

# Large group underwriting guidelines (groups of 100+)

Independence Blue Cross Underwriting Department

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**Independence  
Blue Cross**

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# Eligibility and enrollment requirements

<b>IBC/Keystone Health Plan East (KHPE) service area</b>	<ul style="list-style-type: none"> <li>• Greater Philadelphia five-county area: Philadelphia, Bucks, Montgomery, Chester, and Delaware.</li> <li>• Contiguous counties (counties that border the five counties): Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil.</li> </ul>
<b>Group location requirements</b>	<ul style="list-style-type: none"> <li>• The group must be located within the Greater Philadelphia five-county area, as defined above.</li> <li>• Group members who live in non-contiguous counties and have HMO/POS coverage must be covered under and issued booklets by an affiliate of IBC.</li> </ul>
<b>National account requirements</b>	<ul style="list-style-type: none"> <li>• Definition: A business with employees located in more than one plan area that opts to cover all of its members through a single national contract executed with a control (home) plan.</li> <li>• Business must be domiciled in the Greater Philadelphia five-county area, as defined above.</li> <li>• Minimum enrollment requirement: 1,000 eligible contracts in PPO/HMO/POS or Traditional (Blue Cross/Blue Shield/Major Medical) medical plans.</li> <li>• Must have at least one location outside the IBC/KHPE service area.</li> <li>• Employees located outside of the IBC/KHPE service area are not eligible for HMO/POS coverage.</li> <li>• Participation requirements:             <ul style="list-style-type: none"> <li>• At least 75 percent of all eligible employees in each location must enroll in an IBC or subsidiary product.</li> <li>• Out-of-area employees enrolled in a local HMO plan will be excluded from the calculation of the minimum participation level.</li> </ul> </li> </ul>
<b>Participation requirements (eligible employees)</b>	<ul style="list-style-type: none"> <li>• Minimum 75 percent participation.</li> <li>• Valid waivers:             <ul style="list-style-type: none"> <li>• Employees with group coverage through IBC subsidiaries (coverage through an individual "direct pay" plan is not a valid waiver), Medicare or Medicaid;</li> <li>• Employees covered through their spouse;</li> <li>• Employees covered as an eligible dependent to age 26, in accordance with federal health care reform regulations.</li> </ul> </li> <li>• For groups covering retirees, 100 percent participation is required for retired employees and the group must consist of a minimum of 75 percent active employees. Retiree-only groups will not be accepted.</li> </ul>
<b>Coverage classes</b>	<ul style="list-style-type: none"> <li>• Definition: Distinct categories (classes) within the group, where these classes will receive different levels of health care coverage.</li> <li>• Classes must be determined by conditions relating to employment; must be clearly identifiable; and must exist for purposes other than insurance risk (for example, union/non-union, salaried/hourly, full time/part time).</li> <li>• Excluding a class within a group from coverage is <i>not</i> permitted.</li> <li>• Existing groups may not split into multiple groups to obtain multiple benefit levels.</li> <li>• Qualifier: Subject to the above conditions, IBC will comply with the coverage classifications requested by the employer, but approval of such request is not a representation by IBC to the employer that the requested classifications comply with applicable laws/regulations. The employer should consult with its own legal counsel or tax advisor to determine if the coverage classification is permissible under applicable laws/regulations.</li> </ul>

## Eligibility and enrollment requirements, continued

<b>Employer contribution requirement</b>	<ul style="list-style-type: none"><li>• For contributory plan offerings, the employer must contribute a minimum of 50 percent of the calculated gross monthly premium for each plan offered.</li></ul>
<b>Employee eligibility</b>	<ul style="list-style-type: none"><li>• Eligible employees include all active employees and owners or partners actively engaged in the business who:<ul style="list-style-type: none"><li>• are deemed benefit-eligible according to the employer; and</li><li>• meet all requirements as defined in the carrier's plan documents and fulfilled any authorized waiting period requirements; and</li><li>• work at least 25 hours per week; and</li><li>• reside or work in the applicable service area.</li></ul></li><li>• <i>Ineligible employees include:</i> 1099 contractors; temporary, seasonal, substitute, uncompensated employees; volunteers, silent partners, shareholders or investors only; owners, officers or managing members who are not active, permanent, full-time employees.</li></ul>
<b>Dependent eligibility</b>	<ul style="list-style-type: none"><li>• Employee's spouse; if both husband and wife work for the same company, they may enroll together or separately.</li><li>• Dependent children of the employee (natural, adopted, under legal guardianship or court-ordered custody), as defined in plan documents and in accordance with state and federal laws, are eligible for coverage up to age 26.</li><li>• At employer's request, medical coverage for dependent children may be extended to age 30, if the dependent child meets the following criteria:<ul style="list-style-type: none"><li>• Is not married and has no dependents (need not be a full-time student);</li><li>• Is a resident of the Commonwealth of PA or enrolled as a full-time student in an institution of higher education;</li><li>• Is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program.</li></ul></li><li>• Coverage handicapped dependent children who, in the judgment of IBC, are incapable of self-support due to mental or physical incapacitation (coverage will terminate upon marriage of the dependent).</li><li>• Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan.</li><li>• Domestic partners, only if the employer elects this designation at contract effective or renewal date. (See domestic partner coverage criteria below.)</li><li>• Dependents must enroll in the same benefit option as the employee.</li></ul>
<b>Domestic partner (DP) coverage</b>	<ul style="list-style-type: none"><li>• DP coverage may only be added on group's anniversary date.</li><li>• Must be offered by all in-force carriers in order to add to the IBC/KHPE coverage.</li><li>• Must be added to all groups within an affiliation.</li><li>• Must be added to all lines of business – separate group numbers not permitted.</li><li>• Domestic partners cannot be covered retroactively.</li></ul>
<b>Changes in employee or dependent eligibility criteria</b>	<ul style="list-style-type: none"><li>• Definition: Employer-initiated requests to change group's eligibility criteria (for example, changing minimum hours worked requirement for eligibility; changing dependent eligibility from age 26 to age 30, etc.)</li><li>• Changes in eligibility criteria may only be made on group's anniversary date and with prior notification to underwriting. (Please note that changes to eligibility may affect premiums.)</li><li>• Requests for off-anniversary changes will require Underwriting review and approval.</li><li>• Changes may not be made on a retroactive basis.</li></ul>

<p><b>COBRA</b></p>	<ul style="list-style-type: none"> <li>• COBRA coverage will be extended in accordance with the federal law.</li> <li>• Employers with 20 or more employees (full- or part-time) are eligible to offer COBRA coverage.</li> <li>• COBRA members are not to be included for purpose of counting employees to determine the size of the group. Once the group size has been established and it is confirmed that the law is applicable to the group, COBRA members can be included for coverage subject to the normal underwriting guidelines.</li> </ul>
<p><b>Employer eligibility</b></p>	<ul style="list-style-type: none"> <li>• An employer who employed at least 100 employees on business days during the preceding calendar year and who employs at least 100 employees on the first day of the plan year.</li> <li>• All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code shall be treated as one employer.</li> <li>• Group applicants not meeting this definition of an employer are not eligible for coverage under the Large Group programs, but may be eligible for coverage under the Small Employer or Mid-Market Employer programs – refer to the Small Group Underwriting Guidelines manual.</li> <li>• Organizations must not be formed solely for the purpose of obtaining health coverage.</li> <li>• An employer must be in business for at least six months before applying for coverage.</li> </ul>
<p><b>Common ownership affiliation</b> (two or more companies affiliated or associated)</p>	<ul style="list-style-type: none"> <li>• Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if all of the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below):             <ul style="list-style-type: none"> <li>• One owner has controlling interest of all business to be included; and,</li> <li>• Provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 – Schedule K-1, SS4 – Application for Employer ID, or latest federal tax return – all businesses filed under one combined tax return must be enrolled as one group); and,</li> <li>• Provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible from all entities; and,</li> <li>• Must have common policymaker legally authorized to make benefits decisions for the combined business; and,</li> <li>• Provides letter from employer indicating desire to combine the commonly owned entities.</li> </ul> </li> <li>• Subject to underwriting review and approval on a case-specific basis.</li> <li>• Once common ownership is established and premium rates are provided, the rates must be accepted as presented.</li> <li>• Common ownership groups may later be separated for group coverage only when based on verifiable legitimate business reasons.</li> </ul>
<p><b>Newly formed business</b> (in operation less than 12 months)</p>	<ul style="list-style-type: none"> <li>• The following documentation must be provided for consideration:             <ul style="list-style-type: none"> <li>• Business license (not a professional license). If not available, a copy of the partnership agreement, articles of organization, or articles of incorporation; and,</li> <li>• Employer identification number/federal tax ID number; and,</li> <li>• Quarterly Wage and Tax Statement. If not available, when will one be filed; and,</li> <li>• Letter from Certified Public Accountant listing the names of all employees (full- and part-time), number of hours worked each week, dates of hire, weekly salary, and confirmation of establishment of payroll records.</li> </ul> </li> </ul>
<p><b>Prior IBC coverage</b></p>	<ul style="list-style-type: none"> <li>• Groups that have been terminated for non-payment by IBC will not be eligible to reapply until: (1) 12 months after the termination date; and (2) payment of two months of premium in advance of issuance of health benefits plan. Also, all premium and financial settlement monies (if applicable) still owed on the prior IBC plan must be paid in full.</li> <li>• Medical claims information (medical loss ratio) subject to review along with information provided on the employee application and included in the overall assessment of the group.</li> </ul>

# Product offerings – groups of 100 or more\*

\*(New Business: eligible enrollees; existing business: enrolled contracts)

<b>Medical benefit plans</b>	<ul style="list-style-type: none"><li>• Maximum of three* total benefit levels, plus one HSA-qualified plan.</li><li>• Medical plans include PPO, HMO, POS and traditional plans (Blue Cross/Blue Shield/Major Medical or CMM).</li><li>• All benefit levels may be within one product line or multiple product lines</li><li>• If multiple plans are offered, they must all include or all exclude prescription drug coverage, up to a maximum of two drug plan options. (Exception: when one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans may either include or exclude drug coverage.)</li><li>• Group may not offer the same medical plan with different drug, dental and/or vision options.</li></ul> <p><i>Note: Traditional products will be counted toward the maximum number of benefit levels, but Medicare products will not be counted.</i></p>
<b>Freestanding prescription drug plans</b>	<ul style="list-style-type: none"><li>• Group may choose up to two prescription drug plan offerings.</li><li>• Discount when adding medical or Rx to form package offering:<ul style="list-style-type: none"><li>• Existing business. If group has either medical or prescription drug coverage, but not both, then a two-percent discount will be applied to the in-force medical or the in-force Rx rates for a combined package offering.</li><li>• New business. If group has medical and Rx, but not with the same carrier, then a two-percent discount will be applied to the medical for a combined package offering.</li></ul></li><li>• Surcharge when cancelling either medical or Rx from a package offering: a two percent surcharge will be applied to the remaining line of coverage (medical or Rx) upon termination of either the medical or Rx from the package offering. The surcharge will be applied immediately upon termination.</li></ul>
<b>IBC Vision plans</b>	<ul style="list-style-type: none"><li>• May be offered on a freestanding basis or as a Keystone Health Plan East rider.</li><li>• Biennial or annual benefit options (but group may not offer both an annual and biennial plan).</li><li>• Voluntary and non-voluntary vision benefit plans are available (but group may not offer both a voluntary and non-voluntary plan).</li></ul>

\*Dual-option eligibility determination is based on active employees enrolled in the IBC health plans (excludes retirees, COBRA, or mini-COBRA subscribers, and over-age dependents).

<p><b>Mandated benefits</b></p>	<ul style="list-style-type: none"> <li>• Autism benefit:             <ul style="list-style-type: none"> <li>• Pennsylvania state mandate</li> <li>• Effective July 1, 2009</li> <li>• Will be applied to existing groups with 51 or more enrolled contracts and is required for new and existing groups with 51+ total commercial employees.</li> </ul> </li> <li>• Mental Health and Substance Abuse (MHSA) Parity benefit:             <ul style="list-style-type: none"> <li>• Federal mandate</li> <li>• Effective October 15, 2009</li> <li>• Will be applied to existing groups with 51 or more enrolled contracts and is required for new and existing groups with 51+ total commercial employees.</li> </ul> </li> </ul> <p><i>Notes: A commercial employee includes any non-Medicare employee, including seasonal and/or part-time employees. Self-funded groups should consult with their legal counsel regarding the applicability of mandated benefits to their group.</i></p>
<p><b>Downgrading benefit plans off anniversary date</b></p>	<ul style="list-style-type: none"> <li>• Off-anniversary downgrades are permitted using the following guidelines:             <ul style="list-style-type: none"> <li>• All changes must be completed 180 days prior to anniversary.</li> <li>• Limit of one off-anniversary and one on-anniversary downgrade per contract year.</li> <li>• All requests subject to underwriting approval.</li> </ul> </li> </ul>
<p><b>High-deductible health plans (HDHPs), including HSA-qualified HDHPs</b></p>	<ul style="list-style-type: none"> <li>• Definition:             <ul style="list-style-type: none"> <li>• HDHP: Any plan with an in-network deductible of \$500 Single/\$1,000 Family or higher.</li> <li>• HSA-qualified HDHP: Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS.</li> </ul> </li> <li>• Guidelines for funding deductibles. Employers are not permitted to:             <ul style="list-style-type: none"> <li>• fund more than 50% of the employee/family deductible costs in an HRA or HSA;</li> <li>• provide a supplemental benefits plan that augments the core health insurance plan;</li> <li>• pay more than 50 percent of employee/family deductible costs through an allowance or claims payment;</li> <li>• provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible.</li> </ul> </li> <li>• All HDHP products, including HSA-qualified and Flex HDHPs, are considered downgrades from all current product offerings and can be offered off-cycle, but the full annual deductible will apply to the shortened period – there is no deductible carryover to the next contract year.</li> <li>• An HRA/HDHP or HSA-qualified HDHP may be offered along with other products, as long as the maximum number of product offerings is not exceeded.</li> </ul>
<p><b>Healthy Lifestyles<sup>SM</sup> Rewards</b></p>	<ul style="list-style-type: none"> <li>• Incentive-based program allows members to earn points for healthy behaviors and redeem them for gift cards, HRA contributions or HSA funding.</li> <li>• Eligible members include enrolled Keystone/Personal Choice/PPO members and covered spouses and dependents age 18 or older.</li> <li>• Must be implemented on group's anniversary date.</li> <li>• Administrative fee scaled and based on actual enrolled contracts in program.</li> <li>• Employer pays for gift cards (face value of card plus \$1 per reward fulfillment fee).</li> </ul>

<p><b>BlueSaver Health Reimbursement Account (HRA)</b></p>	<ul style="list-style-type: none"> <li>• May be offered with any medical plan.</li> <li>• May be offered with an HSA qualified plan, but must be a limited-purpose HRA (reimbursement limited to specific types of benefits).</li> <li>• May only be offered on group's anniversary date.</li> <li>• An HRA plan option can be offered along with other products, as long as the maximum number of permitted product offerings is not exceeded.</li> <li>• Employer funding to the HRA cannot exceed 50 percent of annual deductibles.</li> <li>• Seventy-five percent participation guideline is enforced for employers offering an HRA plan.</li> <li>• Only one HRA option is allowed per employer.</li> </ul>
<p><b>BlueSaver Flexible Spending Account (FSA)</b></p>	<ul style="list-style-type: none"> <li>• May be offered with any medical plan.</li> <li>• If offered with an HSA-qualified HDHP, the FSA must be a limited-purpose health FSA (reimbursement limited to specific types of benefits.)</li> <li>• May only be offered on group's anniversary date.</li> <li>• Not available as a stand-alone product.</li> </ul>
<p><b>Health savings account (HSA)</b></p>	<ul style="list-style-type: none"> <li>• Available only with a federally qualified high deductible health plan (HDHP).</li> <li>• Groups adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.</li> </ul>
<p><b>Consumer-driven health care tool kit</b></p>	<ul style="list-style-type: none"> <li>• For more information on HRAs, FSAs, and HSAs, connect to the consumer-driven health care tool kit on the IBC website at <a href="http://www.ibx.com/broker_group">http://www.ibx.com/broker_group</a></li> </ul>



# Rating information

Experience rating programs	
<b>Prospective rating</b>	<ul style="list-style-type: none"> <li>• Standard rating method for groups of 100 or more*</li> <li>• Fully-insured program</li> <li>• No surplus/deficit determination</li> </ul>
<b>Retrospective funding</b>	<p>PLEASE NOTE: THE "RETROSPECTIVE FUNDING" SECTION IS CURRENTLY UNDER REVIEW AND SUBJECT TO CHANGE – FOLLOWING IS BASIC INFORMATION:</p> <ul style="list-style-type: none"> <li>• Fully-insured program</li> <li>• Financial settlement made after each contract period</li> <li>• Cross-application of surpluses and deficits among lines of coverage</li> <li>• Deficits carried forward, except in cases of group termination (see Termination Section).</li> </ul>
<b>Cost-Plus/self-funded/self-insured</b>	<ul style="list-style-type: none"> <li>• Minimum size requirements:*               <ul style="list-style-type: none"> <li>• Employers with managed care programs: 300 or more total enrolled contracts (Keystone HMO/POS and Personal Choice PPO)</li> <li>• Employers with traditional health care programs:                   <ul style="list-style-type: none"> <li>- Blue Cross Hospitalization: 300 or more enrolled contracts</li> <li>- Blue Shield Medical/Surgical: 300 or more enrolled contracts</li> <li>- Major Medical: 300 or more enrolled contracts</li> <li>- Comprehensive Major Medical: 300 or more enrolled contracts</li> </ul> </li> </ul> </li> <li>• Self-funded program employers assume all risks for the cost of the program.</li> <li>• Payment method: Claims reimbursement basis – employer is billed weekly or monthly based on claims plus retention and broker commission (if applicable).</li> <li>• Upfront financial requirements:               <ul style="list-style-type: none"> <li>• Advance deposit required – amount will be reviewed annually.</li> <li>• Bank letter of credit (BLOC) also required if group elects to hold its own reserves for claims incurred but not reported – BLOC should be for an 18-month period and will be reviewed annually.</li> <li>• Escrow account may be considered in lieu of BLOC, upon Underwriting review and approval.</li> </ul> </li> </ul>

\*Note: Availability of rating and/or funding method will be based on number of eligible employees for new groups and on group's current enrollment for existing groups.

## Alternative funding arrangements

### 90% contingency premium arrangement

- Definition: A funding mechanism that provides a cash-flow advantage to the group by allowing it to pay 90% of the calculated premium during the contract year.
- Available only in conjunction with the retrospective funding rating program.
- Group must have 500\* or more enrolled contracts in the coverage being considered for a contingency premium arrangement.
- Bank letter of credit (BLOC) required in the amount of the unpaid premium – BLOC should be for an 18-month period and will be reviewed annually.
- At time of settlement, premium withheld may be recalled to degree needed (up to 100% of full premium rate) to offset a deficit position, including a carryover deficit.
- An interest charge will be assessed on the deferred premium recalled at time of settlement (based on U.S. Treasury Bill rate for 13-week issues).
- Employer will be required to sign a financial agreement setting forth the detailed terms of the arrangement.

## Rate quote submission

### Documentation required when submitting a rate quote request

#### Existing business:

- Requested plan design;
- Marketing strategy and group/broker expectations (if applicable);

Note: If adding new contracts totaling more than 10 percent of existing population, refer to "new business group" requirements outlined below.

#### New business: (including existing business adding new contracts totaling more than 10 percent of existing population)

- Background information:
  - Marketing strategy and group/broker expectations (if applicable)
  - Is prospect a previous IBC customer (if so, provide details)
  - Name of existing insurance carrier
  - Broker and/or consultant information
  - Five-year carrier history
  - Length of time with current carrier
  - Summary of current plan design and detailed current benefit description (source documentation)
  - Employee contribution schedule by plan design (percentage or dollar value)

*documentation required continued on next page*

\*Note: Availability of rating and/or funding method will be based on number of eligible employees for new groups and on group's current enrollment for existing groups.

**Documentation required when submitting a rate quote request** *(cont'd)*

- Claims information:
  - Twelve to 24 months of prior claims data (minimum of 12 months mature experience)
  - Experience period should be defined (specify incurred and paid periods)
  - Specify any benefit changes made within each experience period provided
  - Medical claims broken out by inpatient, outpatient, and professional claim categories
  - Medical claims broken out by facility and zip code
  - Prescription drug claims data to include:
    - Script count
    - Break-out by generic, brand and non-formulary, as well as retail and mail order
  - Enrollment for the claims period (breakdown of contracts by month)
  - Shock claims information (individual claims in excess of \$50,000)
  - Diagnosis and prognosis for excess claims
- Rate information:
  - Current and renewal rates (source documents)
  - Historical rate increases for last three-year period
  - Current financial arrangement
  - Broker commissions (if applicable)
- Census information – in spreadsheet format -- must include:
  - Employee name
  - Date of birth (MM/DD/YYYY)
  - Current plan design indicator (for example, employee John Doe is enrolled in HMO high option plan)
  - ZIP code of current residence
  - Employee gender
  - Coverage status (enrollment by coverage tier)
  - Waivers – eligible employees not electing coverage because they are covered under another plan
  - Opt-outs – eligible employees not electing coverage and who are not covered under another plan
  - New hire information: date hired or date eligible for coverage if employees are in a probationary period
  - COBRA subscribers and expiration date

*documentation required continued on next page*

**Documentation required when submitting a rate quote request (cont'd)**

- Information needed to reprice prescription drug claims: (to provide comparison between gross cost with current PBM versus estimated cost with Futurescripts)
  - Twelve months of claims data, if available (minimum of three months), to include:
    - Eleven-digit NDC
    - Fill date
    - Mail/retail indicator
    - Brand/generic indicator
    - Quantity dispensed
    - Ingredient cost
    - Dispensing fees
    - Any applicable taxes
    - Member liability information (copays, coinsurance, deductibles), if net plan cost comparison needed
  - Additional required information (where applicable):
    - Request for proposal (RFP) with all attachments
    - Competing carrier information (if available)
    - Union agreement

**Right to decline to quote**

- Subject to applicable state and federal laws, IBC reserves the right to decline to quote any group deemed to be an unsatisfactory risk. Such a decision will not be based in any way on the medical condition of the group's members.

# Post-sale submission requirements

## **Post-sale enrollment requirements**

- Rates quoted are conditional pending receipt, review and acceptance of the standard submission requirements.
- Rates are based on final enrollment – IBC reserves the right to re-evaluate rates quoted if final enrolled contracts vary by ten percent, plus or minus.

# Group terminations and reinstatements

## Termination process

- Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act.
- Group may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to IBC.
- For self-insured/Cost-Plus groups, IBC/KHPE may terminate the agreement immediately upon prior written notice for nonpayment. Either party may terminate the agreement for any reason, upon 90 days' prior written notice.
- IBC may terminate the group's coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period.
- IBC reserves the right to terminate a group's coverage off-anniversary if the group fails to meet IBC's underwriting guidelines, including but not limited to minimum participation requirements.

## Terms and conditions upon termination of coverage

- The group is responsible for all due but unpaid premiums and any accrued deficits.
- Payment of Deficits: Any historical deficits are due and payable at time of termination; any deficit from the current policy period is due and payable at point of final financial settlement.
- When active group is terminated, all COBRA groups, retiree groups, and Medicare groups (including Medicare Advantage groups) must also be terminated – COBRA-only, retiree-only, or Medicare-only groups are not allowed.
- Groups terminating to purchase individual coverage will not be eligible for group coverage for 12 months from the date of termination.
- Groups cancelling traditional Blue Cross Hospitalization or Blue Shield Medical/Surgical coverage must also cancel the Major Medical program.

## Reinstatement of coverage

- Applies to groups terminated from coverage due to nonpayment of premium.
- Reinstatement must occur within 60 days of the effective date of cancellation.
- Must be retroactive to the cancellation date.
- Any past-due premium must be paid prior to reinstatement.
- Upon satisfaction of the above conditions, IBC Underwriting will review the case and make a final determination whether or not to approve reinstatement and applicable rate level.
- Limit of one reinstatement per year.



Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.