# Mid-Market Underwriting Guidelines for Brokers (Groups of 51-99)

## Independence Blue Cross Underwriting Department

*Revised 1/2021*



Independence

# Contents

# Mid-Market Underwriting Guidelines (Groups of 51-99)

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 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

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| **Employer eligibility** | ▪ An employer must employ on average at least 51 **full-time employees, including full-time equivalents (FTEs)** on business days during the preceding calendar year.<br>▪ 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.<br>▪ 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.<br>▪ Group members enrolling in HMO/POS coverage must reside within the Independence service area, except for members covered by an Independence affiliate as indicated below.<br>▪ 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. |
| **Group participation requirements (eligible employees)** | ▪ Minimum 75 percent participation for each worksite.<br>▪ Independence is assumed as the sole carrier; if otherwise, rating adjustments may apply.<br>▪ 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.<br>▪ Group Medicare coverage may be available for Medicare-eligible retirees, please refer to the Independence Medicare guidelines for eligibility, participation requirements and other guidelines.<br>▪ Early retirees (under age 65 retirees not eligible for Medicare) cannot represent more than 10 percent of the total group enrollment.<br>▪ Valid waivers:<br>– Employees with group coverage through Independence subsidiaries, Medicare or Medicaid, Veteran or other government issued coverage;<br>– Employees covered through their spouse; |

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| | – Employees covered as an eligible dependent to age 26, in accordance with federal Patient Protection and Affordable Care Act.<br>***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).<br>▪ 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, where these classes will receive different levels of health care coverage.<br>▪ 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).<br>▪ Excluding a class within a group from coverage is **not** permitted.<br>▪ Existing groups may not split into multiple groups to obtain multiple benefit levels.<br>▪ Qualifier: Subject to the above conditions, Independence will comply with the coverage classifications requested by the employer, **but approval of such request is not a representation by Independence 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. |
| **Employee eligibility** | ▪ Eligible employees include all active employees and owners, or partners actively engaged in the business who:<br>– are deemed benefit-eligible according to the employer; and<br>– meet all requirements as defined in the carrier's plan documents and have fulfilled any authorized waiting period requirements; and<br>– work at least 25 hours per week; and<br>– reside or work in the applicable service area when electing HMO/POS coverage.<br>– In accordance with the PPACA laws, employee probationary periods cannot exceed 90 calendar days.<br>Note: To minimize adverse risk selection, it is recommended that employees work at least 25 hours per week.<br>▪ **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** | ▪ Employee's spouse (if both husband and wife work for the same company, they may enroll together or separately.)<br>▪ 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.<br>▪ At the employer's request, medical coverage for dependent children may be extended to age 30, if the dependent child meets the following criteria (Pennsylvania State Law):<br>– Is not married and has no dependents (need not be a full-time student);<br>– Is a resident of the Commonwealth of PA or enrolled as a full-time student in an institution of higher education; |

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| | – Is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program.<br>▪ 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).<br>▪ 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.<br>▪ Domestic partners may be covered, only if the employer elects this designation at contract effective or renewal date. (See domestic partner coverage criteria below.)<br>▪ 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.<br>▪ Off-cycle additions are permitted with authorization from a Director in Sales and Underwriting.<br>▪ Must be offered by all in-force carriers in order to add to the Independence/KHPE coverage.<br>▪ Must be added to all groups within an affiliation.<br>▪ Must be added to all lines of business; separate group numbers are not permitted.<br>▪ 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 dependent eligibility from age 26 to age 30, etc.<br>▪ 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.)<br>▪ Requests for off-anniversary changes will require Underwriting review and approval.<br>▪ Changes may not be made on a retroactive basis. |
| **COBRA** | ▪ COBRA coverage will be extended in accordance with the federal law.<br>▪ Employers with 20 or more employees (full- or part-time) are eligible to offer COBRA coverage.<br>▪ The number of COBRA enrollees is limited to 10% of the group enrollment.<br>▪ 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. |
| **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).<br>▪ Employers are responsible for determining the employee classification for independent contractors and leased employees.<br>▪ Independence reserves the right to perform periodic audits to assure continued compliance with the above requirement. |

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| **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 all the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below):<br>– For mid-sized 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/large businesses;<br>– 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,<br>– Provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible employees from all entities; and,<br>– Must have common policymaker legally authorized to make benefits decisions for the combined business; and,<br>– Provides letter from employer indicating desire to combine the commonly owned entities.<br>▪ Subject to underwriting review and approval on a case-specific basis.<br>▪ Once common ownership is established and premium rates have been provided, the groups are required to be rated as an affiliation and must accept the premium rates as presented.<br>▪ Common ownership groups may later be separated for group coverage only when based on verifiable legitimate business reasons.<br>▪ 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.<br><br>**Small business is defined as employers with 2-50 employees.*<br>***Large business is defined as employers with 100 or more employees.* |

## Product offerings – groups of 51-99

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

**Benefit plans available:**

- **Product Portfolio**
  - A new 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.
  - A subset of plans within the product portfolio is available to groups of 51-99.
  - Product types include PPO, HSA, DPOS, and POS products, with different levels of cost sharing.
  - Groups will have the flexibility to choose from several drug plan options.

- **Product Rules**
  - New groups must select from the products in the most recent product portfolio.
  - Changes to any existing medical or pharmacy plan designs must be selected from the most recent product portfolio.

  Note: If a group has a pre-2018 plan option(s), a change to any one plan design will require all benefit options to be within the most current product portfolio.

- **Ancillary Products**
  - Keystone Health Plan East Dental and Vision Riders (available only with an Independence or Keystone medical plan)
  - Freestanding Dental Plan (UCCI)
  - IBC Vision Plans Available (see section below).

- **Quoting Policy:**
  - Maximum three total packages to include three medical options with two drug riders and one vision.
  - Employers may not offer same medical plan with different drug, dental and/or vision options.
  - Independence prescription drug benefits (drug riders or integrated drug plans) must be offered with all medical plans.

**Independence Vision Plans**

**Benefit Plans Available**

May be offered on a freestanding basis or as a Keystone Health Plan East rider.

**Freestanding IBC Vision Plan**

- Must be offered alongside a medical plan
- Biennial/ annual benefit options (standard: biennial)

**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**

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| | ▪ A minimum of 10 enrolled contracts is required for voluntary vision.<br>▪ When an employer contributes less than 50 percent, a voluntary plan is required.<br>▪ There are no participation requirements for voluntary vision.<br><br>**Non-Voluntary Vision Guidelines**<br>▪ 70 percent participation is required<br>▪ For contributory plan offerings, the employer must contribute a minimum of 50 percent of the calculated gross monthly premium for each plan offered.<br><br>**Rate Guarantee**<br>▪ 24-month rate guarantee for newly purchased vision coverage.<br>▪ Vision renewals have a 12-month rate guarantee. |
| **Cost Sharing** | ▪ Employers are not permitted to:<br>▪ fund more than 50 percent of all the employee cost sharing (co-pay, coinsurance, deductibles etc.);<br>▪ provide a supplemental benefits plan that augments the core health insurance plan;<br>▪ pay more than 50 percent of all the employee cost sharing through an allowance or claims payment;<br>▪ provide any combination of the above that causes the total amount funded to be greater than 50 percent of all the employee cost sharing. |

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| **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.<br>– |
| **Minimum Value requirements** | ▪ **Definition**: According to the IRS an employer sponsored plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan (considering deductibles, copays and coinsurance) based on federal minimum value calculation.<br>▪ 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 validate that at least one of the customers health plan offerings meets minimum value standards.<br>▪ 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.<br>▪ 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:<br>– All changes must be completed 180 days prior to anniversary.<br>– Limit of one off-anniversary and one on-anniversary downgrade per contract year.<br>– Off anniversary benefit changes must be submitted to Underwriting 90 days (or more) in advance of the benefit change effective date.<br>▪ All requests subject to underwriting approval.<br>▪ Off anniversary upgrades are not permitted.<br>▪ Additional benefits may not be added off anniversary.<br>▪ Additions, terminations or changes to ancillary benefits are not permitted off anniversary.<br><br>**Note**: Changes to one or more of existing plan designs (medical or pharmacy) will require all benefits to be changed to the most current product portfolio |

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| **High deductible health plans (HDHPs), including HSA-qualified HDHPs** | **Definition**:<br>– HDHP – Any plan with an in-network deductible of $500 Single/$1,000 Family or higher<br>– HSA-Qualified HDHP – Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS.<br>**Guidelines for funding deductibles – Employers are not allowed to:**<br>– Fund more than 50% of the employee/family deductible costs to an HRA or HSA;<br>– provide a supplemental benefits plan that augments the core health insurance plan;<br>– pay more than 50 percent of employee/family deductible costs through an allowance or claims payment; or,<br>– provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible.<br>▪ When the HSA-qualified HDHP is offered off-cycle, the full annual deductible will apply to the shortened period; there is no deductible carryover to the next contract year.<br>▪ An HSA-qualified HDHP may be offered along with other products, up to the maximum plan offerings (dual plan options) for the size of group.<br>▪ 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; therefore, if a plan provides any prescription drug benefit before the annual deductible is met (except in the case of preventive drugs), it is not a qualifying HDHP for a Health Savings Account<br>▪ 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.<br>▪ 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.<br>▪ Available to groups of 51-99 enrollees (existing business) or eligible employees (new business).<br>▪ May be offered only:<br>– On group's anniversary date;<br>– with a Flex Deductible medical plan option (prescription drug plan selection will follow high-deductible plan rules);<br>▪ Employer funding to the HRA cannot exceed 50 percent of the annual employee/family deductible.<br>▪ Only one HRA option per customer |
| **Health Spending Account (HSA)** | ▪ Definition: A tax-exempt trust or custodial account created to pay for qualified medical expenses of the employee and their dependents.<br>▪ Available to groups of 51-99 enrollees (existing business) or eligible employees (new business).<br>▪ Available only with a federally qualified high deductible health plan (HDHP) with integrated prescription drug benefit.<br>▪ Employers adding or changing to an HSA-qualified plan with a contract year benefit period may change their anniversary date, which would apply to all products. |

## Rating information

### Prospective rating

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| **Definition** | ▪ Fully-insured, experience rating program<br>▪ Employer pays a fixed premium rate to Independence, and Independence assumes the entire claim risk for the covered services.<br>▪ No surplus/deficit determination |
| **Eligibility for prospective rating methodology** | ▪ An employer must employ on average at least 51 **full-time employees, including full-time equivalents (FTEs)** on business days during the preceding calendar year.<br>▪ Standard rating method for groups of 51 or more based on total number of employees for new business; groups of 51 or more renewing coverage will retain the rating method. |
| **Rate tier structure** | ▪ **New Customers**<br>– A standard four-tiered rating structure is required.<br><br>▪ **Existing Customers (with multiple rate tiers or non-standard rate tiers)**<br>– Rate tiers for customers with multiple tier structures (e.g., four tiers for one benefit and five tiers for another benefit) will be updated to one consistent tier at the time of renewal (rate tiers will be updated to be consistent with the rate tier for the benefit that has the most enrollment).<br>– Existing groups with non-standard tiers may retain their current tier unless there is a change to any of their medical or prescription drug benefits.<br>***Note***: Changes to *any* of the customers medical or prescription drug benefits will require all medical and prescription benefit plans to be updated to a standard four-tiered rating structure. This change will be applied to *all* medical and prescription benefit plans, including groups that have not made a benefit plan change.<br><br>▪ **Tier Ratios**<br>– Tier ratios for new and existing groups must be consistent for all medical, prescription drug, and vision plans offered. |

## Early renewal request process

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| **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.<br>▪ Sales manager 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 manager will be routed to UW Management to review. Approved requests will be processed; denied requests will be returned to the account executive.<br>▪ All request must be submitted to CRM for review and approval. Standard requests meeting the below criteria will typically be approved:<br>– Days prior to anniversary renewal is being requested:<br>– 90 days<br>– Lead time – request must be received by underwriting:<br>– At least 75 days in advance of the due date being requested;<br>– At least 75 days prior to the current negotiation date<br>▪ Early renewal request 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, and requested renewal delivery date.<br>Early renewal requests only apply to the year the request was submitted. To make a change to the renewal delivery date for subsequent years, an official request from the Broker to your Account Executive is required. |

## Reports and Extracts:

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| **Reporting and Extracts Available** | Reporting and claims extracts are not available to mid-sized customers (groups of 51-99).<br>Note: Customers that increase in size to over 100 enrollees will not be eligible for reporting until acceptance of a large group experienced rated renewal. |

## Changes in Group Size

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| **Process for conversions based on group size** | ▪ The employer is responsible for notifying Independence if the employee count has changed from mid-market to small employer, or vice versa.<br>▪ 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 until:<br>– The group requests to be rated as a small employer.<br>– Proof is submitted confirming they no longer have 51+ total commercial employees.<br>▪ 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.<br>▪ Underwriting makes the final determination of groups changing from mid to large or vice versa.<br>▪ Employer groups can only change from small employer to mid-market or vice versa on anniversary date. |

## Affiliation groups (multi-employer affiliations)

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| **Definition and requirements** | ▪ Groups of 51 or more that meet specific requirements, may be eligible to join an affiliation.<br>▪ See Large Group underwriting guidelines for affiliation requirements. |

## Rate quote submission

*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.*

**Documentation required when submitting a rate quote request**

**Existing business – employers with 51-99 employees:**

- Requested plan design
- If adding new contracts totaling more than 10 percent of existing population, refer to "new business group" requirements outlined below.
- Groups converting from the small to the mid-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 – employers with 51 to 99 employees:**

- 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 (source documentation)
- Current renewal, including premium rates (source documentation)
- Three-year rate history (if available)
- Employee contribution 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 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.
- ***Rate information:***
  - Current and renewal rates (source documents)
  - Historical rate increases for last three-year period
  - Current financial arrangement
  - Broker commissions (if applicable)

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| | ▪ ***Detailed census – in spreadsheet format – must include the following:***<br>– Employee name<br>– Date of birth (MM/DD/YYYY)<br>– Current plan design indicator (for example, employee John Doe is enrolled in HMO high option plan)<br>– Zip code of current residence<br>– Employee gender<br>– Coverage status (enrollment by coverage tier)<br>– Employees waiving coverage (eligible employees not electing coverage because they are covered under another plan)<br>– Employee opt outs (eligible employees not electing coverage and who are not covered under another plan)<br>– New hire information: date hired or date eligible for coverage if employees are in a probationary period<br>– COBRA subscribers and expiration date<br><br>***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.<br><br>▪ **Additional required information** (where applicable):<br>– Request for proposal (RFP) with all attachments<br>– Competing carrier information (if available)<br>– Union agreement (if applicable)<br><br>▪ **Proof of Business Documentation** *(applicable when additional information is needed to prove that a group is an eligible business)*<br>The following documentation must be provided for consideration:<br>– Most recent UC2-A or<br>– Business license (not a professional license). If not available, a copy of the partnership agreement, articles of organization, or articles of incorporation; and,<br>– Employer identification number/federal tax ID number; and,<br>– Quarterly Wage and Tax Statement. If not available, when will one be filed; and,<br>– Letter from *Certified Public Accountant (on CPA's letterhead) 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.<br>**The CPA cannot be part of the employer group and the CPA license must be active. A letter from an attorney may be accepted in lieu of the CPA letter. The attorneys license must be active, and the attorney cannot be part of the employer group.* |
| **Situations requiring rate quote submission through Independence account executive** | **Existing business:**<br>▪ A change in anniversary date<br>– Documentation Required: Letter from employer (on customer letterhead)<br>▪ A material change in the census (for example, purchasing a new entity)<br>– Documentation required: Proof of common ownership (see "Common Ownership" rules under Eligibility Requirements section of this document<br>– Requires approval by Underwriting<br><br>**New business:** All new business rate quote requests for employers with 51-99 employees should be submitted through an Independence account executive. |

## Post-sale submission requirements

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| **Post-sale enrollment requirements** | ▪ Rates quoted are conditional pending receipt, review and acceptance of the standard submission requirements.<br>▪ 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. |
| **Documents required with group submission** | ▪ The following documentation must be provided for consideration:<br>▪ Application for New Employer Health Benefits (front and back)<br>▪ Universal Enrollment Forms (one for each employee enrolling)<br>▪ Rate Quote<br>▪ Most recent PA UC2A Form (Unemployment Compensation Tax Form)<br>▪ Employers that do not have/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. Documentation should confirm that the business is active and must include the location of the business.<br>▪ Proof of business (provide one):<br>– Current business license (not a professional license)<br>– Corporate Tax Form (Form 1120)<br>– Partnership agreement, articles of organization or articles of incorporation<br>– Official document with Employer Identification Number/federal tax ID number<br>– Federal Form 990 or IRS Exemption letter (for non-profit entities)<br><br>***AND:***<br>▪ Proof of employment (provide one):<br>– Payroll record (Paychex, ADP, QuickBooks etc.)<br>– W-2 for all employees<br>– Independence Eligibility Form for Owners/Partners completed and signed by each owner/partner (requires tax documentation)<br>– 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.<br>– **The CPA cannot be part of the employer group and the CPA license must be active. A letter from an attorney may be accepted in lieu of the CPA letter. The attorneys license must be active, and the attorney cannot be part of the employer group.* |

## Group terminations and reinstatements

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| **Termination process** | ▪ Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act.<br>▪ Group may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to Independence.<br>▪ Independence may terminate the group's coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period.<br>▪ Independence reserves the right to terminate a group's coverage off-anniversary 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.<br>▪ 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.<br>▪ 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.<br>▪ Reinstatement must occur within 60 days of the effective date of cancellation.<br>▪ Must be retroactive to the cancellation date.<br>▪ Independence reserves the right to assess a reinstatement fee for administrative services.<br>▪ 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.<br>▪ Limit of one reinstatement per year.<br>▪ Unpaid premium balances on groups that are denied reinstatement will be pursued by the Accounts Receivable department, either internally or through a third-party collection agency.<br>▪ 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.<br>▪ Groups returning at any time after voluntarily canceling coverage will be considered new business.<br>▪ Any unpaid premium balances on returning groups will be pursued by Accounts Receivable department; either internally or through a third-party collection agency.<br>▪ Returning groups must be in compliance with the Underwriting guidelines prior to coverage being issued. |
| **Guaranteed Availability and Renewability (Internal Only)** | ▪ 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.<br>▪ 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. |

*Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.*