

Small Group Underwriting Guidelines for Brokers (Groups of 2 to 99)

Independence Blue Cross Underwriting Department

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**Independence
Blue Cross**

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Eligibility and enrollment requirements

IBC/Keystone Health Plan East service area	<ul style="list-style-type: none"> • Greater Philadelphia five-county area: Philadelphia, Bucks, Montgomery, Chester, and Delaware. • Contiguous counties (counties that border the five counties): Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil.
Group location requirements	<ul style="list-style-type: none"> • The employer must be located within the Greater Philadelphia five-county area, as defined above. • No more than 50 percent of the eligible employees can be located out of the service area (exceptions must be reviewed by Underwriting and Marketing management). • 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.
Participation requirements (eligible employees)	<ul style="list-style-type: none"> • Employers of 2-19: 100 percent participation. • Employers of 20-50: Minimum 75 percent participation. • Employers of 51-99: Minimum 75 percent participation. • Valid waivers: <ul style="list-style-type: none"> • Employees with group coverage through IBC subsidiaries (coverage through an individual "direct pay" plan is not a valid waiver), Medicare or Medicaid. • Employees covered through their spouse. • Employees covered as an eligible dependent to age 26, in accordance with federal health care reform regulations. • For employers 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.
Coverage Classes	<ul style="list-style-type: none"> • Distinct categories (classes) within the group, where these classes will receive different levels of health care coverage. • 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). • Excluding a class from coverage within a group is not permitted. • Existing accounts may not split into multiple accounts to obtain multiple benefit levels. • Qualifier: Subject to the above conditions, IBC will comply with the coverage classifications requested by the customer, but approval of such request is not a representation by IBC to the customer that the requested classifications comply with applicable laws/regulations. The customer should consult with its own legal counsel or tax advisor to determine if the coverage classification is permissible under applicable laws/regulations.
Employer contribution requirement	<ul style="list-style-type: none"> • For contributory plan offerings, the employer must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single-tier rate for each plan offered.
Employees	<ul style="list-style-type: none"> • Definition: All employees, regardless of eligibility for coverage, including full-time, part-time, or in a probationary period. • Determination of group size classification (small employer versus mid market employer) is based on total number of employees, not "eligible employees", to conform to state benefit mandates which are based on "employees" (51+ employees).

<p>Employee eligibility</p>	<ul style="list-style-type: none"> • Eligible employees include all active employees and owners or partners actively engaged in the business who: <ul style="list-style-type: none"> • are deemed benefit-eligible according to the employer; and • meet all requirements as defined in the carrier's plan documents and fulfilled any authorized waiting period requirements; and • work at least 25 hours per week; and • reside or work in the applicable service area. • If both husband and wife work for the same company and apply for coverage under one contract, premium rates will be based on the oldest adult. • Ineligible employees include: 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.
<p>Dependent eligibility</p>	<ul style="list-style-type: none"> • Employee's spouse. If both husband and wife work for the same company, they may enroll together or separately, except in two life groups, where the spouse must enroll separately. • 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. • 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"> • Is not married and has no dependents (need not be a full-time student). • Is a resident of the Commonwealth of Pennsylvania or enrolled as a full-time student in an institution of higher education. • Is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program. • Overage 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). • 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. • Domestic partners, only if the employer elects this designation at contract effective or renewal date. (See Domestic Partner Coverage criteria below.) • Dependents must enroll in the same benefit option as the employee.
<p>Domestic partner (DP) coverage</p>	<ul style="list-style-type: none"> • DP coverage may only be added on group's anniversary date. • Must be offered by all in-force carriers in order to add to the IBC/KHPE coverage. • Must be added to all groups within an affiliation. • Must be added to all lines of business – separate group numbers not permitted. • Domestic partners cannot be covered retroactively.
<p>Changes in employee or dependent eligibility criteria</p>	<ul style="list-style-type: none"> • 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.) • 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. • Requests for off-anniversary changes will require Underwriting review and approval. • Changes may not be made on a retroactive basis.
<p>COBRA and Pennsylvania State Continuation Coverage (Referred to as Mini-COBRA)</p>	<ul style="list-style-type: none"> • COBRA coverage will be extended in accordance with the federal law. • Employers with 20 or more employees (full- and part-time) are eligible to offer COBRA coverage. • Employers with less than 20 employees (full- and part-time) are eligible to offer mini-COBRA coverage. • Note: COBRA/Mini-COBRA members are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined and it is determined that the law is applicable to the group, COBRA/Mini-COBRA members can be included for coverage subject to the normal underwriting guidelines.

<p>Employer eligibility</p>	<ul style="list-style-type: none"> • An employer who employed at least two but not more than 99 employees on business days during the preceding calendar year, and who employs at least two employees on the first day of the plan year. • 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. • Group applicants not meeting this definition of a small employer are not eligible for group coverage under the Small Employer or Mid-Market Employer plans. • Organizations must not be formed solely for the purpose of obtaining health coverage. • An employer must be in business for at least six months before applying for coverage. • Sole proprietorships or licensed professionals are not eligible for group coverage.
<p>Common ownership affiliation (two or more companies affiliated or associated)</p>	<p>Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one group if the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below):</p> <ul style="list-style-type: none"> • One owner, either a single person or business entity, has controlling interest (greater than 50 percent interest) of all businesses to be included. • Provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 – Schedule K-1, or SS4 – Application for Employer ID, and/or a copy of latest federal tax return – all businesses filed under one combined tax return must be enrolled as one group). • Provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible from all entities. • Must have common policymaker legally authorized to make benefits decisions for the combined business. • Letter from group indicating desire to combine the commonly owned entities. • Subject to underwriting review and approval on case-specific basis. • Also applies to existing groups wishing to add new businesses under common ownership arrangement (i.e., acquisitions, mergers). • Once common ownership is established and premium rates are provided, the rates must be accepted as presented. • Common ownership groups may later be separated for group coverage only when based on verifiable legitimate business reasons. • If group later elects to cover one or more of its businesses through another carrier, the remainder of the group will be subject to cancellation.
<p>Newly formed business (in operation less than 12 months)</p>	<ul style="list-style-type: none"> • Business must be in operation at least six months. • Will be required to provide proof-of-business documentation as outlined in Post-Sale Submission Requirements section of these guidelines.
<p>Prior IBC coverage</p>	<ul style="list-style-type: none"> • 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 premiums still owed on the prior IBC plan must be paid in full. • Medical claims information subject to review along with information provided on the employee application and included in the overall assessment of the group.

Product regulations and requirements

Overview of benefit plan offerings by group size

Group size classification: (small employer versus mid market employer)	Determination of group size classification (small employer versus mid market employer) is based on total number of employees, not "eligible employees", to conform to state and federal benefit mandates, which are based on "employees" (51+ employees).		
Group size:	2 to 4	5 to 50	51 to 99

Benefit plans available:

<ul style="list-style-type: none"> ▪ Blue Solutions for small employers portfolio (medical plan packaged with a Select Drug or Basic Drug Rider and Vision Rider) New groups would select from the Blue Solutions for small employers new business portfolio. <i>Note: Employers may not offer the same medical plan with different drug, dental and/or vision options.</i> 	✓	✓	
<ul style="list-style-type: none"> ▪ Blue Solutions for mid market employers portfolio (with or without a Drug Rider and Vision Plan/Rider) <ul style="list-style-type: none"> – Flexibility to choose from several Select Drug and Basic Drug plan options. – Employer may not offer same medical plan with different drug, dental and/or vision options. – If Drug plans are offered, they must be offered with all medical plans. Exception: If one option is HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans not required to include drug. 			✓
<ul style="list-style-type: none"> ▪ HSA-qualified high-deductible plans - with integrated drug <i>Note: Existing groups without drug benefit may retain their current plan.</i> 	✓	✓	✓
<ul style="list-style-type: none"> ▪ Keystone Health Plan East Dental and Vision Riders (available only with an IBC or Keystone medical plan) 	✓	✓	✓
<ul style="list-style-type: none"> ▪ Freestanding Dental Plan (UCCI) 	✓	✓	✓

Product regulations and requirements, continued

Group size:	2 to 4	5 to 50	51 to 99
<ul style="list-style-type: none"> ▪ Freestanding IBC Vision Plan <ul style="list-style-type: none"> – must be offered alongside a medical plan – biennial/annual benefit options (standard: biennial) <p><i>Note: Voluntary Davis Vision plan is NOT available to groups of 2 to 99.</i></p> 	Not Available	Not Available	✓

Quoting policy:

<ul style="list-style-type: none"> ▪ Maximum number of plans (dual plan options) <ul style="list-style-type: none"> – Medicare products are not counted toward maximum number of plans; traditional products are counted. – Dual option eligibility determination is based on active employees enrolled in IBC health plans (excludes retirees, COBRA, mini-COBRA and over-age dependents) – One additional medical option may be added to HMO/POS if a PPO is needed for out-of-area employees (only the out-of-area employees may enroll in the PPO)—the PPO plan should be equivalent to the local HMO/POS plan. 	1 Complete Package (Medical, Drug Rider and Vision Rider)	2 Complete Packages (Medical, Drug Rider and Vision Rider)	3 Medical 2 Drug Riders 1 Vision (Maximum: 3 total packages)
<ul style="list-style-type: none"> ▪ Rating structure 	4-Tier	4-Tier	4-Tier
<ul style="list-style-type: none"> ▪ Existing Groups with non-Blue Solutions plans 	May not retain existing plan and add a Blue Solution option. Offerings limited to Blue Solutions product suite.		May retain existing plans, but any change in benefits will be to a Blue Solutions product.

Mandated benefits

- Autism Benefit:
 - Pennsylvania state mandate
 - Effective July 1, 2009
 - 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.*
 - Mental Health and Substance Abuse (MHSA) Parity Benefit:
 - Federal mandate
 - Effective October 15, 2009
 - 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.*
- Note: *Commercial employees defined as any non-Medicare employees, including seasonal and/or part-time employees.

<p>Downgrading benefit plans off anniversary date</p>	<ul style="list-style-type: none"> • Off-anniversary downgrades are permitted using the following guidelines: <ul style="list-style-type: none"> • Downgrade existing plan by increasing co-pays and/or deductible. • From traditional program to Personal Choice (PPO) or Keystone coverage; traditional plan must be cancelled. • From Personal Choice to Keystone Point of Service (KPOS) or Keystone HMO. • From Keystone Point of Service to Keystone HMO. • All changes must be completed 90 days prior to anniversary. • Limit of one off-anniversary and one on-anniversary downgrade per contract year. • All requests subject to underwriting approval. • New groups of 2 to 50 enrollees will not be permitted to change benefits until their first anniversary date.
<p>Collective bargaining/ union agreements</p>	<ul style="list-style-type: none"> • Collective bargaining/union agreements will not be honored in those cases where IBC no longer offers a specific benefit or benefit plan.
<p>High-deductible health plans (HDHPs), including HSA-qualified HDHPs</p>	<ul style="list-style-type: none"> • Definition: <ul style="list-style-type: none"> • HDHP – Any plan with an in-network deductible of \$500 Single/\$1,000 Family or higher. • HSA-Qualified HDHP – Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS. • Guidelines for funding deductibles – Employers are not allowed to: <ul style="list-style-type: none"> • Fund more than 50 percent of the employee/family deductible costs to an HRA or HSA; • Provide a supplemental benefits plan that augments the core health insurance plan; • Pay more than 50 percent of employee/family deductible costs through an allowance or claims payment; or, • Provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible. • For employers adding an HSA-qualified HDHP for the first time, it will be considered a downgrade from all current product offerings and can be offered off-cycle as of 1/1/11 on a contract year basis only. When offered off-cycle, the full annual deductible will apply to the shortened period – there is no deductible carryover to the next contract year. • An HRA/HSA-qualified HDHP may be offered along with other products, up to the maximum plan offerings (dual plan options) for the size of group.

BlueSaver health reimbursement account (HRA)	<ul style="list-style-type: none">• Available to groups of 2-99 enrollees (existing business) or eligible employees (new business).• May be offered only:<ul style="list-style-type: none">• on group's anniversary date;• With a Flex Deductible medical plan option (prescription drug plan selection will follow high-deductible plan rules);• HRA/HSA qualified HDHP can be offered along with other products, up to the maximum plan offerings (dual plan options) for the size of group.• Employer funding to the HRA cannot exceed 50 percent of the annual employee/family deductible.• Only one HRA option per customer.• Debit card option not available.
BlueSaver health spending account (HSA)	<ul style="list-style-type: none">• Available to groups of 2-99 enrollees (existing business) or eligible employees (new business).• Available only with a federally qualified high-deductible health plan (HDHP) with integrated prescription drug benefit.• Employers adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.
Consumer-driven health care toolkit	For more information on HRAs and HSAs, connect to the Consumerism Sales Guide on the IBC website at www.ibx.com/broker_group

Rating information

Rating programs	<p>For existing groups, applicable rating method will be based on the employer's current total enrollment in managed care programs (Personal Choice, Keystone HMO, and/or Keystone POS) at time of renewal. For new groups, applicable rating method will be based on the total number of employees.</p>
Medical underwriting for small employer groups	<ul style="list-style-type: none"> • Definition: New business rating: Community-based rates are adjusted for factors such as age, gender, area, group size, plus an adjustment for risk based on an evaluation of individual health questionnaires and other health information for each enrolling employee, spouse and/or dependents. • Renewal rating: Community-based rates are adjusted for factors such as age, gender, area, group size, plus an adjustment for health status for all enrolled contracts. • Group size: Applies to groups of 2 to 50 employees.
Risk-adjusted rating program for mid-market employer groups	<ul style="list-style-type: none"> • Definition: Rates are based on the customer's combined demographic makeup (age, gender, area and group size), along with a risk adjustment. • Group Size: Applies to groups of 51 to 99 employees.
Changes in group size – effect on rating	<ul style="list-style-type: none"> • At time of enrollment (new business), if a small employer group has more than 50 employees, the rating methodology would change to mid-market employer group rating (51+). • The employer is responsible for notifying IBC if the employee count has changed from small employer to mid-market, or vice versa. • If an employer group was previously rated as mid-market and drops below 51 total employees at renewal, the employer group will continue to be rated as mid-market and retain the Mental Health Parity and Autism mandated benefits until proof is submitted confirming they no longer have 51+ total commercial employees. • Retroactive changes in rating methodology will not be permitted. If an employer group was renewed as a small employer and subsequently informs us that their employee count was 51+, the renewal rates would stand until the next anniversary date. • Employer groups can only change from small employer to mid-market or vice versa on anniversary date.
Rate quote submission	<p>Most rate quote requests can be submitted through the ROAM system, but there are situations requiring submission through the IBC account executive.</p>
Situations requiring rate quote submission through IBC account executive	<p>Existing business:</p> <ul style="list-style-type: none"> • A change in anniversary date: <ul style="list-style-type: none"> • Documentation required: Letter from employer (on customer letterhead). • A material change in the census (for example, purchasing a new entity): <ul style="list-style-type: none"> • Documentation required: Proof of common ownership (see "Common Ownership" rules under Eligibility Requirements section of this document). • Requires approval by Underwriting. • Groups with traditional coverage. • Non-standard requests not viewable as alternatives to renewals on ROAM. <p>New business:</p> <ul style="list-style-type: none"> • All requests for employers with 51 to 99 employees.

Documentation required when submitting a rate quote request

Existing business – employers with 2 to 99 employees:

- Requested plan design.
- If adding new contracts totaling more than 10 percent of existing population, refer to “new business group” requirements outlined below.

New business – employers with 2 to 50 employees – medically underwritten program:

- **Step 1:** Broker will submit the following group census information through ROAM to receive an initial sample rate based on group characteristics.

Group census for all eligible employees and COBRA participants, to include:

- Employee name (surname required)
- Date of birth (MM/DD/YYYY)
- Employee gender
- Family 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)
- Zip code (if available)
- **Step 2:** Broker will submit health questionnaires to obtain the official medically underwritten rates. The health questionnaires must be:
 - completed for each enrollee, spouse and/or dependents;
 - signed by the applicant, spouse, and all dependents age 18 and over, if applicable, and must be dated no more than 90 days before the proposed effective date of coverage.

Note: To receive a medically underwritten rate for the proposed effective date, the rate quote request must be received by IBC no later than 15 days prior to the requested effective date. Rates quoted by IBC will be valid up to the “good through” date shown on the rate quote.

New business – employers of 51 to 99 employees:

- Name of existing insurance carrier
- Length of time with current carrier
- Summary of current plan design (source documentation)
- Current renewal, including premium rates (source documentation)
- Three-year rate history (if available)
- Employee contribution (percentage or dollar value)
- Detailed census – in spreadsheet format – must include the following:
 - Employee name
 - Date of birth (MM/DD/YYYY)
 - Current program enrollment (for example, HMO, PPO, Rx, Vision)
 - Zip code
 - 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)
 - Date eligible for coverage for employees who are in a probationary period
- Claims data – if available:
 - Three years of claims data is preferred
 - Enrollment for the claims period (breakdown of contracts by month)
 - Shock claims information (individual claim in excess of \$50,000)
 - Diagnosis and prognosis for excess claims
- Union agreement (if applicable)

Right to decline to quote

- Subject to applicable federal and state laws, IBC reserves the right to decline to quote any group deemed to be in violation of the IBC underwriting guidelines. 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 10 percent, plus or minus. For new business groups of 2 to 50 employees, health questionnaires may need to be submitted for those enrollees not included in the original rate quotation.
- Rates are not guaranteed for 12 months. IBC reserves the right to re-evaluate the premium rates for changes which may affect the underwriting risk. These changes include but are not limited to:
 - Changes in enrollment after the inception of the policy period;
 - Adding or deleting enrollees retroactive to the effective date of the policy.

Documents required with group submission

The following documentation must be provided for consideration:

- Application for New Employer Health Benefits (front and back)
- Small Employer Certification (front and back)
- Universal Enrollment Forms (one for each employee enrolling)
- Rate Quote
- First month's premium check(s)
- Most recent PA UC2A Form (Unemployment Compensation Tax Form)

Employers that do not file a UC2A because they are a newly formed company, family-owned business, or a non-profit entity, must provide one proof of business and one proof of employment from the list below. Newly-formed companies must be in business for at least six months. Documentation should confirm that the business is active and the location of the business:

- Proof of business: (provide one)
 - Current business license (not a professional license)
 - Corporate Tax Form (Form 1120)
 - Partnership agreement, articles of organization, or articles of incorporation
 - Official document with Employer Identification Number/federal tax ID number
 - Federal Form 990 or IRS Exemption letter (for non-profit entities) **AND:**
- Proof of employment: (provide one)
 - Payroll record (Paychex, ADP, etc.)
 - W-2 for all employees
 - IBC Eligibility Form for Owners/Partners completed and signed by each owner/partner (requires tax documentation)
 - Letter from Certified Public Accountant listing the names of all employees (full and part time), number of hours worked each week, dates of hire and weekly salary

Group terminations and reinstatements

Termination process	<ul style="list-style-type: none">• Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act.• Employer may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to IBC.• 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	<ul style="list-style-type: none">• The employer is responsible for all due but unpaid premiums.• When active group is terminated, all COBRA groups and Medicare groups (including Medicare Advantage) must also be terminated – COBRA-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	<ul style="list-style-type: none">• 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 regarding reinstatement and applicable rate level.• Limited to one reinstatement per year.



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