Large Group Underwriting Guidelines (Groups of 100+)

For Brokers

Independence Blue Cross Underwriting Department

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This document not intended to be all inclusive. Independence Blue Cross (Independence) reserves the right to change these underwriting guidelines without notice as Independence, within its sole discretion, believes necessary or to comply with federal and/or state law or as required by federal and/or state regulatory agencies. Independence has the sole discretion and final authority to interpret the scope and application of the underwriting guidelines.
Please note: The guidelines listed in this document are not intended to be a description or summary of applicable laws. These guidelines are applicable to new and renewing customers. Independence reserves the right to apply rate adjustments for new business customers not in compliance with the Underwriting Guidelines. Renewing customers not in compliance with the Underwriting Guidelines may also be subject to rating adjustments or possible termination of the group contract. This applies to pre-or post-sale and renewal business. Unless indicated otherwise, the guidelines in this document are applicable to Quality Care Corporation (QCC Insurance Company (QCC)), Keystone Health Plan East (KHPE), and Independence Hospital Indemnity (IHIP) and existing groups with Independence coverage.

Eligibility and enrollment requirements

Employer eligibility	▪ An employer must employ on average at least 100 employees on business days during the preceding calendar year. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage.
Independence service area	▪ 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	▪ The group must be headquartered within the Greater Philadelphia five-county area, as defined above. ***Note***: In accordance with regulation CFR 147.104, employers with a business address outside of the Independence service area, but headquartered within the state of Pennsylvania, may be eligible for coverage if the employer has enrolling employees who live, work or reside within the Independence service area. ▪ Group members enrolling in HMO/POS coverage must reside within the Independence service area, excluding members covered by an Independence affiliate as indicated below. ▪ Group members who live in non-contiguous counties and have HMO/POS coverage must be covered under and issued booklets by an affiliate of Independence.
National account requirements	▪ 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. ▪ Business must be domiciled in the Greater Philadelphia five-county area, as defined above, and must have at least one location outside the Independence/KHPE service area. ▪ Minimum enrollment requirement: 1,000 eligible contracts in PPO/HMO/POS or Traditional (Blue Cross/Blue Shield/Major Medical) medical plans. ▪ Employees located outside of the Independence/KHPE service area are not eligible for HMO/POS coverage under the national program. ▪ National account terminology: – Control (home) plan: The plan located in the area where the group's corporate headquarters or decision-making authority is situated. This plan sells the benefit plan and serves as main point of accountability for the group. – Par (host) plan: A BC/BS plan that agrees to service a national account sold by the control plan.

Group participation requirements	▪ Minimum 75 percent participation for each worksite. ▪ Independence and affiliates are assumed to be the sole carrier; if other carriers exist, rating adjustments may apply. ▪ For groups covering early retirees (under age 65), 100 percent participation of the early retiree population is required. The group must consist of a minimum of 75 percent participation for the active employees. ▪ Group Medicare coverage may be available for Medicare-eligible retirees, please refer to the Independence Medicare guidelines for eligibility, participation requirements and other guidelines. ▪ Early retirees (under age 65 retirees not eligible for Medicare) cannot represent more than 10 percent of the total group enrollment. ▪ Valid waivers include the following: – Employees with group coverage through Independence subsidiaries (coverage through an individual "direct pay" plan is not a valid waiver), Medicare or Medicaid, Veteran or other government issued coverage; – Employees covered through their spouse; – Employees covered as an eligible dependent to age 26, in accordance with federal Patient Protection and Affordable Care Act. ▪ ***Note***: Coverage through an individual "direct pay" plan is not a valid waiver, which includes employees enrolled in an employer sponsored Individual Coverage Health Reimbursement Agreement plan (ICHRA). ▪ Participation audits: Independence reserves the right to perform periodic audits to assure continued compliance with the above requirements.
Employer contribution requirement	For contributory plan offerings, the employer must contribute a minimum of 50 percent of the calculated gross monthly premium for each plan offered.
Coverage classes	▪ Definition: Distinct categories (classes) within the group; 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 within a group from coverage is **not** permitted. ▪ Existing groups may not split into multiple groups to obtain multiple benefit levels. ▪ Qualifier: Subject to the above conditions, Independence will comply with the coverage classifications requested by the employer, **but approval of such request does not indicate 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.
Employee eligibility	▪ Eligible employees include all active employees and owners or partners actively engaged in the business who: – are deemed benefit-eligible according to the employer; – meet all requirements as defined in the carrier's plan documents and fulfilled any authorized waiting period requirements; – reside or work in the applicable service area when electing HMO/POS coverage; – work at least 25 hours per week. ***Note***: To minimize adverse risk selection, it is recommended that employees work at least 25 hours per week.

	▪ **Off-cycle adds:** Employees who initially waive coverage because they are covered under a spouse's medical plan may be added off-cycle to the group's benefit plan upon the occurrence of a life event (for example, spouse's employment is terminated).
Dependent eligibility	▪ 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 (Pennsylvania state mandate): – Is not married and has no dependents (need not be a full-time student); – Is a resident of the Commonwealth of PA 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. ▪ A handicapped dependent is one who is incapable of self-support due to mental or physical incapacitation. Independence will review the required handicapped documentation to determine eligibility for overage handicapped coverage (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.
Domestic partner (DP) coverage	▪ DP coverage may be added or removed on group's anniversary date. ▪ Off-cycle additions are permitted with authorization from the Director of Sales and a Director in Underwriting. ▪ Must be offered by all in-force carriers in order to add to the Independence/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.
Changes in employee or dependent eligibility criteria	▪ 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. ▪ Changes in eligibility criteria may only be made on group's anniversary date and with at least 120 days' 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.
COBRA	▪ COBRA coverage will be extended in accordance with the federal law. ▪ Employers with 20 or more employees (full- or part-time) are eligible to offer COBRA coverage. ▪ The number of COBRA enrollees is limited to 10% of the group enrollment. ▪ COBRA members are not to be included while 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.

Independent Contractor/Leased Employees	▪ Independent contractors and leased employees are not eligible for group coverage unless they are reclassified as eligible employees based on the IRS common-law test as defined in Reg. § 31.3401(c)–1(b). ▪ Employers are responsible for determining the employee classification for independent contractors and leased employees. ▪ Independence reserves the right to perform periodic audits to assure continued compliance with the above requirement.
Common ownership affiliation (two or more companies affiliated or associated)	▪ 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): – For large employers, one owner must have at least 51 percent controlling interest of all businesses to be included. Note: Customers requesting to combine *small businesses with **mid-sized or large businesses as common ownership, must provide proof that one owner has at least 80 percent controlling interest for all small businesses and at least 51 or more percent controlling interest for all mid-sized/large businesses. – 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). – UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible employees from all entities. – Common policymaker legally authorized to make benefits decisions for the combined business. – Letter from the employer 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 an employer later elects to cover one or more of its businesses through another carrier, the remainder of the group may be subject to rating adjustments. **Small business is defined as employers with 2-50 employees.* ***Mid-sized business is defined as employers with 51-99 employees.*

Product offerings – groups of 100 or more

(New Business: eligible enrollees; Existing Business: enrolled contracts)

Medical benefit plans	▪ Maximum of three* total benefit levels. ▪ Medical plans include PPO, HMO, POS and traditional plans (Blue Cross/Blue Shield/Major Medical or CMM). ▪ Traditional plans are not available to new customers and may not be added as new lines of business to existing customers. ▪ All benefit levels may be within one product line or multiple product lines. ▪ If multiple plans are offered, they must all exclude or all include 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 exclude or include drug coverage.) ▪ Group may not offer the same medical plan with different drug, dental and/or vision options. *Note: Traditional products will be counted toward the maximum number of benefit levels, but Medicare products will not be counted. **Product Portfolio** ▪ A new product portfolio was introduced in 2018 for 51 plus groups. This portfolio is refreshed annually. Existing groups with this portfolio of products will receive the refreshed benefits upon renewal, even when the group has not requested a plan change. ▪ New groups must select from the most recent product portfolio. ▪ Changes to one or more of existing medical plans must be selected from the most recent product portfolio. ▪ Pharmacy only changes will not require changes to existing medical plan designs.
Freestanding prescription drug plans	▪ Groups may choose up to two prescription drug plan offerings. ▪ The following discount applies when adding a fully-insured Rx or self-funded Rx plan to a fully-insured medical package offering: – If a group has medical only and elects to add a fully-insured or self-funded prescription drug plan, then a two-percent discount will be applied to the fully-insured medical. This applies to new and existing groups with medical only coverage, or groups that may have prescription drug coverage with another carrier and elects to add a new prescription drug plan with Independence. ▪ Surcharge when cancelling prescription drug plan: a two percent surcharge will be applied to the remaining fully-insured medical line of coverage upon termination of the prescription drug package. The surcharge will be applied immediately upon termination. Additional fees may apply. ▪ Effective Jan. 1, 2021, Groups with less than 300 enrolled contracts must purchase a prescription drug plan alongside the elected medical option/s.

Independence Vision plans	**Benefit Plans Available** ▪ May be offered on a freestanding basis or as a Keystone Health Plan East rider. ▪ Biennial or annual benefit options (but group may not offer both an annual and biennial plan). ▪ For groups of 100 or more, freestanding vision plans may be offered off-anniversary (subject to Underwriting and Product Management approval); upgrades are only permitted on anniversary date. ▪ For groups of 100 or more, freestanding vision plans may be offered to a "carve out" class, subject to Underwriting and Product Management approval. **Maximum Plan Offerings and Dual Option Guidelines** ▪ One vision offering is standard; Dual options are subject to Underwriting approval. ▪ Voluntary and non-voluntary vision benefit plans are available, but the group may not offer both voluntary and non-voluntary plans. **Voluntary Vision Guidelines** ▪ A minimum of 10 enrolled contracts is required for voluntary vision. ▪ When an employer contributes less than 50 percent, a voluntary plan is required. ▪ There are no participation requirements for voluntary vision. **Non-Voluntary Vision Guidelines** ▪ 70 percent participation is required ▪ For contributory plan offerings, the employer must contribute a minimum of 50 percent of the calculated gross monthly premium for each plan offered. **Rate Guarantee** ▪ 24-month rate guarantee for newly purchased vision coverage. ▪ Vision renewals have a 12-month rate guarantee.
Mandated benefits	▪ Definition: Benefits that are required to cover the treatment of specific health conditions, certain types of healthcare providers, and some categories of dependents, such as children to a certain age. Health care benefits may be mandated by state and/or federal law.
Minimum Value requirements	▪ **Definition**: According to the IRS, an employer sponsored plan provides minimum value if it covers at least 60 percent of the allowed cost of benefits that are expected to be incurred under the plan (considering deductibles, copays and coinsurance) based on the federal minimum value calculation. ▪ If the Independence medical benefit on its own does not meet minimum value standards and Independence is not the prescription drug carrier, Independence may not be able to determine that the customers health plan offering meets minimum value standards. ▪ For employers with a fully insured arrangement, at least one plan design offered must be compliant with minimum value requirements. Employers not meeting the requirements of the Employer Shared Responsibility provision of the Affordable Care Act (which includes the minimum value requirement), may potentially owe an employer shared responsibility payment to the IRS. ▪ Employers offering self-insured coverage should consult with their legal counsel and/or tax advisor to determine if their benefit offerings meet applicable state and federal requirements.

Off anniversary changes	▪ Off-anniversary downgrades are permitted using the following guidelines: – All changes must be completed 180 days prior to anniversary. – Limit of one off-anniversary and one on-anniversary downgrade per contract year. – All requests subject to underwriting approval. – Off anniversary benefit changes must be submitted to underwriting 90 days (or more) in advance of the benefit change effective date. – Off anniversary upgrades are not permitted. ***Note***: Changes to any of existing medical plan designs will require all benefits to be changed to the most current product portfolio.
High deductible health plans (HDHPs), including HSA-qualified HDHPs	▪ Definition: – 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 permitted to: – fund more than 50% of all the employee/family deductible costs in an HRA or HSA; – provide a supplemental benefits plan that augments the core health insurance plan; – pay more than 50 percent of all the employee/family deductible costs through an allowance or claims payment; – provide any combination of the above that causes the total amount funded to be greater than 50 percent of all the employee/family deductible costs. – An HSA-qualified HDHP may be offered along with other products, up to the maximum plan offerings for the size of group. ▪ HSA-qualified HDHPs: Health Savings Account (HSA) regulations have distinct requirements for prescription drug coverage. Federal requirements for HSA-qualified HDHPs do not allow a separate prescription drug program (or rider) to provide benefits before the HDHP annual deductible is satisfied; if a plan provides any prescription drug benefit before the annual deductible is met (except in the case of preventive drugs), the plan does not qualify for a Health Savings Account. If the employer group has a prescription drug program through another carrier, the group may request Independence to combine the Rx claims with the Independence medical plan claims. Such requests are subject to underwriting review, and if approved, an administrative fee will apply for this service. ▪ If an HDHP product is offered off cycle, the full annual deductible will apply to the shortened period — there is no deductible carryover to the next contract year. ▪ An HDHP or HSA-qualified HDHP may be offered along with other products, as long as the maximum number of product offerings is not exceeded.

Health Reimbursement Account (HRA)	▪ Definition: Health reimbursement accounts (HRAs) are personal accounts funded solely by an employer used to reimburse employees for qualified medical expenses. Employer contributions are tax deductible for employers and generally excluded from an employee's gross income. ▪ May only be offered on group's anniversary date. ▪ May be offered with any medical plan, but typically offered with HDHP. ▪ May be offered with an HSA-qualified plan but must be a limited-purpose HRA (reimbursement limited to specific types of benefits). ▪ Employer funding to the HRA cannot exceed 50 percent of annual deductibles. ▪ Only one HRA option is allowed per employer. ▪ Debit card for medical, prescription drug, dental and vision options are available.
Health Savings Account (HSA)	▪ Definition: A tax-exempt trust or custodial account created to pay for qualified medical expenses of the employee and their dependents. ▪ Available only with a federally qualified high deductible health plan (HDHP). ▪ 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.
Flexible Spending Account (FSA)	▪ Definition: Flexible spending accounts (FSAs) are pre-taxed accounts generally funded solely by employees. FSAs help reduce members' tax liability when they set aside money for qualified medical expenses. ▪ May be offered with any medical plan. ▪ If offered with an HSA-qualified HDHP, the FSA must be a limited-purpose health FSA (under a limited purpose FSA, only eligible vision and dental expenses are reimbursable; general medical expenses **are not** eligible for reimbursement). ▪ May only be offered on group's anniversary date. ▪ Not available as a stand-alone product.
Achieve Well Being	▪ Incentive-based program allows members to earn "dollars" for healthy behaviors. ▪ Eligible members include all enrolled commercial group members, their covered spouses and dependents age 18 or older.
Cost Sharing	▪ Employers are not permitted to: – fund more than 50% of all the employee cost sharing (copay, coinsurance, deductibles etc.); – provide a supplemental benefits plan that augments the core health insurance plan; – pay more than 50 percent of all the employee cost sharing through an allowance or claims payment; – provide any combination of the above that causes the total amount funded to be greater than 50 percent of all the employee cost sharing.

Rating information

Experience rating programs – Fully-Insured

Prospective rating

Description	▪ Fully-insured program ▪ Employer pays a fixed premium rate to Independence, and Independence assumes the entire claim risk for the covered services. ▪ No surplus/deficit determination
Eligibility for Prospective Rating Methodology	▪ Standard rating method for groups of 100 or more: – Based on total number of eligible employees for new business; – Renewing groups will be based on the number of enrollees.
Rate Tier Structure	▪ Rate tiers and tier ratios must be consistent for all medical and prescription drug plans offered.

Affiliation (multi-employer affiliations)

Definition and requirements	▪ Definition: Two or more groups combining for experience-rating purposes. ▪ Affiliations may include one or more of the following scenarios: – Groups having common ownership; – Groups within an affiliation must have 51 or more employees, qualifying as an experienced rated group. – Groups not having common ownership but with other valid evidence for combination — for example, common industry classification or common union affiliation (e.g., carpenters locals). ▪ New affiliations must be approved by Independence Underwriting. ▪ Must have an affiliation leader to serve as the main point of contact for the affiliation; **the leader must have the** authority to make decisions, including financial decisions, on behalf of the affiliation. ▪ All groups in the affiliation pay the same rates for the same benefits. ▪ Must have a minimum of 1,000 combined contracts. ▪ Must be affiliated for all lines of business. ▪ Additional underwriting guidelines may apply (i.e., for school affiliations).
Groups joining an existing affiliation	▪ After initial enrollment, other groups may join the affiliation at any time, provided that the affiliation gives prior approval, and the group that plans to join the affiliation did not yet receive their renewal. ▪ The affiliation is subject to re-rating if the new group's size equals 5 percent of the total affiliation contracts; re-rating may also occur upon a 5 percent cumulative enrollment change resulting from multiple groups joining throughout the year. ▪ A group may join an existing affiliation at a different premium rate, with rates adjusted to the affiliation rate at the next renewal date. ▪ If the new group enters an affiliation that is in a deficit position, the new group will assume the deficit position of the affiliation.

Groups leaving an affiliation	▪ The affiliation is subject to re-rating if the size of the group leaving equals 5 percent of the total affiliation contracts, or upon a 5 percent cumulative enrollment change resulting from multiple groups leaving throughout the year. ▪ If a group leaves the affiliation, it may not re-enter until the second anniversary date following the separation from the affiliation; re-entry requires approval from the affiliation. ▪ **Effect on the premium rates**: If a group leaves the affiliation (on or off the affiliation's anniversary date): – **After being notified of the affiliation's renewal rate change:** – The group must maintain the affiliation rates for the balance of the current contract period and through the next contract period, subject to any increase or decrease based on benefit changes. – The group will be rated by Independence based on its own claims experience at the subsequent anniversary date. – **Prior to the notification of the affiliation renewal rate change:** – The group will continue to pay the affiliation rates for the balance of the current contract period, subject to any increase or decrease based on benefit changes. – The group will be rated by Independence based on its own claims experience at the subsequent anniversary date. – **If the group enters into a self-funded or prospective funding arrangement with Independence**: – The balance from the final settlement will be payable by the applicable party within 30 days after the settlement is completed.

Experience rating programs –self-funded

Employer Eligibility	▪ Minimum Size Requirements: – Groups with managed care programs: 300 or more total anticipated enrolled employees for new business or total enrolled contracts for existing groups (Keystone HMO/POS and Personal Choice PPO). ▪ Groups with traditional health care programs: 300 or more enrolled contracts in *each* line of business (Blue Cross hospitalization, Blue Shield medical/surgical or comprehensive major medical).
Overview	▪ Group assumes all risks for the cost of the program. ▪ Independence is obligated to pay claims to providers, and then bill the group for reimbursement. This differs from an ASO arrangement, where the carrier is not obligated to pay providers until sufficient funds are transferred to the group's account. ▪ Group is responsible for payment of claims plus applicable fees. ▪ Groups will be invoiced weekly for claims and monthly for other applicable fees.
Contract Year Reconciliation:	Independence HMO/POS/QCC/HBS (Highmark Blue Shield): a financial settlement is made within 180 days following the end of the contract period—surplus funds are refunded to the group and deficits are due and payable by the group unless outstanding balances are owed.
Upfront financial requirements	▪ Self-funded customers are required to ensure they have sufficient funds to cover the cost of run-out claims. This is commonly known as a claims reserve. ▪ Independence may require evidence that the reserve funds are secured. ▪ Evidence may include: cash, Bank Letter of Credit (BLOC) or an escrow account. ▪ BLOC should be for an 18-month period initially and will auto renew. The BLOC will be reviewed upon renewal. ▪ Escrow account may be considered in lieu of BLOC, upon Underwriting review and approval. ▪ Advance deposit required amount will be reviewed upon renewal or if there is a significant shift in enrollment (10% or greater).
Administrative Services Agreement (ASA)	▪ Group will be required to sign a financial agreement outlining the basic terms of the self-funded rating arrangement. ▪ In the absence of a signed ASA, remittance of required payment is deemed as acceptance of the ASA. ▪ Account executive must notify the group underwriter at the time of sale so that this agreement can be prepared.
Additional fees (if applicable)	Bi-Directional Feed Fee: ○ If a bi-directional data feed is required for customers with an external Pharmacy Benefit Manager, the cost of establishing and maintaining the feed will be passed on to the group. Note: Additional fees may apply. ▪ Termination Fee: ○ A one-time termination fee in the amount of 100% of the per Subscriber Administrative Fee, multiplied by the sum of the enrollment for the three (3) months prior to termination will be charged for post termination claims services.

Self-funded Pharmacy

Formulary Quoting Guidelines

New and existing customers may elect from the following self-funded formulary options.

- **Premium Formulary**
  - The Premium Formulary maximizes manufacturer rebates. It has fewer non-covered drugs than comparable formularies of other PBMs to support more choice and less disruption.
  - Recommended formulary option for all self-funded quotes.

- **Select Drug Program ®Formulary**
  - The Select Drug Program Formulary provides the broadest access to cost-effective covered prescription drugs including generics, brands, and specialty drugs.
  - Available quoting for existing customers or new groups on an exception only basis.

Note: One formulary option may be quoted for each self-funded customer. Multiple formularies on the same quote may be allowed on an exception only basis.

- **Rebate Guarantees**
  - Rebates are defined as a negotiated dollar value that pharmaceutical manufacturers pay to Pharmacy Benefit Managers (PBM) for a list of pre-determined drugs.
  - Rebate guarantees may be adjusted in proportion to the impact of unexpected releases of Generic Drugs to market or the withdrawal or recall of existing Brand Drugs.
  - Customers must adopt Independence's formulary and formulary exclusions, including any changes Independence makes to its formulary and formulary exclusions.
  - Rebate guarantees may be provided as a fixed rebate, pass-thru arrangement or as an offset to the administrative fee.
- **Fixed Rebates**
  - Fixed rebates will be paid on a quarterly basis, approximately 150 days following the end of the quarterly period.
  - Fixed rebates will not require a year-end reconciliation.
- **Pass-through Rebates**
  - Independence will pass on 100 percent of the net rebates received from our Pharmacy Benefit Manager (PBM) in a pass-through rebate arrangement.
  - Pass-through rebates reflect a minimum guarantee.
  - Pass-through rebates will be paid on a quarterly basis, approximately 180 days following the end of the quarterly period.
  - Rebate reconciliation may be available for customers on a pass-through arrangement.
- **Offset to the Medical Administrative Fee**
  - As an alternative to receiving rebate payouts, a customer who has an Independence self-funded medical plan may receive an offset to their medical administrative fee.
  - The offset value is predetermined at the time of quoting and will not be adjusted until the next contract period.
  - No rebate reconciliation will be provided.
- **Discount Guarantees**

Independence pricing guarantees are as follows for traditional spread arrangements and pass-through arrangements:

- **Traditional Spread**

- Guarantees are structured so that discounts applied at the customer level may be different than what Independence receives from our PBM.
- An administrative fee is typically not charged in a traditional spread arrangement.

- **Pass-through**
  - Guarantees are structured so that discounts applied at the customer level are the same as what Independence receives from our PBM.
  - Pass-through guarantees are typically only offered at the retail channel.
  - Mail and specialty guarantees are only offered as traditional spread.
  - An administrative fee may be charged in a pass-through arrangement.

- **Integrated Drug Claims**
  - An integrated drug claim is when the medical and pharmacy shares the same deductible.
  - Integrated drug claims are always on a pass-through basis for all channels (retail, mail, and specialty).
  - An administrative fee is charged for integrated drug claims.
  - If the customer is 100 percent integrated, no pricing guarantees will be provided.

***Note**:* Any material modification of the plan design or program specifications may result in pricing modifications.

- **Early Termination**
  - If the client terminates prior to the end of the contract term, the following applies:
    - Any outstanding settlement will not be completed.
    - For groups with a fixed or a passthrough rebate arrangement, Independence will retain all unpaid rebates as compensation for the early termination.
    - If the group terminates prior to the end of the guarantee period, the rebate credit will be removed from the medical administrative fee for the final six-months of prescription drug coverage.
  - Note: The base medical administrative fee may be increased.

- **Pricing Guarantees Reconciliation**
  - Independence will calculate and report the actual ingredient cost discounts for brand and generic drugs respectively, as billed for the contract year, within 180 days after the end of each contract year.
- **Prescription Drug Requirements for quoting:**
  - Current Pharmacy Benefit Manager (PBM)
  - Length of contract with current PBM
  - Current PBM pricing, including Average Wholesale Price (AWP) discounts and current fees
  - Current PBM discount arrangement, traditional, pass-through, etc.
  - Current plan designs
  - A detailed prescription drug claims file with at least 12 months of claims is needed if prescription drug pricing is requested. File should include the following data fields:
    - Eleven Digit NDC
    - Fill Date
    - Quantity Dispensed
    - Day Supply

	▪ NABP number – (National Association Board of Pharmacy) ▪ Mail/Retail Indicator ▪ Ingredient Cost ▪ Dispense Fee ▪ U&C ▪ AWP

Stop-loss coverage (reinsurance)

Overview	• Groups on a self-funded arrangement may purchase stop-loss coverage from Independence's third-party stop-loss carrier or reinsurer. • Independence has the expectation that groups with less than 5000 enrolled employees will purchase stop Loss. • Customers that purchase stop-loss coverage through Independence's stop-loss carrier may receive a fee credit as a result of savings achieved on administrative costs. ▪ Stop-loss coverage is available on a specific basis, aggregate basis, or a combination of both. ▪ The terms of the paid and incurred periods for specific and aggregate stop-loss coverage should be clearly specified. ▪ Stop-loss carrier is responsible for all facets of administering this coverage, including underwriting, premium accounting, stop-loss policy issuance, excess claims adjudication, and risk pool establishment/accounting. ▪ Independence may provide certain claims information to the stop-loss carrier to enable it to quote initial and renewal rates, and to process excess claims for the self-funded group. ▪ Stop-loss reporting may be subject to additional administrative and reporting fees. ▪ The employer is responsible for ensuring the stop loss carrier is informed and has approved any plan and eligibility changes. ▪ HIPAA regulations require legal agreements to be signed by account and stop-loss carrier before claims information can be released.

Early renewal request process

Criteria and process

- All Early renewal requests must be requested through CRM. An automated email will be generated from CRM to notify the appropriate Underwriting director or manager for renewal assignment, which will include the following: Group CID number, group name, requested renewal date, and the business reason for exception request.
- Sales director will review request—approved requests will be sent to underwriting director or manager; denied requests will be returned to the account executive. Requests approved by Sales director will be routed to UW Management to review. Approved requests will be processed; denied requests will be returned to the account executive.
- All request must be submitted to CRM for review and approval. Standard requests meeting the below criteria will typically be approved:
  - Days prior to anniversary renewal is being requested:
  - 120 days: All 100+ segments
  - 150 days: All 300+, national, and health/welfare customers
  - 180 days: All 1000+ customers
  - Lead time – request must be received by underwriting:
  - At least 45 days in advance of the due date being requested;
  - At least 45 days prior to the current negotiation date

The criteria listed above does not apply to 1st year renewal of a New to Blue customer. Timing for release of first renewal to New to Blue customers must be approved by Underwriting during the New Business quoting process.

For a detailed overview of this process, please view the Early Renewal Request Process Guide.

Reports and Extracts:

Reporting Available	**The following reports are available to customers online** ▪ **For customers with 100 or more contracts:** – Standard Trend Report which includes the following: ▪ Performance Overview ▪ Claims Enrollment ▪ Demographic Profile ▪ Office Visit Utilization ▪ Top Facilities ▪ Clinical Condition Profile ▪ Impact of High Cost Claimants ▪ **For customers with 250 or more contracts:** – Enhanced Detailed Trend Report ▪ Includes all details of the standard trend report listed above in addition to the following: ▪ Enhanced Impact of High Cost Claimants ▪ Inpatient by condition ▪ Outpatient by service type ▪ Professional by service type ▪ Top Drug Report ▪ Top American Hospital Formulary Service (AHFS) – Supplemental Reports may also be available. Refer to the companion guide for guidance on supplemental reports available based on group size. Companion Guide ▪ **For customers with 500 or more contracts:** – Care Ratio reports are available for groups of 500 or more. – Underwriter review is required prior to releasing a Care Ratio report.
Data extract types available:	– Claims extract reports are available to all self-funded customers, regardless of contract count. – For fully insured customers with an average of 500 or more contracts, limited claims extract reports are available for pharmacy and Flexible spending accounts (FSA) data. – Reconciliation extracts are available for self-funded customers only. – Extract frequency may be on an annual, quarterly, monthly or weekly basis. – Charges and fees will apply for data extracts. Please refer to the proposal for details.
Impacts to reporting due to changes in group size	*Decrease in group size* – If a group falls below 100 contracts, reporting will no longer be available. *Increase in group size* – Enhanced reporting will be available on a go forward basis upon acceptance of an experience rated renewal that reflects 100 or more enrolled contracts.
Change in funding status	– Customers changing funding arrangements will be eligible for applicable reporting on a go forward basis upon acceptance of the renewal reflecting the new funding status.

Other reporting available	–	***Note***: For fully-insured customers, information provided in data extract requests or other reporting will be available at the customer level. Reporting for a subset of customer data (i.e. by group number or product) that falls below 100 contracts is not allowed. For claims extracts, business justification is required for extracts requested on a weekly basis. Also, reconciliation extracts will be on the same frequency as the self-funded invoice. For a detailed list of available reporting for large group, please review the Index Reporting crosswalk via the following link: **Index Reporting for Large group**

Rate quote submission

Documentation required when submitting a rate quote request	**Incomplete submissions may impact our ability to evaluate the group application and provide a competitive proposal. Subject to applicable state and federal laws, Independence reserves the right to pend quote requests. Such a decision will not be based in any way on the medical condition of the group's members. This section is not inclusive of all underwriting requirements; additional requirements may apply.**
Existing business requirements	**The following is required when requesting a quote for 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. ▪ Groups converting from the small or mid-market to the large group market for the purpose of new pricing and benefits, should refer to the new business requirements below. ▪ Groups converting from a self-funded arrangement to a fully insured arrangement, may only convert back to a self-funded arrangement once in a three-year period.
New business requirements	**The following is required when requesting a quote for new business** (including existing business adding new contracts totaling more than 10 percent of existing population): ▪ ***Background information***: – Sales strategy and group/broker expectations – Is prospect a previous Independence customer (if so, provide details) – Name of existing insurance carrier – Current funding arrangement – 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 and rating tier (percentage or dollar value). ▪ ***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 – Enrollment stated for each month of the experience period – Shock claims information (individual claims in excess of $50,000) – Diagnosis and prognosis for excess claims. – Prescription drug claims data to include: – Script count – Break-out by generic, brand and non-formulary, as well as retail and mail order.

New business requirements (continued)

- ***Rate information:***
  - Current and renewal rates (source documents)
  - Historical rate increases for last three-year period
  - Current financial arrangement
  - Broker advisory fee (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)
  - Employees waiving coverage (eligible employees not electing coverage because they are covered under another plan)
  - Employee 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

  Note: Submission of paper waiver forms are not required, but employers should be sure to keep a copy of waiver forms on file for auditing purposes.

- ***Additional required information (where applicable***):
  - Request for proposal (RFP) with all attachments
  - Competing carrier information (if available)
  - Union agreement

- ***Proof of Business documentation*** *(applicable when additional information is needed to prove that a group is an eligible business)*
- The following documentation must be provided for consideration:
  - Business license (not a professional license). If not available, a copy of the partnership agreement, articles of organization, or articles of incorporation; and,
  - Employer identification number/federal tax ID number; and
  - Quarterly Wage and Tax Statement. If not available, when will one be filed; and.

Pharmacy repricing	▪ ***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 – NABP number – (National Association Board of Pharmacy) – Any applicable taxes – Member liability information (co-pays, coinsurance, deductibles), if net plan cost comparison needed

Benefit customization requests:

Online process	▪ Any request to customize standard benefits (e.g., add/exclude/change benefits, or alter visit limits) for PPO, HMO, POS, Rx, Vision and Dental products. ▪ Request can be initiated through ROAM. ▪ All changes associated with a non-standard benefit request should be submitted for review. ▪ If full operational review is required to determine Independence's ability to meet customer requirements, Underwriting will not release a rate quote until operational review is complete and approval is received. ***Note***: Customization must be created using the current large group product portfolio.
NEED MORE HELP?	▪ Questions regarding benefit customization requests should be directed to the appropriate Independence product manager for the customer segment.

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 – Independence reserves the right to re-evaluate rates quoted if final enrolled contracts vary by ten percent, plus or minus.
Guarantee Availability and Renewability	▪ In accordance with federal requirement § 147.104 Guaranteed availability of coverage, Independence offers insurance coverage to individuals and employers, and will accept applications for its products from all individuals and employers in accordance with the ACA, state law, and its Underwriting Guidelines. ▪ In accordance with federal requirement § 147.106 - Guaranteed renewability of coverage, Independence guarantees renewal or continued coverage in its individual or group insurance plan market.

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 Independence. ▪ For self-funded/Cost-Plus groups, Independence/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. ▪ Independence may terminate the group's coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period. ▪ Independence reserves the right to terminate a group's coverage off-anniversary with 30-day advance notice, if the group fails to meet Independence's underwriting guidelines.
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, Medicare Prescription Drug Plans, and Medigap groups) must also be terminated – COBRA-only, retiree-only, or Medicare-only groups are not allowed. ▪ 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. ▪ Independence reserves the right to assess a reinstatement fee to returning groups that have been terminated due to non-payment. ▪ Upon satisfaction of the above conditions, Independence 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. ▪ Unpaid premium balances on groups that are denied reinstatement will be pursued by the Accounts Receivable team – either internally or through a third-party collection agency. ▪ Reinstatements will be in compliance with Patient Protection Affordable Care Act regulations.
Former Independence coverage	▪ Groups that have been terminated for non-payment by Independence and are reapplying for coverage within 12 months will be reviewed for ACA compliance prior to being offered coverage. ▪ Groups returning at any time after voluntarily canceling coverage will be considered new business. ▪ Any unpaid premium balances on returning groups will be pursued by accounts receivable department – either internally or through a third-party collection agency. ▪ Returning groups must be in compliance with the Underwriting guidelines prior to coverage being issued.