

Underwriting Guidelines Update

We are pleased to announce that the Independence Blue Cross (IBC) Underwriting Guidelines have been revised and updated in accordance with our new products, policies, rating methodologies, and all applicable federal and state benefit mandates. We realize this was an extended process and we appreciate your patience during this time.

The most significant revisions to the Underwriting Guidelines include:

Section 1 — Eligibility:

- Standard age for dependent children was increased to cover dependent children and young adults to age 26, in compliance with federal health care reform, and accordingly reference to "students" was removed. (page 6)

Section 2 — Types of rating and rating component:

- Demographic rating description was removed and replaced with "Adjusted Community Rating" (for groups of 2 to 50) and "Risk Adjusted Rating" (for Groups of 51-99). We also clarified that rates are based on total enrollment in all managed care programs (Personal Choice PPO, Keystone HMO, and Keystone POS). (page 8)
- The "Types of Rating" chart was adjusted to reflect the above information. (page 9)

Section 3 — Alternative funding arrangements:

- Contingency premium arrangement — minimum group size was increased from 300 to 500 enrolled contracts. (page 11)

Section 4 — Product regulations and size requirements:

- Changes were made to the product offerings, showing that groups now choose their benefits from the Blue Solutions medical/prescription drug/vision packaged product portfolios:
 - Groups of 2-50 may choose from the Blue Solutions for small employers plans; (page 13)
 - Groups of 51-99 may choose from the Blue Solutions for mid-market employers plans. (page 15)
- The number of plans a group may have is determined by the group's size, for new business count eligibles and for renewals count enrolled:
 - Groups of 2-4: One package with integrated medical, drug, and

- vision coverage; (page 14)
 - Groups of 5-50: Two packages with integrated medical, drug, and vision coverage; (page 14)
 - Groups of 51-99: Three packages with up to three medical plans, two drug riders, and one vision plan. (page 16)
- Freestanding prescription drug program — the minimum group size requirement has been increased to 100+ enrolled contracts, previously, it had been 51+. (page 19)
- discount/Surcharge for medical/prescription drug package reflects an increase from 1% to 2%. (page 19)
- Guidelines for Autism Mandates and Mental Health Parity. (page 21, 22)
- Guidelines for Health LifestylesSM Rewards. (page 24)

Section 4 — HDHPs and savings accounts:

Employers may not:

- Fund more than 50% of the employee/family deductible costs to an HSA; (pages 25)
- Provide a supplemental benefits plan that augments the core health insurance plan; (pages 25)
- Pay more than 50 percent of the employee/family deductible costs through an allowance or claims payment; (pages 25)
- Provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible. (pages 25)

In addition:

- HSA-qualified health plans are only available with integrated prescription drug and are available on a contract year basis only. (page 26)
- Clarification that deductible/out-of-pocket (OOP) credit will not be allowed for groups moving from an existing HSA-qualified HDHP with a calendar year deductible/OOP accumulation to a contract year deductible/OOP accumulation basis. (page 26)

Section 7 — When a rate quote is not available through ROAM:

- Mid-size groups (51-99): A rate request is required for all new business and for any non-standard requests not available as an alternative to renewals on ROAM. (page 28)

You can access the updated Underwriting Guidelines via [ROAM](#) by selecting "Links" on the Home tab and clicking on "Underwriting Guidelines Website".

If you have any questions, please contact your Brown & Brown Account Manager.

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