Large Group Underwriting Guidelines (Groups of 100+)

For Brokers

Independence Blue Cross Underwriting Department

Applies to groups effective or renewing on or after 1/1/2016

This document is for informational purposes only and is 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 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. These guidelines supersede any previously released guidelines.

Independence

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Please note: The guidelines listed in this document are internal policies and 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.

Eligibility and enrollment requirements

Independence/Keystone Health Plan East (KHPE) 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 located within the Greater Philadelphia five-county area, as defined above. ▪ 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 members enrolling in HMO/POS coverage must reside within the Independence service area.
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; in some cases, these employees may be covered under a local area HMO plan, subject to Underwriting approval. ▪ Participation requirements: – At least 75 percent of all eligible employees in each location must enroll in an Independence or subsidiary product. – Out-of-area employees enrolled in a local HMO plan will be excluded from the calculation of the minimum participation level. ▪ Participation audits: Independence reserves the right to perform periodic audits to assure continued compliance with the above requirements. ▪ 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. ▪ Independence and affiliates must be the sole carrier for groups with less than 1000 enrolled (this excludes national accounts) ***Note***: This guideline does not apply to employees of a group that are headquartered outside of the Independence service area. If there is an out of area population, Independence and affiliates must be the sole carrier for the local population only. ▪ Valid waivers: – 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. ▪ For groups covering retirees, 100 percent participation is required for retired employees and the group must consist of a minimum of 75 percent active employees. Retiree-only groups will not be accepted. 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. ▪ 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 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: – 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. – work at least 25 hours per week – In accordance with the PPACA laws, employee probationary periods cannot exceed 90 calendar days. ***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. ▪ Overage handicapped dependent children who, in the judgment of Independence, 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.
Domestic partner (DP) coverage	▪ DP coverage may only be added or removed on group's anniversary date. ▪ 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 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.
Employer eligibility	▪ An employer must employ on average at least 100 **full-time employees, including full-time equivalents (FTEs)** on business days during the preceding calendar 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. ▪ New group applicants not meeting this definition of large group employer are not eligible for coverage under the Large Group programs, but may be eligible for coverage under the Small Employer or the 51-99 Employer programs — refer to the Small Group or the 51-99 Underwriting Guidelines manual. ▪ Organizations must not be formed solely for the purpose of obtaining health coverage.
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): o 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. o One owner has controlling interest (generally greater than 80 percent interest) of all business to be included; ***Note***: In general, there must be at least 80% controlling interest to qualify for common ownership. Independence Underwriting may allow groups with at least 51% controlling interest to be combined contingent upon receipt of documentation verifying common control exists. For combining groups with 51% or greater controlling interest, but less than 80%, each of the groups must be greater than (and maintain) 50 full-time equivalent employees (FTE). – 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 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 employer later elects to cover one or more of its businesses through another carrier, the remainder of the group will be subject to cancellation (upon renewal).

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.
Freestanding prescription drug plans	▪ Group may choose up to two prescription drug plan offerings. ▪ Discount when adding a fully-insured medical or fully-insured Rx plan to form package offering: – Existing business: If group has either medical or prescription drug coverage, but not both, then a two-percent discount will be applied to the in-force fully-insured medical or the in-force fully-insured Rx rates for a combined package offering. – New business: If group has medical and Rx, but not with the same carrier, then a two-percent discount will be applied to the fully-insured medical for a combined package offering. ▪ Surcharge when cancelling either medical or Rx from a package offering: a two percent surcharge will be applied to the remaining fully-insured line of coverage (medical or Rx) upon termination of either the medical or Rx from the package offering. The surcharge will be applied immediately upon termination.
Independence Vision plans	▪ May be offered on a freestanding basis or as a Keystone Health Plan East rider. ▪ A minimum of 10 enrolled contracts is required. ▪ Biennial or annual benefit options (but group may not offer both an annual and biennial plan). ▪ Voluntary and non-voluntary vision benefit plans are available (but group may not offer both a voluntary and non-voluntary plan). ▪ Freestanding vision plans may be offered off-anniversary; upgrades are only permitted on anniversary date. ▪ Freestanding vision plans may be offered to a “carve out” class, subject to Underwriting and Product Management approval.

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. ▪ Examples of mandated benefits and how implemented for Independence health benefit plans: – Autism benefit – Pennsylvania State mandate effective July 1, 2009: 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 Parity benefit – federal mandate effective October 15, 2009: Applied to existing groups with 51 or more enrolled contracts and is required for new/existing groups with 51+ total commercial employees. – Notes: (1) A commercial employee includes any non-Medicare employee, including seasonal and/or part-time employees; (2) Self-funded groups should consult with their legal counsel regarding the applicability of mandated benefits to their group.
Downgrading benefit plans off anniversary date	▪ 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 75days (or more) in advance of the benefit change effective date.
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; 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. 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 additional 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)	▪ An employer funded account used to reimburse employees for qualified medical expenses. ▪ 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)	▪ 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)	▪ 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.
Healthy Lifestyles Solutions	▪ Incentive-based, value-added program allows members to earn points for healthy behaviors and redeem them for gift cards, HRA contributions or HSA funding. ▪ Eligible members include enrolled Keystone/Personal Choice/PPO members and covered spouses and dependents age 18 or older. ▪ Must be implemented on group's anniversary date. ▪ Administrative fee scaled and based on actual enrolled contracts in program. ▪ Employer pays for gift cards (face value of card plus a fulfillment fee).

Defined Contribution Products

Description	▪ For defined contribution products employers contribute a defined amount towards the employees' premium. The employee is responsible to pay the remainder of the premium after the employer contribution. ▪ The defined contribution products are available to fully insured groups of 100 or more enrolled (new and existing business).
Maximum Product Offerings	▪ The defined contribution product portfolio for large groups consists of 5 packages of products (packages A-E). Each package of products consists of 15-20 product options to choose from. ▪ The employer may select a maximum of 5 defined contribution products from one of the defined contribution packages of products. ▪ Benefit exceptions are not allowed for defined contribution products. If an employer elects to offer the maximum number of defined contribution packages, one of the offerings must be a PPO option. Group offerings may not exceed five packages, including a PPO for out-of-area enrollment.
Product Guidelines	▪ Defined contribution products must be purchased with prescription drug coverage offered with the selected medical package. Some defined contribution products may include integrated RX coverage. ▪ Employers may not offer the same defined contribution medical product with different drug. ▪ Defined contribution products cannot be combined with coverage options from non-defined contribution products.
Participation Requirements	A minimum of 75 percent participation is required.
Employer Contribution	For contributory plan offerings, employers must contribute a minimum of 25 percent of the lowest cost option's gross monthly premium or 75 percent of the single tier rate of the lowest cost option offered.
Rate Tiers	A four-tiered standard rating structure is required.
Dental and Vision	▪ If an employer elects to offer vision and/or dental coverage with defined contribution products, vision and/or dental must be offered with all defined contribution products offered by the employer. ▪ Employers may select from multiple group sponsored (non-voluntary) or voluntary PPO vision options to offer to their employees. ▪ Dependent enrollment in a defined contribution voluntary vision plan is not contingent upon the dependent enrolling in the defined contribution medical coverage. Dependents may enroll in voluntary vision plans even if they elect to waive the medical coverage. ***Note:*** The employee must be enrolled in the voluntary vision plan in order for the dependent to be eligible for enrollment in the voluntary vision plan. ▪ Employers may select from the one dental HMO and multiple dental PPO Group Sponsored and Voluntary dental options available for their employees*. **Multiple PPO dental options are not allowed. Limit one PPO dental option per customer* The following dental product combinations are available with defined contribution packages:

Group Sponsored (non-voluntary) Dental	Voluntary Dental
The one HMO dental option for all packages	The one HMO dental option and one of the PPO dental options for all the packages
One of the PPO dental options for all packages*	
The one HMO dental option and one of the PPO dental options for all the packages	

**Multiple PPO dental options are not allowed. Limit one PPO dental option per customer.*

Off-Cycle Benefit Changes	Upgrades and downgrades to defined contribution products will be allowed only on anniversary.

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 100 or more: – Based on total number of employees for new business; – Renewing groups will retain their current rating method.
Rate Tier Structure	▪ Rate tiers and tier ratios must be consistent for all medical and prescription drug plans offered.

Risk share retrospective funding (effective July 1, 2012)

Description	▪ Fully-insured arrangement ▪ Claims risk is shared by the employer and carrier; the employer pays a fixed premium during the contract year. ▪ A financial settlement is completed after each annual contract period to determine the premium payable based on the terms of the funding arrangement. Customers may elect either: – to receive a payment for surpluses or make a payment for any deficits; or, – set up a premium stabilization reserve account that may carry forward surpluses and deficits (see premium stabilization reserve account guidelines below). ▪ A retrospective rating charge is assessed, which is the risk charge applicable to this rating arrangement. ▪ Contingency premium arrangement may be utilized, with underwriting approval (see contingency premium section for details). ▪ Applicable only to HMO, PPO, and Rx lines of business ▪ Independence must be the sole carrier of medical benefits for the customer
Eligibility for retrospective funding Arrangements	▪ Available retrospective funding arrangements – eligibility based on actual enrolled contracts for both new business and existing business: – **+/- 5% risk share retrospective funding:** – Claims risk share is inside a 95-105 percent corridor. – Available for new and renewal customers with 250 or more contracts. – **+/- 10% risk share retrospective funding:** – Claims risk share is inside a 90-110 percent corridor. – Available for new and renewing customers with 250 or more contracts. – **Outside corridor risk share retrospective funding** – Claims risk share is outside a 95-105 percent corridor. – Available for new and renewing customers with 1,000 or more contracts. – **Standard risk retrospective funding** – 100 percent claims risk share. – Available for new and renewing customers with 1,000 or more contracts. ▪ Groups cannot combine different funding arrangements except in the case of a self-funded Rx alongside a retrospectively rated HMO/PPO. ▪ Claims experience is an aggregation of HMO, PPO and Rx (if applicable) lines of business rated under the retrospective risk share arrangement over the contract year.

	▪ Customers are subject to initial and ongoing credit risk checks. ▪ Existing customers must have a history of timely payment of all monies due Independence.
Employers changing funding arrangements	▪ Customers may only change to a different funding arrangement once in a three-year period. ▪ Customers with an existing risk-share retrospective funding arrangement (for example, a +/- 10 percent risk share arrangement) may only change to an alternate risk-share retrospective funding arrangement to decrease their risk exposure (for example a +/- 5 percent risk share arrangement) once in a three year period. ▪ Customers with an existing risk-share retrospective funding arrangement may change to an alternate retrospective funding arrangement that increases the risk exposure annually, upon the policy renewal date. ▪ All changes in funding arrangements must be made via written notice to Independence at least 90 days prior to the affected policy renewal date. No retroactive funding changes. ▪ Groups will be reviewed at time of their annual rate renewal to make sure they continue to meet the minimum enrollment requirements for the retrospective risk share arrangement. Groups that no longer qualify will be removed from this financial arrangement. The process for transitioning these groups to another rating arrangement will be determined by Underwriting on a customer-specific basis.
Financial settlement provisions	▪ Definition: At the end of each contract period, the actual claims expense is compared with expected claims expense. Actual claims expense at the end of the contract period is calculated as explained in the contract. The variance between the expected claims expense and the actual claims is then subject to the terms of payment, including either immediate payment of any outstanding premium balances by either party or application of the difference to the Premium Stabilization Reserve Account, as described below. ▪ Prepared within 180 days after completion of the run out period, using the appropriate claims paid-through dates, and the completion and pooling factors as specified in the contract. ▪ Surplus and deficit recovery rules: – Cross-application of deficits and surplus apply to common retrospectively funded lines of business (i.e., Medical and Rx). – If a premium stabilization reserve (PSR) account is not utilized, payment of a surplus or deficit is due within 30 days of the date of issuance of the settlement. – If a PSR account is utilized, surplus funds must be used to offset previous years' deficits, or current contract year deficits must be offset by an existing surplus fund balance. ▪ Deficit carry forward rules - see Premium Stabilization Reserve Account (below). ▪ Handling of existing groups rated under a retrospective arrangement prior to July 2012: – These groups will be phased in to the risk-share retrospective funding arrangement on their next anniversary commencing on or after July 2012. – The process for transitioning these groups to the risk-share retrospective funding arrangement, including the application of the final financial settlement under the retrospective arrangement, will be determined by Underwriting on a customer-specific basis.

Premium Stabilization Reserve Account (PSR)	▪ Definition: Monetary funds that are maintained by the insurance carrier (Independence) under a group insurance contract. ▪ Funds may only be used for the purpose of paying medical claims for covered beneficiaries of the plan in accordance with applicable laws and regulations. ▪ Notice to Independence of participation is required at least 60 days prior to the first applicable policy period. ▪ A three-year commitment is required, unless the customer is moving to a self-funded arrangement with Independence. ▪ Surplus funds must be used to offset previous years' deficits, or current contract year deficits must be offset by an existing surplus fund balance. ▪ The following PSR account balance limits and requirements apply: – If the PSR account **surplus** balance: – Exceeds 5 percent of the annual premium in the current contract year, up to 50 percent of surplus funds but no more than 7.5 percent of estimated annual premium in the affected future contract year may be used as a pre-payment and offset against future policy period premiums provided Independence receives 45 days written notice prior to the affected contract period. No interest credit applies. – Exceeds 25 percent of the projected annual premium in the current contract year as calculated during the annual settlement, Independence will provide a refund for the estimated amount in excess of the 25 percent within 30 days of the issuance date of the settlement. No interest credit applies. – If the cumulative PSR account **deficit** balance: – Exceeds 15 percent of the projected annual premium in the current contract year, Independence may apply an upward adjustment to future contract periods premiums of up to 3 percent of billed premium. If the upward adjustment to billed premium generates a surplus, then the group will be entitled to an interest credit on the surplus funds. – Exceeds 25 percent of the projected annual premium in the current contract year, Independence will be obligated to apply an upward adjustment of up to 3 percent but not more than 7.5 percent of billed premium. If the upward adjustment to billed premium generates a surplus, then the group will be entitled to an interest credit on the surplus funds. ▪ In the event of termination from the risk-share retrospective funding arrangement for any reason (on or off anniversary), the following provisions will apply: – Cumulative surplus will be refunded and cumulative deficits are due within 30 days of the issuance date of the final settlement. – Independence and the customer are subject to interest penalties for respective balances not paid within 30 days of the issuance date of the final settlement. ▪ No interest will be credited or charged for surpluses or deficits held in the PSR account while the customer is actively participating in the retrospective arrangement.

Contingency premium arrangement

Overview	▪ Definition: A funding mechanism that gives the group an opportunity to effectively manage its cash flow by allowing it to pay a percentage (plus or minus) of the premium during the contract year. ▪ Requests for this arrangement require Underwriting approval. ▪ Two types of contingency premium arrangements available: – Discounted contingency premium arrangement – Premium-plus contingency premium arrangement ▪ Available only in conjunction with a risk-share retrospective funding arrangement.
Discounted contingency premium arrangement	▪ Definition: This arrangement allows the group to pay a percentage of the premium less than the required premium during the contract year, providing the group with a cash-flow advantage. ▪ Group must have a minimum of 250 enrolled contracts in the coverage being considered for this contingency premium arrangement. ▪ Available only in conjunction with a risk-share retrospective funding arrangement. ▪ The percentage amount of the contingency premium withheld is limited to the lower end of the risk share corridor for the chosen option. ▪ Only offered in contract years when there is no outstanding cumulative deficit, and an evaluation of the loss ratio and/or preliminary settlement data for the most recent period do not indicate a deficit position. ▪ At time of settlement, premium withheld will be recalled to degree needed (up to 100 percent of the full premium rate) to offset a current or cumulative deficit position. ▪ An interest charge will be assessed on any deferred premium recalled at time of issuance of financial settlement.
Premium-plus contingency premium arrangement	▪ Definition: This arrangement allows the group to pay a percentage of the premium greater than the required premium during the contract year, providing the group with an opportunity to manage their cash-flow position and earn an interest credit. ▪ Group must have a minimum of 250 enrolled contracts in the coverage being considered for this contingency premium arrangement. ▪ Available only in conjunction with a risk-share retrospective funding arrangement. ▪ The percentage amount of the contingency premium prepaid is limited to the upper end of the risk share corridor for the chosen option. ▪ At time of financial settlement, an interest credit will be applied to any surplus monies generated by the upward adjustment to the premium.

Affiliation groups (multi-employer affiliations)

Definition and requirements	▪ Two or more groups combining for experience-rating purposes: – 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, with 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. ▪ Affiliations must establish an affiliation trust account in order to participate in a risk-share retrospective funding arrangement. ▪ 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 10 percent of the total affiliation contracts, or upon a 10 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 10 percent of the total affiliation contracts, or upon a 10 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 and must have the approval of 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 on 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. ▪ **Effect on financial settlements:** When the affiliation is on a retrospective funding arrangement and the group leaving: – **Secures coverage through another carrier** (on or off-anniversary):

	– The group forfeits all rights to any surplus. – The group's premiums and claims will be included in the overall affiliation settlement, and any surplus attributable to the group's experience will be applied to the affiliation. – The group will be liable for its share of any deficit from the current and all preceding contract periods. – **Enters into a retrospective funding arrangement with Independence:** – The group will carry forward to their new individual contract their allocated share of any accrued surplus or deficit from previous affiliation settlements, including the last contract period in which they were part of the affiliation, and the net balance from the final settlement will be handled as follows: ▪ If the group elects a Premium Stabilization Reserve Account (PSR), the final settlement balance will become the opening balance of their individual PSR account; ▪ If a PSR account is not utilized, the final settlement balance will be due and payable by applicable party within 30 days after the settlement is completed. – **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.
Financial Settlement – Surpluses and Deficits	▪ The financial settlement is completed on an overall affiliation basis only, with no group-specific accounting. – **When the overall affiliation settlement results in a surplus position:** The surplus will be apportioned to each of the participating groups based on a pro-rated premium allocation, to be distributed and/or allocated to the PSR by the affiliation trust account. – **When the overall affiliation settlement results in a deficit position:** The deficit will be apportioned to each of the participating groups based on a pro-rated premium allocation, to be invoiced and/or allocated to the PSR by the affiliation trust account. – **Affiliations with a contingency premium arrangement:** Refer to the contingency premium arrangement section of the guidelines.

Experience rating programs – self-funded/self-insured

Cost-Plus

Overview	▪ Group assumes all risks for the cost of the program. ▪ No risk charge included in the retention. ▪ 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 retention fee. ▪ Payment method: Claims reimbursement -group is billed based on claims plus retention and broker commission (if applicable). – Billing frequency options available to the group: – Weekly – Monthly (requires Underwriting approval) – this option may require a greater upfront advance deposit. ▪ Financial settlement: – Independence HMO/POS/QCC/HBS (Highmark Blue Shield): a financial reconciliation is made within 180 days following the end of the contract period—surplus monies are refunded to the group and deficits are due and payable by the group unless there are outstanding balances owed. ▪ Upfront financial requirements: – Reserve requirements may be satisfied by cash, escrow or a BLOC. – Advance deposit required – amount will be reviewed upon renewal or if there is a significant shift in enrollment (10% or greater). – Bank letter of credit (BLOC) also required if group elects to hold its own reserves for claims incurred but not reported – BLOC should be for an 18-month period 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. ▪ Financial agreement requirement: – Group will be required to sign a financial agreement outlining the basic terms of the cost-plus rating arrangement. – Account executive should notify the group underwriter at time of sale so that this agreement can be prepared. ▪ Stop-loss reporting may be subject to additional administrative reporting fees. 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. ▪ 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.
Employer Eligibility	▪ Minimum Size Requirements: – Groups with managed care programs: 300 or more total eligible 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).

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. • Customers that purchase stop-loss coverage through Independence's stop-loss carrier may receive a premium 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. ▪ HIPAA regulations require legal agreements to be signed by account and stop-loss carrier before claims information can be released.

Early renewal request process

Pre-approved thresholds

- Criteria below are pre-approved and can be submitted directly to Underwriting for processing:
  - 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
- Early renewal request must be e-mailed to the appropriate Underwriting director or manager for renewal assignment, to include: Group CID number, group name, and requested renewal delivery date.

Note: 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 to your Account Executive is required.

Requests not meeting pre-approved criteria

- Early renewal request must be e-mailed by the account executive to his or her sales director to request an exception, to include: 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.

Reports and Extracts:

Reporting Available

The following reports are available to customers online

- **For customers with 100 or more contracts:**
  - Standard Trend Report (Blue Info Report)
- **For customers with 250 or more contracts:**
  - Enhanced Detailed Trend Report (Enhanced Blue Info Report)
  - Supplemental Reports (capitation report etc.)
- **For customers with 500 or more contracts:**
  - Financial Summary Reports
  - Claims extract reports to include all medical lines of business, pharmacy and Flexible spending accounts (FSA) data are available to fully insured groups with an average of 500 or more contracts over the prior 12 month period.
  - Claims extract reports are available to all self-funded customer, regardless of contract count.
- **Data Extract types available:**
  - Comprehensive analytical extract (full-file)
  - Reconciliation extracts (for self-funded customers only)
  - Extract frequency may be on an annual, quarterly, monthly or weekly basis.

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. The reports listed above are available to all funding types (unless stated otherwise). 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.

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:

- Requested plan design;
- Marketing strategy and group/broker expectations (if applicable);
- Note: If adding new contracts totaling more than 10 percent of existing population, refer to "new business group" requirements outlined below.

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

- ***Background information***:
  - Marketing strategy and group/broker expectations (if applicable)
  - Is prospect a previous Independence customer (if so, provide details)
  - Name of existing insurance carrier
  - Broker and/or consultant information
  - Five-year carrier history
  - Length of time with current carrier
  - Summary of current plan design and detailed current benefit description (source documentation)
  - Employee contribution schedule by plan design 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
- ***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)
- Waivers – eligible employees not electing coverage because they are covered under another plan
- Opt-outs – eligible employees not electing coverage and who are not covered under another plan
- New hire information: date hired or date eligible for coverage if employees are in a probationary period
- COBRA subscribers and expiration date

- ***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,
  - Letter from Certified Public Accountant listing the names of all employees (full- and part-time), number of hours worked each week, dates of hire, weekly salary, and confirmation of establishment of payroll records.

- ***Information needed to reprice prescription drug claims:*** (to provide comparison between gross cost with current PBM versus estimated cost with Futurescripts)
  - Twelve months of claims data, if available (minimum of three months), to include:
    - Eleven-digit NDC
    - Fill date
    - Mail/retail indicator
    - Brand/generic indicator
    - Quantity dispensed
    - Ingredient cost
    - Dispensing fees
    - Any applicable taxes
    - Member liability information (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.
Paper process	▪ Any request for custom non-standard benefits (e.g., cost sharing changes, add/exclude benefits, alter visit limits) for traditional Independence hospitalization, Highmark Blue Shield medical/surgical, major medical and/or CMM products. ▪ Requests must be submitted via paper form. ▪ Requires full operational review to determine Plans' ability to meet customer requirements.
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.

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-insured/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, including but not limited to minimum participation requirements.
Terms and conditions upon termination of coverage	▪ The group is responsible for all due but unpaid premiums and any accrued deficits. ▪ Payment of Deficits: Any historical deficits are due and payable at time of termination; any deficit from the current policy period is due and payable at point of final financial settlement. ▪ When active group is terminated, all COBRA groups, retiree groups, and Medicare groups (including Medicare Advantage groups) must also be terminated – COBRA-only, retiree-only, or Medicare-only groups are not allowed. ▪ Groups terminating to purchase individual coverage will not be eligible for group coverage for 12 months from the date of termination of the group coverage. ▪ 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.
	▪ Groups that have been terminated for non-payment by Independence will not be eligible to reapply until: (1) All outstanding financial balances are paid in full; and (2) the group makes payment of six months of premium in advance of issuance of health benefits plan. Prior Independence Medical claims information (medical loss ratio) subject to review along with information provided on the employee application and included in the overall assessment of the group.
	▪ For former Independence groups reapplying for coverage, determination of group status will be based on the following criteria:
	  ○ Groups returning within 12 months of termination will be deemed "renewal" business;
	  ○ Groups returning more than 12 months following termination will be deemed "new business."
	▪ 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.