under PPACA: Small Group shall be defined as a group with fewer than 51 employees. Mid-Market Group shall be defined as a group with more than 50 employees and less than 105 expected enrollees. Large Group shall be defined as a group with more than 50 employees and 105 or more expected enrollees. Underwriting Compliance reserves the right to make limited exceptions. Capital will initially define group segment based on enrollment data available unless a Certification of Group Size attestation form has been submitted.

- 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**. This information is intended only for personal and confidential use of the individual to whom it is issued and may contain information that is privileged, confidential, and protected by law. If you are not the intended recipient, you are hereby notified that any use or disclosure of the information contained herein is strictly prohibited. If you have received this information in error, please notify Capital BlueCross immediately. Your compliance is appreciated.

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

Capital BlueCross
Group Underwriting Compliance Guideline Index

Page

I. PPACA REGULATIONS AND IMPACTS

A. Defining Group Size Segments

PPACA—The Patient Protection and Affordable Care Act—is a federal statute aimed at improving the access of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mandates, subsidies, and tax credits to employers and individuals.

In 2014 and 2015, under the law, Large Groups are considered to be any group that has over 50 employees and are required to offer health care coverage.

Capital defines group sizes for product availability in the following three segments:

1. A Small Group is a group of fewer than 51 employees. This size segment is only permitted to enroll in standard benefits (no customization of benefits). These groups are not eligible for MCC (multi-coverage credit) when purchasing dental and/or vision with their medical coverage. In addition, only the groups that have at least 20 enrolled contracts may enroll in ASO (self-insured) products and Capital private exchange products (these products are explained in Section III of these guidelines).

*Pursuant to transitional relief guidance issued by the federal government in March 2014, certain Small Groups with pre-PPACA policies in effect prior to January 1, 2014 are able to keep their current health care benefit plan into 2017 as the carrier decides on an annual basis. Capital implemented the transitional relief extension of non-PPACA programs for Small Groups that had renewals between June 2014–December 2014. Alternatively, these Small Groups were able to elect instead to transition to PPACA-compliant options. All new business must be sold with PPACA-compliant products. (See part B of this section for more information on the transitional relief extension.)

2. A Mid-Market Group is a group of 51 or more employees, with an expected enrollment of less than 105 enrollees. This size segment is only permitted to enroll in standard benefits. These groups are eligible for MCC when purchasing dental and/or vision with fully-insured medical coverage. ASO products and Capital private exchange products are available, as well.

3. A Large Group is a group of 51 or more employees with an expected enrollment of more than 105 enrollees. This size segment is permitted to customize benefits (some limitations apply). These groups are eligible for MCC when purchasing dental and/or vision with fully-insured medical coverage. ASO products are available. Capital private exchange products are available, as well, however, cannot be customized.

Capital will use the enrollment census information provided during prospect quoting, and current enrollment information of existing customers, to determine the group size for rating purposes. If, under PPACA regulations, a group should be in a different segment than they received on the quote, they will need to complete the Certification of Group Size form. The sales representative will need to follow internal processes to have the group size updated accordingly in the system. After they receive confirmation the update has been made, a new quote can be run.

B. Transitional Relief Extension

On Wednesday, March 5, 2014, the U.S. Department of Health and Human Services (HHS) announced that its November 2013 transitional guidance is extended for up to two years, which allows insurers—with concurrence from their state insurance commissioner—to offer individual consumers and Small Groups the option to renew their existing health plans beyond 2013. Under the new guidance, individuals and Small Groups who were enrolled in non-PPACA compliant policies purchased before the end of 2013, including "early renewal" plans, may retain their coverage into 2017 as the carrier decides on an annual basis.

*IMPORTANT NOTES ABOUT SWITCHING PRODUCTS:

1. Product Changes—In accordance with the guidance, groups that want to keep what they have must maintain the same product options as their current products. For example, if a group offers PPO 1000 today, they may keep that product or change to another 2013 PPO product. They may not switch to a 2013 HMO product. Likewise, if the group currently offers HMO products and wants to keep what they have, they must select products from within the 2013 HMO portfolio. They cannot switch to or add PPO products. If the group decides to move to PPACA-compliant plans, they may add or change legal entities at that time.

2. Multi-Coverage Credit (MCC)—Small Groups that have dental and/or vision plans that contain MCC from their 2013 benefits are allowed to keep the plans with the MCC. Any group that decides to add dental and/or vision may add any plan. However, if adding the Dental Value 75 MCC and/or the Discount Vision MCC, they must also purchase a buy-up plan and meet the 2013 participation requirements (ten or more enrolled with a minimum of three enrolled in each option)

C. FFM SHOP and Off-Exchange Groups

1. Off-exchange groups are defined as Small Groups that purchase Capital insurance through Capital BlueCross directly or through a producer and follow the normal group path. (Quoted and sold through our sales department.)

2. FFM SHOP groups are defined as groups that choose to purchase Capital products through the FFM (federally-facilitated marketplace). The products offered through the FFM will be different from the standard Capital BlueCross products offered. In addition, the Underwriting Guidelines for FFM SHOP groups will differ (please see Section XII of this document for specific limitations or variances for these groups).

D. Per Member Rate Calculation (PMRC)

PMRC is applicable to fully-insured Small Groups effective on a fully-insured Small Group's anniversary in 2014.* Small Group rates will be determined by the age and tobacco-use status of each member and the geographic location of the group. This means that every person covered by the group, including dependents, may have a different rate applied to him/her. Those rates will then be added together to determine the rate for the entire family. Additionally, each employee will be listed with his or her unique rate on the monthly premium statement.

*Pursuant to transitional relief guidance issued by the federal government in March 2014, certain Small Groups with pre-PPACA policies in effect prior to January 1, 2014 are able to keep their current health care benefit plan into 2017 as the carrier decides on an annual basis. Capital implemented the transitional relief extension of non-PPACA programs for Small Groups that had renewals between June 2014–December 2014. PMRC does not apply to groups that elected the transitional relief. Alternatively, these Small Groups were able to elect instead to transition to PPACA-compliant options. All new business must be sold with PPACA-compliant products. PMRC applies to all Small Group PPACA-compliant products.

Rate development and billing will remain unchanged for Mid-Market Groups, Small ASO, fully-insured and self-insured Large Groups, and Small Groups electing to retain pre-PPACA benefits under the transitional relief policy.

E. Employer's Annual Special Open Enrollment Period

Small Group group/member participation requirements will be waived during an employer's annual special open-enrollment period that begins on November 15 and extends through December 15 of each year for coverage effective the following January. Any Small Group applying during the special-enrollment period as described herein does not need to meet the participation requirements. All other audit criteria must still be met (eligibility, common-law employee, the group is a legal entity with an active EIN located within our 21-county service area, etc.). Small Groups enrolling outside the special-enrollment period are required to meet participation requirements, including the 25 percent residency requirement and 75 percent of their eligible employees enrolled as subscribers for the group contract to be issued or renewed. This participation requirement may be met by enrollment in Capital (to include KHP Central, CAIC, and CAAC) products.

F. Pediatric Dental

Beginning with 2014 sales and renewals, fully-insured Small Groups (groups with fewer than 51 employees) are required under PPACA to enroll in a pediatric dental program. This applies to both FFM-SHOP and direct Capital Small Groups. (*Please refer to part B regarding the transitional relief policy.)

All Small Groups that chose to not use the transitional relief option and instead convert to PPACA-compliant products must purchase pediatric dental, regardless if they have any applicable members under age 19 enrolled through the group. All members enrolling in medical must also be enrolled in a pediatric dental product. Capital offers medical packages that include an embedded pediatric dental benefit and also offers standalone dental products containing the pediatric dental benefit.

If a Small Group purchases a medical product that includes the embedded pediatric dental benefit, no other information is needed from the group. All subscribers and members will be enrolled in the pediatric dental product.

However, if a Small Group purchases a medical product that does not include the embedded pediatric dental benefit, the group must complete a Certificate of Enrollment in Pediatric Dental form, which provides Capital with reasonable assurance of the group's compliance with this PPACA requirement. The completed form is the group's attestation that it is aware of the pediatric dental requirement, that each group subscriber has purchased a standalone pediatric dental product (through Capital or another carrier), and that the group is not able to enroll any members who have waived pediatric dental coverage. If a Small Group does not purchase embedded pediatric dental and does not provide the Certificate of Enrollment in Pediatric Dental form, Capital will not be able to enroll the group's members in medical coverage.

G. Senior™ Product Eligibility

Effective December 1, 2014 for all new groups and existing groups at renewal: the Senior products will only be open to Medicare-eligible, not actively-working employees. True retired or otherwise not actively-working employees such as COBRA eligibles, may continue to be enrolled in Senior medical or remain enrolled in the Senior Rx if they are already enrolled in the prescription Rx plan. Senior products will not grandfather any current, actively-working, Medicare-eligible enrollment. Please note, the Senior Rx plans are not creditable.

Actively-working, Medicare-eligible employees will be allowed to enroll in the group commercial medical and drug plans offered by the group (must enroll in both medical and drug if the group elects this option) or may enroll in SecureBlue, an individual Medicare Supplement program (this product contains no drug offering). Please note, if the group offers an HSA, actively-working, Medicare-eligible employees enrolled in Medicare Part A or B cannot contribute to an HSA due to IRS regulations. The group is also not permitted to make contributions to an HSA for a Medicare enrollee.

Existing groups wishing to add the Senior product or new Senior enrollees beginning with their first renewal on or following December 2014 will need to confirm the enrollees are not actively-working and eligible to be enrolled in the Senior product. Both existing groups and new groups will be required to confirm member eligibility for the Senior product (via completion of a Certification of Employment Status for Senior form).

II. 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. 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. An eligible group must contain at least one common law employee. Owners/partners/officers, spouses, and/or dependents of owners/partners/officers are excluded from the definition of common law employees. Owner-only groups are not permitted.

3. Capital reserves the right to deny, cancel, or rerate any group that does not meet Underwriting guidelines. (Subject to restrictions as identified through PPACA)

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 BlueCross BlueShield Home Plan (the BlueCross BlueShield plan which services the area where the business is headquartered). Any group which is headquartered outside our area and applying for group coverage 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.

2. Participation rules require that Small and Mid-Market Groups have a residency requirement of at least 25 percent of the enrolled employees 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

IRS aggregation rules will apply when reviewing requests to combine multiple entities for the purposes of applying for health insurance coverage. Proof of aggregation will need to be supplied in order to be approved. Groups must also complete and submit a Certification of Group Eligibility to Combine Form. There must be only **one** Policymaker 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

Business that generates only investment income will not be considered a basis for group health coverage. Business that generates only rental income will not be considered eligible unless ancillary services are provided to multiple units and/or the group has at least one eligible employee.

E. Employee Class

A group may set their probationary period, premium contributions, or products offered by type or class of employee within the limitations of PPACA, 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.

F. Multiple Options

Off-Exchange Enrollment Requirements
(Reference Section VI for FFM-Marketplace Requirements)

For Health and Rx Lines of Business Sold/Renewed Effective January 1, 2015

PPO, CMM, POS, HMO, Traditional, Rx, Senior
(This includes Capital private exchange products.)
(Example: Single option = one PPO, one Rx, one Senior
Dual option = one PPO, one HMO, two Rx, one Senior)

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Small Group (1–19)	Up to three options	**Option mix can contain only one Rx program for each medical option offered.** **Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **No MCC available on dental and/or vision.**	• **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. • A **minimum** of at least **one contract** enrolled in **EACH** option offered. **CareConnect℠ Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured ONLY for this group size. Group must be headquartered in Dauphin, Cumberland, or Perry County.

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Small Group (20–50)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. **Option mix can contain only one Rx program for each medical option offered.** Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **NO MCC available on dental and/or vision**.	• **Can be sold fully-insured or ASO**. • Fully-insured—at least **75** percent participation. * • ASO—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. • A **minimum** of at least **one contract** enrolled in **EACH** option offered. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. **PPO Choice Product Suite** Available in this size segment to ASO ONLY. Group must be headquartered in Berks, Lancaster, York, or Adams County. Product was designed to be offered as full replacement. Rerating will be applied if any other medical product is offered 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.

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Mid-Market Group (up to 105)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. **Option mix can contain only one Rx program for each medical option offered.** Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **Note: MCC is not available for Mid-Market ASO groups**.	• **Can be sold fully-insured or ASO**. • Fully-insured or ASO—Groups without at least **75** percent participation will be subject to rerating. • At least **25** percent of enrolled subscribers must reside within our service area. • A **minimum** of at least **one contract** in **EACH** option. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. **PPO Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Product was designed to be offered as full replacement. Rerating will be applied if any other medical product is offered 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.
Large Group (106+)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. Noncompliance issues will be addressed at renewal for existing groups. These programs can be offered with Prospective or ASO arrangements.	• Fully-insured—Groups without at least **75** percent participation will be subject to rerating. • ASO—at least **25** percent participation. • A **minimum** of at least **one contract** in **EACH** option. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. **PPO Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Product was designed to be offered as full replacement. Rerating will be applied if any other medical product is offered 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.

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Capital private exchange products (20+)		Any grandfathered group, who elects to enroll in the Capital private exchange products, will lose their grandfathered status. Any combination of the Capital private exchange medical products can be selected. **Option mix can contain only one Rx program for each medical option offered.** **Note: MCC is not available**. The minimum monthly defined contribution per employee can be either: 1) 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. 2) 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. (Does not apply to Large Group.) • There is no minimum enrollment needed in each product.

Exceptions must be approved by Underwriting Compliance.
***Except during Special Enrollment period of November 15th through December 15th for a January 1st effective date**.

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, and HMO 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. (Please note: refer to Section XII for FFM SHOP.)

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.

III. PARTICIPATION REQUIREMENTS

A. Fully-Insured Groups

75 percent participation is required for all fully-insured Small Groups applying for group coverage with Capital off-exchange, outside the employer's annual special open enrollment period. Mid-Market and Large fully-insured groups are required to either meet the 75 percent participation requirement or be subject to rerating.

Multi-Coverage Credit (MCC) for dental and vision is not available for Small Groups under PPACA.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be counted as enrolled for participation calculation purposes. Employees with other coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage by any carrier and those with public coverage such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. 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 and Mid-Market ASO Groups—75 percent participation is required for all self-insured Small (20–50 group size) Groups applying for coverage with Capital outside the employer's annual special open enrollment period. Mid-Market self-insured groups are required to either meet the 75 percent participation requirement or be subject to rerating. Specific and aggregate 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.

Paperwork to enroll must include all new group paperwork as defined in Section IX of this booklet along with **member disclosure authorization forms** (for group sizes 20–50 only) and the **signed ASO proposal rate sheet and rate exhibit**.

Large Group ASO—Large self-insured groups are required to either meet a 25 percent participation requirement or be subject to rerating. Specific and aggregate 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. 1–19 Contracts

For groups having between one and 19 contracts (excluding Senior), the following participation requirements determine eligibility*:

Total 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

***Except during Special Enrollment Period of November 15 through December 15 for a January 1 effective date**.
****Total enrolled employees plus valid other insurance waivers**.

D. Capital Private Exchange

Groups with 20 or more enrolled subscribers may apply to use the defined-contribution tool. Every eligible employee will need to log on to the enrollment tool and either enroll in coverage or waive coverage.

The group must take at least one of the products offered in the Capital private exchange 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 ancillary-only contracts or MCC available with the Capital private exchange 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 participation rule that applies to their group size. Complete waiver information will be required. (Please see Section IX, Letter D of this document for definition of a complete waiver.)

Paperwork to enroll must include all new group paperwork as defined in Section IX of this booklet along with the Capital private exchange setup form and an open enrollment load file of those employees enrolling. Individual paper applications and waivers are not required (except under special circumstances). **Checks/eChecks for Capital private exchange 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 (Small, Mid-Market, and Large) Group or an existing ASO Small Group falls below the required 75 percent 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 with other insurance coverage elsewhere will be counted in the calculation towards the total participation percentage required. Employees with other group coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage and those with public coverage, such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. Capital reserves the right to verify the presence of active coverage with other carriers.

IV. EMPLOYEE/EMPLOYER CONTRIBUTION

For Capital private exchange 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 participation rule that applies to their group size.

For all other products, there are no contribution limits at this time.

V. EMPLOYEE/SUBSCRIBER ELIGIBILITY

A. Group Subscriber Eligibility

1. An eligible employee is defined as a common-law employee 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. The maximum amount of hours a group can set for eligibility purposes is 40 hours (groups must consider their own penalties under PPACA if over 30). *For SHOP groups, the maximum eligibility requirement can be no more than 30 hours.

2. The definition of what a group considers “full-time” and “part-time” is determined by the group. All employees that are working the required number or eligibility hours set by the group will be considered eligible for coverage, regardless if they are full-time or part-time.

3. Owners/partners that are employees and are actively participating in their business are considered to be eligible and are included in the participation calculation. Owners/partners who only have a financial interest are not considered eligible. Groups cannot be comprised of owners/partners only enrolling. A group must have at least one common-law employee enrolled.

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

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

6. For the purposes of health care reform, the spouse and/or dependant(s) of a sole proprietor are NOT considered common-law employees. A sole proprietor/business owner and his/her spouse and/or dependent(s) are not considered an eligible group. However, once the sole proprietor/business owner(s) has an average of one common law employee (that is not his/her spouse and/or dependent[s]) and has that employee on the first day of the plan year, then it will be considered an eligible employer group. The common-law employee and the owner(s) can obtain group coverage. The spouse and/or dependent(s) of a business owner may work for the company and (if meeting eligibility requirements) enroll in group coverage, but cannot be used to satisfy group eligibility requirements.

7. 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 or mini-COBRA and who do not meet the established retiree policy are not eligible to remain enrolled.

8. An existing subscriber found to be ineligible for group enrollment would be given at least a 30-day notification of cancellation. 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 legally-married same/opposite-sex spouses, 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 exceptions may apply if a disability is present. Effective October 1, 2010 at renewal, the dependent age increased 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, Mid-Market, and Large Groups. An affidavit and supporting documentation is required for all Small and Mid-Market 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. A group can add this coverage on or off-renewal.

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 are dictated by the group and the employee. The employee and the dependents may only select products offered by the group.

   Dependents of an enrolled employee can only enroll in products selected by the employee.

   Child-only contracts may be permitted under certain circumstances.

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 and Mid-Market 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 (active or retired) enrolled will have some flexibility in their product design and should contact their Account Executive to obtain information.

4. Participation rules require that 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. With limited scenerios, Capital will allow retiree-only groups with a minimum of two contracts when no active employees are covered through Capital. The employer group must be an active business with 20 or more actively-working employees, even if they are not covered through Capital. The business must have an established retiree policy, which is applied uniformly to all employees. A retiree affidavit may be requested during an audit or at enrollment of new contracts. Retiree-only groups will be able to enroll in the standard Senior medical product only (no Senior drug coverage).

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

7. Senior products are not available for enrollment through the Capital private exchange platform. Retirees needing Senior products will be handled outside of the Capital private exchange platform.

   Please note—Capital's Medicare Advantage products are not covered by these Underwriting guidelines.

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. Participation rules require that 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 enrollment through the Capital private exchange platform must be discussed with Sales Administration.

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 1–19 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.

VI. RATING METHODS/PRODUCT CHANGES

A. Rating Methodology and Limitations

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

a. Fully-insured Small Groups should be quoted using PMRC-based rates and Small Group products.

b. Small Groups expecting to enroll 20–50 contracts as self-insured should be quoted using demographic base rates with ASO products.

c. Mid-Market Groups expecting to enroll as fully-insured or self-insured should be quoted using a demographic rates and Mid-Market products. Groups with fewer than 51 on the census submitted will require a Certification of Group Size form that attests that the group has 51–99 employees.

d. Large Groups expecting to enroll more than 105 contracts should submit a quote request to Case Underwriting using normal procedures and supplying required documentation.

e. Underwriting Compliance will have the final determination as to whether a new group will be deemed Large, Mid-Market, or Small at the time of the initial audit prior to enrollment based on actual enrollment received.

2. SIC Code Determination:

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

B. Group Termination—Small and Mid-Market Groups

When a Small or Mid-Market Group voluntarily terminates coverage with Capital and reapplies for coverage **within the same 12-month period**, they will not be considered a new business. New member applications may be required to obtain rates. Please refer to Account Administration policies surrounding additional requirements for groups requesting cancellation and reinstatement.

C. Preliminary Rate Process

Underwriting Compliance will provide preliminary rates for all ASO Small 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 producer authorization letter from the group and submit to Compliance when the Service Request is submitted.

The preliminary rates are provided to the 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.

D. 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—for ASO Small Groups only) will be the basis for the final rate. If the rate must change, the representative will be notified and given two working days to return a decision from the group stating they approve or reject the new rates. A new signed rate sheet is required.

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

For Mid-Market 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.

E. Product Change—Off-Renewal

1. A Small or Mid-Market 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., Healthy Benefits PPO 250.20 PD to a Healthy Benefits PPO 1000.0 10 PD).

2. A Large Group may choose to change products or add during their contract period. These product changes are group specific and will be considered on a case-by-case basis by the Director of Case Underwriting.

3. 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 or Vice President of Actuarial. This applies to Small, Mid-Market, and Large Group business.

4. All product change activity for Small and Mid-Market Groups will be frozen 120 days prior to the renewal date.

5. A Small or Mid-Market Group must be fully paid to date prior to requesting any benefit change or a move to another risk pool (e.g., fully-insured to ASO).

6. "Material" benefit change paperwork must be submitted 75 days in advance of the effective date requested to meet the PPACA requirement of 60-day notice to employees when off-renewal changes are made.

7. Small Groups electing to retain pre-PPACA benefits under the transitional relief policy may be limited in the benefit changes allowed. These groups will not be able to select products from a different legal entity (e.g., PPO group can't switch to HMO group or add certain dental and/or vision plans).

VII. REPOOLING EXISTING GROUPS

Each group is evaluated annually prior to their renewal to determine if they are in the appropriate market segment for rating and product selection purposes. Criteria considered may include: PPACA-guaranteed renewability regulations, enrollment in Capital products over the prior 12-month period, group size based on reported average number of employees, anticipated change to an account's corporate structure, and other historical fluctuations:

A. Capital Small Groups Moving to Mid-Market

If the average total enrollment for all health options over a 12-month period is more than 50 contracts, the group may be repooled on their next anniversary date. A Mid-Market Group renewal is generated and delivered to the group approximately 90 days prior to their anniversary. Benefits must be changed to reflect benefits offered to Mid-Market Groups. *This does not apply to groups that choose to elect transitional relief. (*Please refer to section I, part B regarding the transitional relief policy.)

B. Capital Mid-Market Groups Moving to Small

If the average total enrollment for all health options over a 12-month period is less than 51 contracts and the group falls to less than 51 employees, the group may be repooled on their next anniversary date. A Small Group renewal is generated and delivered to the group approximately 90 days prior to their anniversary. Benefits must be changed to reflect PMRC and benefits offered to Small Groups.

C. Capital Mid-Market Groups Moving to Large

If the average total enrollment for all health options over a 12-month period is more than 99 contracts, the group may be repooled on their next anniversary date. A Large Group renewal is generated and delivered to the group approximately 60 days prior to their anniversary.

D. Capital Large Groups Moving to Mid-Market

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 may be repooled. Benefits must be changed to reflect benefits that are offered to Mid-Market Groups.

E. 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 (e.g., fully-insured Small or Mid-Market Group moving to ASO) should be quoted using the existing enrollment. 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. Exceptions can be made for Small Group segment. Groups can leave consortiums off renewal to quote direct business.

VIII. OTHER UNDERWRITING COMPLIANCE GUIDELINES

A. Audit Selection Criteria

1. The following actions require a full audit to be completed:

a. All new fully-insured off-exchange groups. All products will be audited.

b. All new 20–99 ASO groups. All products will be audited.

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

d. All existing groups moving from one risk pool to another (e.g., Large rated group to Mid-Market, fully-insured to Small or Mid-Market ASO, and vice versa).

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 and Mid-Market 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. Any group not responding to reporting requirements, regulatory mandates, or legal issues.

3. Underwriting Compliance will notify the Account Executive and/or producer within 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 to comply will be clearly communicated 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. This includes, but is not limited to, verification of correct product selection, such as pediatric dental and Senior eligibility.

IX. NEW GROUP ENROLLMENT PAPERWORK (OFF-EXCHANGE)

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. No electronic signatures are permitted.

B. **Signed Rate Acceptance Pages**—Each size segment will be required to sign the applicable rate page. Small Groups must include the PMRC rate sheet. Mid-Market Groups must include the composite rate sheet. Large Groups must include the Underwriting rate sheet. In addition to the signed rate acceptance, groups that enroll in Small Group ASO will be required to submit the signed rate exhibit page.

C. **Group Attestation Forms (as applicable)**—Multiple groups combining as one entity must complete a Group Certification of Group Eligibility to Combine form. Any groups that have over 50 employees, but have enrollment below 51 subscribers, must complete a Certification of Group Size form. Small Groups enrolling in a medical plan WITHOUT embedded pediatric dental must complete a Certificate of Enrollment in Pediatric Dental form.

D. **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 Excel template. Electronic signatures are permitted on individual applications and disclosure statments from approved vendors (FormFire and Easy App) **only**.

Capital private exchange products: Applications not required; however, the Open Enrollment file is required.

E. **Waiver Forms**—All eligible employees must complete a waiver form if they are choosing not to enroll. Electronic signatures are permitted from approved vendors (FormFire and Easy App) **only**. Capital does also have an acceptable electronic waiver Excel template.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be counted in the calculation towards the total participation percentage required. Employees with other coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage by any carrier and those with public coverage, such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. 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.

Capital private exchange products: Every eligible employee will need to log on to Connected Health and either enroll in coverage or waive coverage. The Connected Health site will collect the other insurance waiver information.

F. **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.g., HRA set-up form, eGEMS® service agreement, etc.).

G. **Premium Deposit (must be received in Cash Processing)**—**All new Small and Mid-Market Group applications must be accompanied by a one-month premium deposit (check or eCheck)**. **Capital will not accept a postdated check**. **All deposit checks for Small and Mid-Market Group coverage must be made payable to "*Capital BlueCross*." Underwriting will verify the funds have been received in Cash Processing when they receive the new group paperwork**. ***Special payment arrangements can be made for billing agents with signed agreement forms.**

Capital private exchange 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 a delinquent payment history exists.

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

2. W-2 for any current employee that does not appear on the UC-2.

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

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

I. **Ownership Tax Documentation**—The most recent tax documentation filed yearly with the Internal Revenue Service must be presented for the following:

1. All groups choosing to combine multiple business entities for rating purposes, regardless of group size. (All companies wishing to combine must submit tax documents along with a Certification of Group Eligibility to Combine form.)

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

These forms include, but are not limited to:

Schedule C, 1065 U.S. Return of Partnership Income (including all K-1s), 1120 U.S. Corporation Income Tax Return, 1120S U.S. Income Tax Return for an S-Corp (including all K-1s), or 990 Return of Organization Exempt from Income Tax.

*If group is a brand new entity, we will require them to submit the following:

1. SS-4 or PA-100.

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

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

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 Director of Actuarial Operations.

**Please note to CBC internal users ONLY—Paperwork Checklists are maintained on STAT (Sales Tools At a Touch on CrossNet).

X. BLUE CROSS DENTAL[SM] ENROLLMENT REQUIREMENTS

Market Segment (Enrolled Subscribers)	Minimum Participation Required	Product Selection	Additional Requirements
Small Group (1–19)	Refer to 1–19 chart	**Standard products only**.	• Single-option dental only up to nine enrolled contracts. • Dual option available to ten+ enrolled contracts with a minimum of three enrolled in each option. • No other dental carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • **No MCC (Multi-Coverage Credit) for PPACA groups. (transitional groups only)**
Small Group (20–50)	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 carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • **No MCC for PPACA groups. (transitional groups only)**
Mid-Market (51–105)	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 carrier can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • ASO groups and DHMO products 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. • ASO groups and DHMO products are not eligible for MCC.
Voluntary (20–105)	25%	**Standard product only.**	• Cannot be sold as dental only. • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as dental only.
Family Dental Only (Ancillary Only)	75%	1–105 standard products only. 106+ products can be customized.	• Not eligible for Voluntary dental product. • Single-option dental up to nine contracts enrolled. • Dual-option dental is allowed for ten+ enrolled.
Capital private exchange products (20+)	Follows Medical	**Standard products only.**	• Not eligible for MCC. • Cannot be sold as dental only.

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 dental only (i.e., can only be sold in conjunction with medical).

No MCC allowed for Small PPACA fully-insured groups, DHMO products, or ASO groups.

Fully-insured groups that offer either the Dental Value 75 Plan or the Dental Value 80 Plan with Multi-Coverage Credit (MCC) MUST also offer a buy-up plan, and the minimum enrollment must be met for each plan based on the group size.

MCC requires minimum of 75 percent participation in both medical and dental plans.

There will be no SIC Codes excluded.

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

Participation chart for less than 20 employees:

Total Eligible Employees	***Non-Voluntary* 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 plus valid other insurance waivers**.

XI. BLUE CROSS VISION[SM] ENROLLMENT REQUIREMENTS

Market Segment (Enrolled Subscribers)	Minimum Participation Required	Product Selection	Additional Requirements
Small Group (1–19)	Refer to 1–19 chart	**Standard products only**.	• Single-option vision only up to nine enrolled subscribers. • Dual option available to ten+ enrolled contracts with a minimum of three enrolled in each option. • No other vision carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • **No MCC (Multi-Coverage Credit) for PPACA groups. (transitional policy groups only)**
Small Group (20–50)	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 carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • **No MCC (Multi-Coverage Credit) for PPACA groups. (transitional policy groups only)**
Mid-Market (51–105)	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 carriers 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. • ASO groups are not eligible for MCC.
Voluntary (20–105)	25%	**Standard product only.**	• Cannot be sold as vision only. • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as vision only.
Stand-Alone (Vision Only)	75%	2–105 standard products only. 106+ products can be customized.	• Single-option vision up to nine contracts enrolled. • Dual-option vision is allowed for ten+ enrolled. • Not eligible for Voluntary vision product.
Capital private exchange products (20+)	Follows Medical	**Standard products only.**	• Not eligible for MCC. • Cannot be sold as vision only.

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 vision only (i.e., can only be sold in conjunction with medical).

Fully-insured groups that offer either the Discount Vision Plan or the Vision Plus Plan with Multi-Coverage Credit (MCC) MUST also offer a buy-up plan, and the minimum enrollment must be met for each plan based on the group size.

No MCC allowed for Small PPACA fully-insured groups or ASO groups.

MCC requires minimum of 75 percent participation in both medical and vision plans.

There will be no SIC Codes excluded.

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

Participation chart for less than 20 employees:

Total Eligible Employees	***Non-Voluntary* 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 plus valid other insurance waivers**.

XII. SMALL GROUPS ON THE FFM SHOP

A. Definition of FFM

FFM stands for federally-facilitated marketplace. It is a federally-run website that will offer Small Group employers an opportunity to purchase Capital products. Our SHOP products offered will not be the same as those offered to our direct customers. All 2015 SHOP group transactions will come from FFM SHOP to Capital via XML and 834 file transfers. Sales Services will process the SSR for these groups. The appropriate "Public Exchange" catalog will need to be selected on the quote.

B. Employer's Annual Special Open-Enrollment Period and Participation

Participation requirements will be waived during an employer's annual special open-enrollment period that begins on November 15 and extends through December 15 of each year for coverage effective the following January. Any group applying during that time does not need to meet the participation requirement. Groups enrolling outside the special enrollment period are required to have 70 percent enrollment and at least 25 percent residency within CBC service area for the group contract to be issued or renewed. Underwriting will verify that the group is a legal entity with an active EIN, is located within our 21-county service area, there is at least one common-law employee enrolling, and that they have at least **70 percent** participation.

Employers that no longer meet FFM eligibility/participation criteria as described in 45 CFR § 155.710 of the HHS final SHOP establishment rule may no longer participate in the FFM. Minimum participation rates are calculated once a year at the time of initial group submission and subsequently at the time of renewal.

C. Group Location

Only employers with a business location within a given state may participate in the FFM serving that state. Multi-state employers may establish one FFM account and enroll in a qualified health plan with multi-state provider networks. Alternatively, multi-state employers may establish a separate SHOP account in each state where they have a business location.

D. Product Selection

Capital product selection will be more limited to the SHOP groups. Groups may only select **one** qualified health product (QHP). The products will all be different than our off-exchange products. It is the group's responsibility to purchase separate pediatric dental coverage outside of the SHOP.

E. Audits

For any group that enrolls with SHOP products, Capital will perform an audit. All Underwriting Compliance guidelines will need to be met. There are two main differences between SHOP groups and off-exchange groups:

1. SHOP groups will only be required to meet 70 percent participation, while direct Capital customers will be required to meet 75 percent participation (except during the employer's annual special open enrollment period).

2. SHOP groups will only be able to elect one QHP (medical/Rx), while direct Capital customers can offer multiple options based on group size requirements.

   If Underwriting Compliance denies a SHOP group for coverage, Capital must call the FFM SHOP call center to confirm denial is possible.

F. Paperwork Requirements (FFM SHOP)

There will be no initial paperwork requirements for FFM SHOP groups. Groups will apply online at the FFM SHOP website. An electronic file will be sent to Capital. This file will be placed into a SHOP Enrollment Extract file exported to paper, which will be used to set up the group or process any changes.

G. Group/Subscriber Eligibility

The maximum number of hours a SHOP group can set for employees to be eligible for coverage is 30 hours per week. Every employee working a minimum of 30 hours per week on average must be offered coverage.

The issuer is NOT required to obtain reasonable assurance of pediatric dental coverage from any group enrolled through the SHOP.

XIII. PAPERWORK DUE DATES (OFF-EXCHANGE)

Effective Date	New Group Paperwork Due Date*	Existing Group Plan Changes**	Ten Day Cancel Date***
January 1, 2015	12/15/2014	12/29/2014	12/16/2014
January 15, 2015	12/31/2014	01/12/2015	12/31/2014
February 1, 2015	01/15/2015	01/28/2015	01/19/2015
February 15, 2015	02/02/2015	02/11/2015	02/02/2015
March 1, 2015	02/13/2015	02/25/2015	02/16/2015
March 15, 2015	03/02/2015	03/11/2015	03/02/2015
April 1, 2015	03/16/2015	03/27/2015	03/18/2015
April 15, 2015	03/31/2015	04/10/2015	04/01/2015
May 1, 2015	04/15/2015	04/28/2015	04/17/2015
May 15, 2015	05/01/2015	05/12/2015	05/01/2015
June 1, 2015	05/15/2015	05/27/2015	05/15/2015
June 15, 2015	06/01/2015	06/10/2015	06/01/2015
July 1, 2015	06/15/2015	06/26/2015	06/17/2015
July 15, 2015	07/01/2015	07/10/2015	06/30/2015
August 1, 2015	07/15/2015	07/29/2015	07/20/2015
August 15, 2015	08/03/2015	08/12/2015	08/03/2015
September 1, 2015	08/14/2015	08/27/2015	08/18/2015
September 15, 2015	09/01/2015	09/10/2015	08/31/2015
October 1, 2015	09/15/2015	09/28/2015	09/17/2015
October 15, 2015	10/01/2015	10/12/2015	10/01/2015
November 1, 2015	10/16/2015	10/28/2015	10/19/2015
November 15, 2015	11/02/2015	11/11/2015	11/02/2015
December 1, 2015	11/13/2015	11/20/2015	11/13/2015
December 15, 2015	12/01/2015	12/10/2015	12/01/2015

***** 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.

****** It is the group's responsibility to provide the SBC document to their employees within the timeframes required by PPACA. If the group fails to meet the PPACA notification requirements, penalties may be incurred.

******* Termination requests must be received by Capital prior to the end of business on this date. Producers may submit termination requests from groups to: cbcgrptermreq@capbluecross.com.

- ALL SHOP groups must enroll on the FFM SHOP website by the 15th of the month prior to the effective date. NO EXCEPTIONS.
- 15th of the month effective dates are not available for medical HMO products.
- A late letter signed by the group is required if paperwork is received less than 30 days prior to the effective date.

XIV. 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. Paperwork should not be received in pieces.

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. Missing paperwork could delay longer.

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 groups may have electronic enrollment and will not require paper applications. The spreadsheet is forwarded to the Account Administration mailbox. 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?

An updated group application will be requested by the UW Compliance Specialist working the group audit. 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 quote?

For fully-insured groups sized fewer than 51: all active enrolling employees should be entered into the census, as well as all of their dependents, COBRA contracts, dependents through age 29 (Act 4—need enrolled as own single contract), and retirees. Medicare primary indicator and current employment status should be marked appropriately.

For self-insured 20+ and fully-insured 51+: all active enrolling employees, COBRA contracts, and retirees. Medicare primary indicator and current employment status should be marked appropriately. *Dependents through age 29 will be enrolled as a single contract; however, they should NOT be included in this 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 may change for ASO groups and fully-insured groups of 51 or more, however, the group will always have the opportunity to reject the new rates and pull the application prior to actual enrollment.

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

Capital's 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 producer 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 producers should never assume responsibility for this task.

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. There can only be ONE Policymaker. The Policymaker may designate a Group Leader/Group Administrator, who will handle the daily operation and employee issues of a group program. The Policymaker may also designate in writing the specific names of other individuals who are able to sign in their absence, such as rate pages.

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

Capital 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 files. The documents are filed within this department's locked filing cabinets or in access-restricted electronic folders. At Capital, we take our customer's privacy very seriously.

How does a group know if they are required to have pediatric dental coverage?

All fully-insured Small Groups (groups with fewer than 51 employees) are required under PPACA to purchase pediatric dental coverage. Furthermore, all employees enrolling in group medical and prescription drug coverage MUST enroll in pediatric dental coverage. If any employee waives or does not have pediatric dental coverage with a qualified issuer, they will be denied eligibility to enroll in Capital's medical and drug coverage.

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