Independence Blue Cross Underwriting Guidelines Manual

This document is for information purposes only and is not intended to be all inclusive. Independence Blue Cross (IBC) reserves the right to change these underwriting guidelines without notice as IBC, 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. IBC has the sole discretion and final authority to interpret the scope and application of the underwriting guidelines.

Independence Blue Cross

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Note: Independence Blue Cross has the final authority to interpret the scope and application of the underwriting guidelines.

Independence Blue Cross (IBC) is the region's leading health insurer with nearly 3.1 million members in the Philadelphia area. For more than 70 years, IBC has offered quality health care products and services designed to meet the changing health care needs of our customers.

At a time when employers are forced to pass more of today's rising health care costs on to their employees, our programs can provide effective cost-sharing alternatives to help alleviate the pressure of rising costs. Our unique packaging of health benefits allows you and your customers to choose a plan that delivers the coverage they need, at a price they can afford, from the name they know and trust.

Personal Choice® (PPO) — Rated the No. 1 PPO in the region by a leading consumer publication, Personal Choice members may receive care from any doctor without a referral. Members maximize their benefits by obtaining care through our expansive network of more than 60,000 doctors and 100 hospitals. Plus, members have in-network coverage coast-to-coast through Blue Card®PPO, one of the largest provider networks in the United States, with more than 750,000 participating physicians and more than 5,000 hospitals.

Keystone Health Plan East (HMO) —Rated the No. 1 HMO in the region by a leading consumer publication, our HMO provides members with a full range of benefits. HMO members' medical needs are coordinated by their primary care physicians (PCPs), who provide electronic referrals for specialty care. With a network of more than 64,000 physicians and 100 hospitals, Keystone HMO is easy to use and cost-effective. Members have emergency care coverage anytime, anywhere, and the guest membership program provides temporary benefits for students and travelers out of the area.

Keystone Direct POS (DPOS) is a quality, cost-effective managed care benefits program. What's unique about Keystone Direct POS is that while members must select primary care physicians, they may use virtually all health care services in or out of the network without a referral. Referrals are required only for routine X-rays, podiatry, spinal manipulation, and physical/occupational therapy.

Blue Solutions® is IBC's new suite of products for customers with up to 99 employees. The Blue Solutions portfolio is based on our most popular products and provides customers with comprehensive coverage, including doctor visits, hospital admissions, emergency room treatments, maternity care, lab tests, X-rays, and more. Plus, Blue Solutions products comply with health care reform, including coverage for designated preventive services from in network providers at 100 percent, coverage for dependent children to age 26, and the elimination of annual or lifetime maximums on essential services.

ibxpress.com is IBC's secure online portal that allows group administrators or business owners to safely and conveniently manage their group's account. With ibxpress℠, many tasks can be completed quickly and easily, and all transactions are secure.

As a member, ibxpress is a powerful tool for health and wellness information. In collaboration with WebMD®, an independent company, known as one of the most recognized sources for health information, ibxpress provides tools targeted for specific health situations and helps members better manage physician visits, monitor prescription drugs they use, easily find a doctor or hospital equipped for their needs, learn more about the risks and benefits of various health decisions, and use interactive applications to improve their health.

Connections℠ Health Management Programs are designed to help members become better informed health care consumers. Members with chronic conditions such as diabetes, lung or breathing problems, or heart conditions can learn how to improve their health and overall quality of life. In addition, Connections supports members who are facing a significant medical decision as well as members who have everyday health concerns.

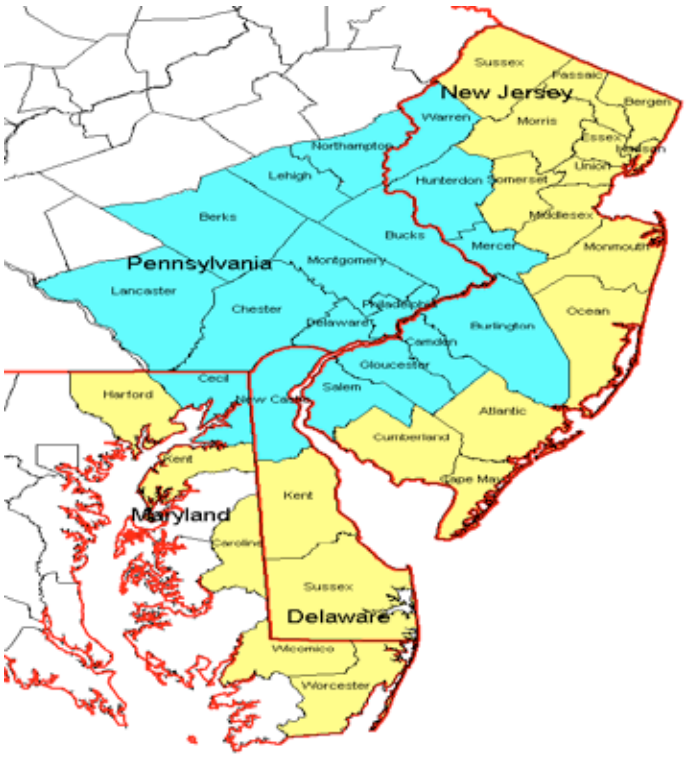
We're here for you every step of the way.

Section 1 — Eligibility

In the application of the general principles of health insurance to our specific company criteria and policies, the Independence Blue Cross (IBC) Underwriting Guidelines require that certain conditions be met before considering a group for coverage.

IBC/Keystone Health Plan East service area

The IBC/Keystone Health Plan East service area includes the Greater Philadelphia five counties of Philadelphia, Montgomery, Bucks, Chester, and Delaware and the respective contiguous counties that border the five counties. Those contiguous counties are: Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil. (Note: A group must have its corporate headquarters or an entity located in the Greater Philadelphia five-county area). In view of Blue Cross and Blue Shield Association requirements, if a local group's members live in noncontiguous counties and have HMO/POS coverage, those members must be covered under and issued booklets by an affiliate of IBC.



Excluded classes

Classes of employees excluded for coverage by the employer will not be counted in determining participation requirements.

Section 1 — Eligibility (continued)

Participation requirements

For groups of fewer than twenty subscribers, all eligible subscribers must be enrolled. For groups of twenty or more subscribers, the minimum participation is 75 percent of eligible subscribers. Credit will be given for those eligible subscribers who opt out because they have coverage elsewhere with subsidiaries of IBC or through Medicaid, or who are covered through their spouse. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 100 percent participation requirement.

For groups of 2 – 9 eligible contracts, IBC requires full participation to assure an equitable spread of risk across the population. Failure to do so may give rise to an adverse experience situation whereby only those who are sick will choose to enroll.

To ascertain whether IBC will be willing to accept a given group for coverage, it is necessary to determine the total number of eligible employees and calculate the percentage of the total group that will be receiving insurance through IBC. This stipulation is in place to restrict the funneling of "high-risk" cases to IBC while diverting a "low-risk" population to another carrier — resulting in an adverse experience situation for IBC. When determining the number of eligible employees, it is necessary to deduct those individuals who have coverage through a spouse or other employer.

Eligible employees

All individuals who are active employees, including an owner or partner actively engaged in the business, are eligible to apply for coverage provided they have fulfilled the waiting periods. Contractors, 1099s, owners and shareholders or members of boards of directors who are not active, permanent, full-time employees of the group are not eligible for coverage. An *eligible employee* is defined as someone who:

- is benefit-eligible according to the employer;
- meets all requirements as defined in each carrier's plan document;
- resides or works in the HMO's defined service area (for HMO products);
- works at least 25 hours per week.

IBC considers all active employees as eligible for coverage and uses this number as the basis for determining participation criteria. An enrolled contract is defined as an eligible employee who has coverage in force within a particular line of business within IBC and its subsidiaries (including IBC non-group coverage).

Eligible dependents (including domestic partners)

Only the spouse (married or common-law), the natural or adopted children of the employee or the employee's spouse, or those children legally placed in the employee's home for purposes of adoption will be recognized as belonging to the regular class of eligible dependents. In addition, the Pennsylvania Insurance Department has approved IBC allowing groups to add coverage for unmarried opposite-sex and same-sex "domestic partners." This does not apply to our non-group (individual or Medicare) business. Domestic partners would continue to be enrolled separately under our non-group products. Domestic partner coverage may only be added on the anniversary of the policy.

Section 1 — Eligibility (continued)

Overage dependent standards

Coverage is available for dependent children and young adults up to age 26.

Handicapped dependents

Unmarried dependent children age 26 or older who, in the judgment of IBC, are incapable of self-support due to mental or physical incapacitation, may continue group coverage. These dependents must be supported continuously by the employee-subscriber, and the rate paid must include such dependents. Coverage of the dependent child will terminate upon marriage of the dependent.

Common ownership

The definition of ownership is a single person or business entity having greater than 50 percent (controlling majority) interest in a business, subject to verification.

Multiple businesses may be combined as a common ownership affiliation based on the following requirements:

- Under the combined arrangement, the group must also have a common policymaker who is legally authorized to make benefits/human resources decisions for the combined businesses.
- The group must be able to provide verifiable proof of ownership to support the common ownership of the businesses (i.e., tax/legal documentation). Combined arrangements will not be quoted until proof of common ownership is supplied.
- Existing groups wishing to add other businesses under a common ownership arrangement are also subject to the above requirements (e.g., newly acquired companies, mergers, or businesses that were previously enrolled through another carrier). Changes of this nature are subject to review and approval for participation and rate adequacy.
- Groups electing to combine their businesses under a common ownership arrangement do not have the option of breaking the group apart at a later date to obtain more favorable rates. If the group later elects to cover one or more of its businesses through another carrier, the remainder of the group will be subject to cancellation.
- Common ownership groups may be separated for group coverage based on verifiable legitimate business reasons (e.g., one of the businesses was sold, etc.).

Section 1 — Eligibility (continued)

Eligibility and COBRA

The federal government recognized the need to create legislation that assured the continuation of health insurance coverage to individuals who had lost benefits through work-related or life-change events.

As a result, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) was enacted. COBRA extends the eligibility provisions for coverage under group health insurance plans to include qualified beneficiaries. Qualified beneficiaries include the spouse and dependent children of the covered employee and — in the case of a reduction in hours, layoff, or termination of employment — the covered employee. Generally, the company must have 20 or more full- and/or part-time employees to be required to offer COBRA continuation coverage to qualified beneficiaries. These qualified beneficiaries must be permitted to elect continued coverage under a group's health plan. Should these individuals elect continued coverage, they may be — and, most often, are — responsible for reimbursing the group for premium payments (although usually these payments are substantially less than the price of similar benefits outside the group coverage). These qualified beneficiaries include:

- widowed spouses and dependent children;
- employees (and their spouses and dependent children) who have been terminated from employment — either voluntarily or involuntarily[1] — or who have experienced a reduction in hours that places them below a group's eligibility threshold;
- divorced or separated spouses and their dependent children;
- Medicare-ineligible spouses (that is, an individual and his or her eligible dependents whose coverage terminated because his or her spouse became eligible for Medicare);
- dependent children no longer meeting the plan's definition of a dependent child (for example, an overage dependent or a dependent who no longer qualifies as a full-time student).

Upon the occurrence of a "COBRA qualifying event" — such as termination of employment, death of a covered employee, reduction in employment hours, divorce/legal separation, Medicare eligibility, etc. — the qualified beneficiary is entitled to continue coverage for up to either 18 or 36 months. If the loss of health coverage is due to reduction in work hours, retirement, voluntary resignation, layoff, or employment termination other than for gross misconduct, 18 months applies. If the loss of health coverage is due to the death of a covered employee, divorce or legal separation, a dependent child ceasing to be a dependent, or a covered employee becoming entitled to Medicare, 36 months applies. In return for providing these extended benefits, the employer may charge the individual a maximum 2 percent administration fee above the actual premium rate charged to the group to partially compensate for the additional administrative work involved with keeping this individual under the group coverage.

[1]The exception to this stipulation would be those individuals who have been terminated for gross misconduct.

Section 2 — Types of rating and rating components

IBC determines rates using several types of rating mechanisms. They are: community rating, adjusted community rating, risk-adjusted rating, experience rating (including prospective, retrospective, and group-specific), and types of self-funding, including Cost-Plus.

Types of rating

Community (or pooled) rating. *Pure community rating* is the development of rates so that all subscribers pay the same rate for the same level of benefits. Small groups are not individually underwritten but are given the opportunity to purchase products that blend the experience of many small groups to achieve a reasonable amount of credibility. The total anticipated costs are spread evenly over all contracts — all contracts with the same family status and benefits pay the same rate.

Adjusted community rating. The rating methodology for Personal Choice®, Keystone Health Plan East, and Drug Rider groups of 2 - 50 contracts is adjusted community rating. For new groups, the determination for *adjusted community rating* is based on eligible contracts; for existing groups, determination is based on enrolled contracts. Under adjusted community rating methodology, community-based rates are *adjusted* for factors such as age, gender, area, group size, and health status (applicable to renewal only) and are applied through the application of a "final classification *factor.*"

Risk-adjusted rating. The rating methodology for Personal Choice and Keystone Health Plan East and Drug Rider groups of 51 - 99 contracts is risk-adjusted rating. For new groups, the determination is based on total number of eligible enrollees; for existing groups, it is based on total enrollment in managed care programs (Personal Choice, Keystone HMO and/or Keystone POS). Under this rating arrangement, rates are based on the customer's combined demographic makeup (age, gender, location, and group size), along with a risk adjustment.

Experience rating. Experience rating uses each group's own historical experience multiplied by a trend factor to estimate the claims that will be incurred during a future rating period. This new rating period is, most often, one year. The trend factor takes into account anticipated increased benefits costs (inflation) and increased incidence of care (utilization). In addition, for PPO and HMO, because groups with fewer than 500 contracts cannot generate claims experience that is fully credible, a credibility adjustment may be applied. The credibility threshold may be different for the other product lines.

These calculations (with the addition of retention dollars and, if necessary, broker commissions) derive the *required income* amount for the group. This required income level is compared to the *premium at the latest rate level* (or *income at current rates*) to determine the rate change (or *rate multiplier*) that is necessary.

Section 2 — Types of rating and rating components (continued)

Lines of coverage	Community[1]	Adjusted community[2]	Risk-adjusted rating[2]	Experience
Traditional hospitalization	2 – 50 enrolled	n/a	n/a	51+ enrolled
Traditional medical/surgical	2 – 50 eligibles	n/a	n/a	51+ eligibles
Traditional major medical	2 – 99 enrolled	n/a	n/a	100+ enrolled
CompSelect®	n/a	n/a	n/a	51+ enrolled
Freestanding prescription drug	n/a	n/a	n/a	100+ enrolled
Personal Choice®	n/a	2 – 50 enrolled	51 - 99 enrolled	100+ enrolled
Personal Choice Rx rider	n/a	2 – 50 enrolled	51 - 99 enrolled	100+ enrolled
Keystone Health Plan East HMO/POS	n/a	2 – 50 enrolled	51 - 99 enrolled	100+ enrolled
Keystone Health Plan East Rx, dental, and vision riders	n/a	2 – 50 enrolled	51 - 99 enrolled	100+ enrolled
Freestanding dental (UCCI)	2 – 49 enrolled	n/a	n/a	50+ enrolled
Freestanding IBC Vision	2 – 99 enrolled	n/a	n/a	100+ enrolled
All national account coverages	n/a	n/a	n/a	1,000+ total enrolled in medical lines

[1]Required enrollment is by product.
[2]Required enrollment is based on total managed care plan enrollment (PPO, HMO, POS).

Types of experience rating

- **Prospective rating**. Under this arrangement, the entire risk is assumed by the carrier. The group pays a fixed rate for the entire contract period and there is no after-the-fact financial settlement between carrier and group. Once the rate has been established via the rating formula, the group is obligated to pay that level amount throughout the rating period, and the carrier is obligated to pay all claims covered under the terms of contract. Neither party has recourse to collect surpluses or deficits from the other party; surpluses are not returned to the group, and deficits are not loaded into the renewal rates or billed to the group.

Section 2 — Types of rating and rating components (continued)

- **Retrospective funding.** Unlike prospective rating, under this arrangement, a financial settlement is made after each contract period (normally, one year), at which time a surplus (excess premium funds over incurred claims plus retention and broker commissions) may be returned by the carrier to the group. Any year-end deficit (where claims plus retention plus broker commissions exceeds premium) is carried forward one or more years for possible recovery from future surpluses. For retrospectively funded local groups, Personal Choice, Blue Cross® Hospitalization, CMM, and prescription drug deficits are carried forward for one year for possible recovery. For national Blue Cross groups and local and national lines of Blue Shield® and Major Medical, deficits are carried forward indefinitely for possible recovery. Keystone Health Plan East lines of business are not eligible for retrospective rating.
- **Cost-plus/self-funded/self-insured.** Allowable for groups with 300 or more enrolled contracts. Cost-plus is a rating arrangement (not an alternative funding arrangement) that shifts the burden of financial risk (payment obligations) from the carrier to the group itself. The group is responsible for payment of claims plus retention fee. Under a cost-plus arrangement, a financial settlement is normally calculated after each contract period, at which time any surplus is returned to the group and any deficit is due and payable to the carrier. The billing under a cost-plus arrangement can be based either on a predetermined rate (rate basis) or on the actual claims of the group (claims reimbursement basis). An IBC group under a cost-plus arrangement may or may not have state-mandated benefits and/or hold its own claim reserves.

Section 3 — Alternative funding arrangements

Cost-plus payment method

Claims reimbursement

- Under the claims reimbursement arrangement, remittance takes place with either a monthly bill or a weekly wire based on claims paid, adjusted for discounts, plus retention charge and broker commission (if applicable).
- Advance deposit. For new cost-plus customers, an advance deposit is required. Since invoices are presented to the group based on prior paid claims, there will be a delay between the time IBC pays the claim and the time IBC receives reimbursement from the group. Accordingly, the group will provide advance deposit monies, as identified by IBC, representing costs that are anticipated to be incurred by IBC on behalf of the group. The advance deposit is reviewed annually for adequacy and either increased or decreased accordingly.
- Bank letter of credit (BLOC). When a group elects to hold its own reserves for claims incurred but not reported, upon execution of this cost-plus arrangement the group will provide IBC with an irrevocable BLOC. The initial BLOC should be for an 18-month period and will be renewed by the group annually with no lapse in coverage and must be in an amount as determined by IBC to cover IBC's obligations under the financial arrangement.

Contingency premium

90-percent contingency premium — minimum 500 enrolled contracts

Under a 90-percent contingency premium arrangement, accounts may choose to pay 90 percent of the calculated monthly premium if it meets a *minimum enrollment of 500 contracts in the coverage being considered for a contingency premium program.* (The 500-contract minimum requirement cannot be met by aggregating contracts from other coverages, and the size requirement is based on enrolled contracts and not eligible contracts.) Groups with a contingency arrangement must have the same contingency percentage for all lines of coverage.

Upon completion of the year-end settlement, should the year-end claims experience exceed the 90-percent contingency amount paid, IBC will collect up to the remaining 10 percent as is necessary to satisfy the maximum premium liability plus any existing deficit carry-forward. Any year-end claims experience that exceeds the 100-percent-maximum premium cannot be recovered in the current year but will be carried forward as a deficit for possible recovery from future periods.

Section 3 — Alternative funding arrangements (continued)

This funding mechanism is particularly useful for those accounts that believe the projected premium is too high and wish to improve their cash flow through the reduced monthly payment. Prior to the start of the contract period, IBC will request a bank letter of credit in the amount of the 10 percent unpaid premium to assure that the funds will be available upon completion of the contract-year settlement. A BLOC is a guarantee by the group's financial institution of choice that, in the event the group defaults on its payment obligations to IBC, the financial institution will be contractually obligated to pay those obligations. The term of the initial BLOC must be for an 18-month period. The amount is reviewed annually by IBC and, upon being notified of the new amount by IBC, the group must renew the BLOC accordingly.

IBC also assesses an interest charge on the deferred premium that is recalled based on the U.S. Treasury Bill rate (for 13-week issues) plus 1 percent. This amount is due at the time of year-end settlement.

Important considerations concerning contingency premium include:

- An account must be retrospectively funded to be eligible for a contingency premium arrangement.
- Accounts currently on a contingency premium arrangement that incur a deficit during the period are subject to review on a case-by-case basis and may or may not be renewed under this arrangement.
- The account is required to pay IBC any settlement monies due within 20 days of invoice. Failure to pay within 20 days will result in additional interest charges and potential cancellation of the contingency premium arrangement.
- An account on a contingency premium arrangement will receive the contingency premium rates (but not the full premium rates) as a part of its rate renewal notification. Acknowledgment of the rate renewal notification will constitute acceptance of the contingency premium arrangement for the upcoming period.
- A financial agreement, which sets forth the basic terms of the contingency premium arrangement, will be issued by IBC to the group for sign-off.

When a group or an affiliation is comprised of a single entity, the annual financial settlement is calculated as follows (this example is based on a 90-percent contingency premium arrangement):

- If the group's contract-year required premium amount, as determined by the settlement, exceeds the 90-percent contingency annual premium payments paid by the group but is less than the maximum (100 percent) annual premium, *and there is no carryover deficit from previous contract periods,* the group is liable to IBC for the required premium amount that exceeds the 90-percent annual premium payments (i.e., the additional premium amount).
- If the group's contract-year required premium amount as determined by the settlement exceeds the 90-percent contingency annual premium payments paid by the group but is less than the maximum (100 percent) annual premium, *and a deficit carryover exists from previous contract periods*, IBC may collect up to the remaining 10-percent amount to apply to the required premium amount that exceeds the 90-percent annual premium payment (i.e., the additional premium amount) as well as to the existing carryover deficit. Depending on the coverage, any remaining deficit not recovered may be carried over to future contract periods.
- For local accounts, Personal Choice, traditional hospitalization, CMM, and prescription drug retrospectively rated coverages contain a one-year deficit carry-forward provision. All other retrospectively rated coverages and all national accounts (regardless of line of coverage) have indefinite carry-forward provisions.

Section 4 — Product regulations and size requirements

Guidelines for new business are based on eligible contracts. Guidelines for existing business are based on enrolled contracts.

Personal Choice/Keystone Health Plan East/Blue Solutions®, 2 – 50 covered contracts*

Type of rating. This segment is rated under the adjusted community rating program, including prescription drug, Keystone Health Plan East Dental, and Keystone Health Plan East Vision riders (IBC Vision and UCCI Dental are community-rated). Rates for these groups are community-based rates updated quarterly. These rates are then adjusted for the specific age/sex makeup of the covered group. The group's rates will be based on the effective date of its Personal Choice or Keystone Health Plan East coverage and will change on its anniversary date.

Effective date. When an existing group *adds* Personal Choice or Keystone Health Plan East, the existing anniversary date will apply to the Personal Choice/Keystone Health Plan East coverage.

Tier type. All tiers will be offered on a standard four-tiered rating structure. Tier structure must be the same throughout all medical products.

Quoting policy:

- For new business, Personal Choice and/or Keystone Health Plan East groups of fewer than 51 eligible contracts, only adjusted community rates will be issued.
- The group must be located within the Philadelphia five-county service area and have not more than 50 percent of its eligible population located out-of-area. Groups with more than 50 percent out-of-area must be reviewed by Underwriting and Marketing management.
- If the number of eligible contracts is greater than 50 and only Personal Choice and/or Keystone Health Plan East HMO/POS is being offered, only risk adjusted rates will be issued.
- At the time of renewal, if the enrollment under the Personal Choice and/or Keystone Health Plan East line of coverage is 51 or more, the Personal Choice and/or Keystone Health Plan East will be renewed under the risk adjusted rating method.
- All changes to medical benefits for existing customers will be to a Blue Solutions for Small Employers medical plan, with corresponding Select or Basic Drug and Vision Program®, and/or an HSA-qualified high-deductible health plan, with integrated drug and vision program. If the customer has a current grandfathered medical or drug coverage with IBC, he or she must move all medical and prescription coverage to a Blue Solutions medical plan with corresponding Select or Basic Drug and Vision Program when changing medical plans.
- Customers of 2 - 50, with existing non-Blue Solutions plans *may not* maintain their current medical or Rx plan option and add a Blue Solutions for Small Employers medical plan with corresponding Select or Basic Drug and Vision program and/or an HSA-Qualified High Deductible Health Plan with integrated drug and vision program. The offerings in the Blue Solutions product suite are the only options available to 2 - 50 life groups.

* For product descriptions please turn back to page 3.

Section 4 — Product regulations and size requirements (continued)

Available benefits options for new business, 2 – 50 eligibles; existing enrolled business, 2 – 50 contracts:

- All new business offerings and all changes to medical benefits for existing groups may select from the following:
  - Blue Solutions for Small Employers medical plan with a corresponding Select or Basic Drug and Vision program.
  - HSA-qualified high-deductible health plans with integrated drug;
  - Keystone Health Plan East Dental rider;
  - Freestanding Dental (UCCI).
- Within groups of 2 - 50 (eligibles for new business, enrolled for existing business) groups of 2 - 4 may offer one medical plan for all enrollees, packaged along with one corresponding Select or Basic Drug and Vision plan.
- A second medical option may be added to HMO/POS only if a PPO is needed for out of area employees. Groups of 5 - 50 may offer two medical plans along with their corresponding Select or Basic Drug and vision plan. Groups must select the corresponding drug and vision program that is paired with their medical plan selection.
- A third medical option may be added to HMO/POS only if a PPO is needed for out of area employees.The combination of offerings for groups 5 - 50 will be limited to **two** total packages of combined medical and drug and vision options, three with out of area exception.
- For the purposes of calculating the number of enrolled contracts only those active employees enrolled on the IBC health plan will be counted. Retirees, dependents, individuals enrolled under COBRA coverage or mini-Cobra coverage and individuals enrolled as "overage dependents to age 30" will be excluded from the calculation of the number of enrolled contracts.
- Groups selecting a Blue Solution medical plan will be paired with a corresponding Select or Basic drug rider and a corresponding Vision program.
- If a group selects an HSA-qualified high-deductible health plan (HDHP), this coverage may be offered only with integrated drug. Note: See section 5 for definition of HDHPs and related funding requirements.
- Prescription drug and vision benefits are standard, they must be offered with *all Blue Solution* medical products.
- All prescription drug options must include oral contraceptives. There are no options without oral contraceptives.
- Medicare products will *not* be counted toward the maximum number of benefit levels. Traditional products *will* be counted towards the maximum number of benefit levels.

Section 4 — Product regulations and size requirements (continued)

Personal Choice/Keystone Health Plan East/Blue Solutions, 51 – 99 covered contracts

Type of rating. This segment is rated under the risk adjusted rating program, for Personal Choice and Keystone HMO/POS including Rx, Keystone Dental, and Keystone Vision riders (IBC Vision and UCCI Dental are community-rated). The group's rates will be based on the effective date of its Personal Choice or Keystone coverage and will change on its anniversary date.

Effective date. When an existing group adds Personal Choice or Keystone, the existing anniversary date will apply to the Personal Choice/Keystone coverage.

Tier type. Standard four-tiered rating structure is standard.

Quoting policy:

- For new business Personal Choice and/or Keystone groups of greater than 50 and fewer than 100 eligible contracts, risk-adjusted rates only will be issued.
- A group must be located within the Philadelphia five-county service area and have no more than 50 percent of its eligible population located out-of-area. Groups with more than 50 percent out-of-area must be reviewed by underwriting and marketing management.
- At the time of renewal, if the enrollment under the Personal Choice and/or Keystone line of coverage is 51, the Personal Choice or Keystone will be renewed under the risk-adjusted rating program.
- All changes to medical benefits for existing customers will be to a Blue Solutions for 51 to 99 mid-market employers medical plan with a Select or Basic Drug and /or an HSA-Qualified high-deductible health plan with integrated drugs (subject to dual option guidelines). If the customer has current grandfathered medical and/or drug coverage, he or she must move all medical and prescription coverage to a Blue Solutions for 51 to 99 plan when changing medical plans.
- Customers of 51 - 99, with existing plans may maintain their current medical or Rx plan options and add a Blue Solutions for 51 - 99 mid-market employer medical plan with Select or Basic Drug and/or an HSA-Qualified high-deductible health plan with integrated drug (subject to dual-option guidelines).

Section 4 — Product regulations and size requirements (continued)

Available benefits options for new business, 51 – 99 eligibles; existing enrolled business, 51 – 99 contracts:

- All new business offerings and all changes to medical benefits for existing groups may select from the following:
  - Blue Solutions for 51 - 99 mid-market employers medical programs with or without a Select or Basic Drug plan (Personal Choice of Keystone Rx Rider);
  - HSA-qualified high-deductible health plans with integrated drug;
  - Keystone Health Plan East Dental and Vision riders;
  - Freestanding Dental (UCCI);
  - Freestanding IBC Vision.
- Groups may select up to three medical benefit plans and up to two Select or Basic Drug options. The combination of offerings will be limited to three total packages of combined medical and drug options for groups of 51 - 99.
- For the purposes of calculating the number of enrolled contracts only those active employees enrolled on the IBC health plan will be counted. Retirees, dependents, individuals enrolled under COBRA coverage or mini-Cobra coverage and individuals enrolled as "overage dependents to age 30" will be excluded from the calculation of the number of enrolled contracts.
- If prescription drug benefits are offered, they must be offered along with all medical benefits (maximum of two drug options). Note these exceptions:
- When one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans are not required to include drug coverage.
- The customer may select differing prescription drug copayment options with each of the medical plans (HMO/POS and PPO), subject to a maximum of two drug options (if Select Rx is offered, both drug options must be Select and/or a combination of Select and/or Basic Drug options).
- All prescription drug options must include oral contraceptives. There are no options without oral contraceptives.
- Groups with current different levels (one line with orals and one without orals) of prescription drug benefits will be grandfathered, until they make a plan change, then the customer must come into compliance.

Section 4 — Product regulations and size requirements (continued)

- A group may not offer different drug, dental, and/or vision options if identical medical products are offered.
- Groups selecting Blue Solutions for 51 to 99 Mid-Market Employer programs may choose from the following Select Drug Program benefits: $10/$20/$35, $15/$35/$50, $20/$40/$60, $250/$20/$40/$60 or the following Basic Drug benefits: $4/discount, $7/50%($125).
- If a group selects an HSA-Qualified high-deductible health plan, this coverage can only be offered with integrated drug. Note: See section 5 for definition of HDHPs and relating funding requirements.
- Medicare products will *not* be counted toward the maximum number of benefit levels. Traditional products *will* be counted towards the maximum number of benefit levels.

Personal Choice/Keystone Health Plan East, 100+ covered contracts

Type of rating. This segment is experience-rated for Personal Choice and Keystone Health Plan East HMO/POS. Self-funding is available if the group meets eligibility and enrollment requirements.

Tier type. A four-tiered rating structure is standard, but other rating structures may be available in competitive situations. The tiered rating structure must be consistent between Personal Choice and Keystone Health Plan East products.

Quoting policy:

- Rates are adjusted annually on the anniversary date of the group.
- For new groups, rates are guaranteed for 90 days from the quoted effective date. (If HMO, rates change quarterly.)
- New business rates for groups of 100+ contracts may be wholly or partly based on the group's own experience.
- If there are more than 99 eligible contracts, an experience rate will be issued.
- At renewal, if the group has maintained an average of fewer than 100 covered contracts per month for the experience period for the Personal Choice and/or Keystone Health Plan East line of coverage, the affected line of coverage will be converted to the risk-adjusted rating program.
- New business Personal Choice and Keystone Health Plan East rates are guaranteed for 90 days (subject to Keystone Health Plan East quarterly rate changes) and are typically quoted on a 12-month contract basis. Extended rating periods exceeding 12 months may be considered for off anniversary requests, depending on the circumstances of the request.
- Personal Choice and Keystone Health Plan East lines of coverage should have the same anniversary dates. When an existing Keystone Health Plan East group adds Personal Choice, the existing anniversary date will apply to the new Personal Choice coverage, and vice versa

Section 4 — Product regulations and size requirements (continued)

- The funding arrangement must be consistent among all in-force medical coverages. Split funding (insured medical and self-insured prescription drug) will be permitted for groups for which IBC has the insured medical only with at least 300 medical contracts enrolled.

Note: If the group falls below 100 enrolled contracts, it can maintain its existing medical and Rx benefits until a benefit change is made. At that time, the group must purchase a product from the Blue Solutions for 51 - 99 mid-market employer program.

Available benefits options:

- A maximum of *three* total benefits levels among all in-force medical coverages are permitted, plus one HSA-qualified plan. All three benefits levels may be within one product line. If multiple product options are offered, they must all include or all exclude prescription drug coverage (up to a maximum of two drug options).
- One HSA-qualified plan may be offered along with other products as long as the customer does not exceed the maximum number of product offerings. For example, a customer may offer a standard HMO, a PPO, a POS, and one HSA-qualified plan.
- When multiple options are offered, the following prescription drug coverage rules apply:
  - When one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans are not required to include drug coverage.
  - When one option is an HSA-qualified HDHP with no drug, other non-HSA-qualified plans may either include or exclude drug coverage.
  - When one option is a Flex HDHP with freestanding or PPO rider drug, then all other non-Flex HDHP options should include drugs.
  - When one option is a Flex HDHP with integrated drug, then all other non-Flex HDHP options should include drug.
- All Flex HDHP products will be considered downgrades from all current product offerings, including HSA-qualified HDHPs, and can thus be offered off-cycle.
- One HSA-qualified HDHP may be offered alongside a Flex HDHP as long as the maximum number of product offerings is not exceeded. Note: See section 5 for definition of HDHPs and related funding requirements.
- A group may not offer different drug, dental, and/or vision options if identical medical products are offered.
- Medicare products **will not** be counted toward the maximum number of benefit levels. Traditional products *will* be counted towards the maximum number of benefit levels.

Section 4 — Product regulations and size requirements (continued)

Freestanding prescription drug, 100+ covered contracts

Type of rating. Experience rating. Freestanding drug coverage is not available for groups of 2 - 99.

Tier type. Four-tier is standard.

Quoting policy:

- Rates are adjusted annually on the anniversary date of the group.
- For new groups, rates are guaranteed for 90 days from the quoted effective date.
- New business rates may be based wholly or partly on the group's own experience.

Discount when adding medical or Rx to form package offering:

For *experience-rated* medical and *experience-rated* prescription drug lines of coverage, a two percent overall discount will be applied to the medical and prescription drug lines of coverage if one of those coverages is added to form a combined medical/Rx package offering.

Existing business:

- Group already has combined medical/Rx package offering with IBC: no discount applied.
- Group has medical or Rx with IBC but not both: two percent discount will be applied to both medical and Rx for combined medical/Rx package offering.

New business:

- Group has combined medical/Rx package offering with same carrier: no discount applied.
- Group has medical and Rx but not with the same carrier: two percent discount will be applied to both medical and Rx for combined medical/Rx package offering.

Surcharge when terminating medical or Rx from package offering:

- For *experience-rated* medical and *experience-rated* prescription drug lines of coverage, a two percent surcharge will apply to the remaining line of coverage if a group cancels either the medical portion or the prescription drug portion of its combined medical/Rx package offering.
- If the termination occurs on-anniversary, the 2 percent surcharge (when applicable) would be applied on that anniversary date.
- If termination occurs off-anniversary, the 2 percent surcharge will be applied immediately.

Section 4 — Product regulations and size requirements (continued)

- Experience-rated (100+) medical with Freestanding Rx: two percent surcharge will apply to the medical if Freestanding Rx is cancelled; two percent surcharge will apply to the Freestanding Rx if the medical is cancelled.
- Experience-rated (100+) medical with Rx Rider: two percent surcharge will apply to the medical if the Rx Rider is cancelled.
- (51 - 99) medical with Rx Rider: two percent surcharge *will not apply* if the Rx Rider is cancelled..

IBC Vision

IBC Vision may be offered on a freestanding basis or as a Keystone Health Plan East rider.

Type of rating. Community rating, 2 – 99 enrolled contracts; experience rating, 100+ contracts (if there are fewer than 100 enrolled at renewal, the vision product will be converted to community rating).

Tier type. All rate tiers are available. The standard structure is four-tier.

Quoting policy:

- Community rates are filed and approved on a periodic basis as warranted.
- New business community rates will be based on the group's effective date of coverage.
- Experience-rated vision rates are adjusted annually on the anniversary date of the group.
- For new experience-rated groups, rates are guaranteed for 90 days from the quoted effective date.

Available benefits options 2 – 99:

- Maximum of one freestanding offering per customer.
- Freestanding vision is not available in conjunction with an HMO/POS vision rider.
- Freestanding vision-only offerings are not permitted. Vision must be offered in conjunction with a medical program.
- Unequal vision riders (different options) within a line of business (LOB) are permitted (e.g., in conjunction with two different HMO offerings or two different POS offerings).
- Biannual and annual vision benefits are available with freestanding products. Standard HMO/POS vision riders are biannual for groups of all sizes.
- Annual benefits may not be offered in conjunction with a biannual offering.
- Voluntary Davis Vision benefits are not available.

Section 4 — Product regulations and size requirements (continued)

Available benefits options, 100+:

- Maximum of one freestanding offering per customer.
- Freestanding vision is not available in conjunction with an HMO/POS vision rider.
- Freestanding vision-only offerings are not permitted. Vision must be offered in conjunction with a medical program.
- Unequal vision riders (different options) within a LOB are permitted (e.g., in conjunction with two different HMO offerings or two different POS offerings).
- Unequal vision riders (different options) across LOBs are permitted (e.g., in conjunction with one HMO and one POS).
- Vision may be offered on one LOB and not the other.
- Annual and biannual benefits are available.
- Voluntary and non-voluntary vision benefits are available. Annual benefits are not available in conjunction with a biannual offering.

Pennsylvania Autism Benefit Mandate (Effective July 1, 2009)

Existing business:

- If, at renewal, the group does not have the mandated autism benefit but has 51 or more *enrolled* contracts at the time the renewal is calculated, the autism benefit *will* be automatically included in the renewal.
- If, at renewal, the group does not have the autism benefit and did not have 51+ enrolled contracts, but its group size has since increased to 51 or more total commercial employees the benefit is required to be added upon anniversary, the group must provide a census to prove that it is now qualified to receive the autism benefit. Proof of eligibility must be provided by the sales rep via a rate request and is subject to Underwriting review and approval. Any quotes issued by Underwriting to add the benefit must be returned for processing at least 30 days prior to the effective date of the renewal.
- If, at renewal, the group has the autism benefit, it will be renewed with the autism benefit regardless of its number of *enrolled* contracts. If the group size has decreased to less than 51 total commercial employees the benefit is required to be removed upon anniversary, the group is required to provide a census to prove that it no longer has 51+ total commercial employees. Proof of eligibility must be provided by the sales rep via a rate request and is subject to Underwriting review and approval. Any quotes issued by Underwriting to remove the benefit must be returned for processing at least 30 days prior to the effective date of the renewal.
- If the group makes an off-cycle plan change during its policy year, the autism mandate cannot be added or deleted at the time of the off-cycle benefit change. Changes to the autism benefits can only occur on the anniversary date of the group. All changes are subject to Underwriting review and approval.

Section 4 — Product regulations and size requirements (continued)

New business:

- The PA state-mandated autism benefit will be automatically included at inception if the group has 51 or more total commercial employees.
- If a group does *not* have 51+ total commercial employees at inception, the group is not eligible and the mandated autism benefit will not be included.
- If a group does not have 51+ total commercial employees at inception but grows to 51 or more total commercial employees during its policy year, it cannot add the mandated benefit off-cycle. Groups must wait until its anniversary date to request the addition of the mandated benefit. Requests to review the number of total commercial employees and add the mandated benefit upon anniversary must be submitted through the IBC account executive via a rate request and are subject to Underwriting review and approval. Any quotes issued by Underwriting to add the benefit must be returned for processing at least 30 days prior to the effective date of the renewal.
- If a group falls below 51 total commercial employees during its policy year, it cannot remove the mandated benefit off-cycle. Groups must wait until their anniversary date to request the removal of the mandated benefit. Requests to review the number of total commercial employees and remove the mandated benefit upon anniversary must be submitted through the IBC account executive via a rate request and are subject to Underwriting review and approval. Any quotes issued by Underwriting to remove the benefit must be returned for processing at least 30 days prior to the effective date of the renewal.
- If the group makes an off-cycle plan change during its policy year, the autism mandate cannot be added or deleted at the time of the off-cycle benefit change. Changes to autism benefits can only occur on the anniversary date of the group. All changes are subject to Underwriting review and approval.

Federal Mental Health and Substance Abuse (MHSA) Parity (Effective October 15, 2009)

New business. The federal MHSA benefit will be automatically included at inception if the group has 51 or more total commercial employees.

Renewing business. The federal MHSA benefit will be automatically included in the renewal for groups with 51 or more *enrolled* contracts at the time the renewal is calculated.

Affiliations. With multiple CIDs totaling 51 or more total commercial employees (for *new business*) or 51 enrolled *contracts* (for *renewals*), the MHSA benefit will be automatically included and will be applied to each group under the CID within the affiliation, regardless of the eligible or enrolled employee count at the CID level.

Exclusions. Exclusion from the federal MHSA parity mandate for individual CIDs with fewer than 51 total commercial employees (for new business) or fewer than 51 enrolled (for renewals) within an affiliation, will be considered upon request.

Section 4 — Product regulations and size requirements (continued)

Exclusions are limited to:

- affiliations that are *not* commonly owned; and,
- will require disaffiliation of the group requesting exclusion.

Exclusion of the federal MHSA parity benefit will not be granted to CIDs totaling fewer than 51 total commercial employees or enrolled under affiliations *with* common ownership.

Collective bargaining exclusions. Requests to be excluded from implementation of the MHSA benefit for new business or conversion to the MHSA benefit for renewing business because of an existing collective bargaining agreement that was entered into before October 3, 2008, are contingent upon Underwriting's receipt, review, and acceptance of a current, valid bargaining agreement.

Including the benefit:

New business. If a group does not have 51+ total commercial employees at inception, the group is not eligible, and the mandated MHSA benefit will not be included. If the group grows to 51 or more total commercial employees during its policy year, it cannot add the MHSA benefit off-cycle.

Renewing business. If at renewal the group does not have 51+ enrolled commercial contracts and the MHSA benefit in force, the group will not be renewed with the mandated MHSA benefit. If the group grows to 51 or more commercial employees during its policy year, it cannot add the MHSA benefit off-cycle. Groups must wait until their anniversary date to request the addition of the mandated benefit.

Removing the benefit:

For new business. If a group has the MHSA benefit at inception but falls below 51+ total commercial employees during its policy year, it cannot remove the mandated MHSA benefit off-cycle.

For renewing business. If at renewal the group has the MHSA benefit, it will be renewed with the MHSA benefit regardless of its number of enrolled commercial contracts. If the group size has decreased to less than 51 total commercial employees the benefit is required to be removed and the group must submit a census proving it has fewer than 51 commercial eligible employees. The group cannot remove the MHSA benefit off-cycle. Groups must wait until their anniversary date to request the removal of the mandated benefit.

Requesting a review:

Requests to review number of total commercial employees and add or remove the mandated benefit upon anniversary:

- must be submitted through sales rep via a rate request;
- are subject to Underwriting review and approval.

- Any quotes issued by Underwriting to add the benefit must be returned for processing at least 30 days prior to the effective date of the renewal.

Off-cycle plan change:

If group makes an off-cycle plan change during its policy year, the federal MHSA benefit cannot be added or deleted at the time of the off-cycle benefit change. Changes to mandated benefits can occur only on the anniversary date of the group. All changes are subject to Underwriting review and approval.

Healthy Lifestyles℠ Rewards

Overview:

- Incentive-based program designed to encourage members to engage in and maintain healthy behaviors.
- Members complete the Personal Health Profile (PHP) to enroll in the program.
- Points awarded as members complete activities. 1 point = $1.
- Members redeem points for gift cards, HRA contributions, HSA funding, or premium contributions.
- Employer groups can select specific activities to offer, designate point values for those activities, and set the annual point maximum.
- Program may be implemented at any time.

Eligibility:

- Program available to experience-rated customers for their managed care members only (i.e., at least one line of coverage must be experience-rated for customer to qualify for program).
- Eligible members include enrolled Keystone/Personal Choice members along with their covered spouses and dependents age 18 or older.
- For BlueSaver Health Reimbursement Accounts (HRA), member rewards are employer contributions to the employee's HRA account. Customer must have a BlueSaver Flex Deductible HMO/DPOS/PPO or Flex HDHP PPO. HRA funding is in addition to the program administrative fee.
- For BlueSaver Health Spending Account (HSA), member rewards are employer contributions to the employee's HSA account. Customer must have a BlueSaver PPO qualified high-deductible health plan. HSA funding is in addition to the program administrative fee.

Program cost:

- Customer pays monthly administrative fee — billed by IBC.
- Administrative fees are scaled and are based on actual enrolled contracts in the program.
- Customer pays for gift cards (face value of card + $1 per reward fulfillment fee) — billed by IncentOne.

Section 5 — HDHPs and savings accounts

High-deductible health plans (HDHP)

An HDHP is any plan with an in-network deductible of $500 Single/$1,000 Family or higher. HSA-qualified HDHPs are plans that must follow prescribed Federal guidelines and requirements, which are updated annually by the IRS.

Employers are not allowed to:

- fund more than 50 percent of the annual employee/family deductible costs to an HRA, FSA or HSA ;
- provide a supplemental benefits plan that augments the core health insurance plan;
- pay more than 50 percent of annual employee/family deductible costs through an allowance or claims payment, or;
- provide any combination of the above that causes the total amount funded to be greater than 50 percent of the annual employee/family deductible.

For groups adding an HSA-qualified HDHP for the first time, it will be considered a downgrade from all current product offerings and can be offered off-cycle as of January 1, 2011, on a contract year basis only.

An HRA/HSA-qualified HDHP may be offered with other products, up to the maximum plan offerings for the size of the group.

BlueSaver℠ Health Reimbursement Account (HRA)

- The HRA product is available to the 2 - 99 and 100+ (eligibles) market segments. This product cannot be sold as a stand-alone product.
- For the 2 - 99 market segment the HRA product may be offered with a Blue Solutions Deductible medical plan option (prescription drug plan selection will follow high-deductible plan rules)
- HRA can be offered along with other products up to the maximum plan offering for the size of the group.
- Debit card option is not available to 2 - 99 groups.
- For 100+ market segment, the HRA product can be offered with any medical plan except an HSA high-deductible health plan.
- The 75 percent participation guideline is enforced for all customers offering an HRA.
- The HRA product can only be offered on the customer's anniversary date.
- Multiple options within the HRA are not permitted. The customer is limited to one HRA plan.
- The prescription drug plan selection will follow the high-deductible health plan rules. Any requested variations, such as drug only, will require prior underwriting approval.
- Employer funding to the HRA cannot exceed 50 percent of the annual employee/family deductible.

Section 5 — HDHPs and savings accounts (continued)

BlueSaver℠ Flexible Spending Account (FSA)

- The FSA product is available to the 100+ (eligibles) market segment only. It can be offered in conjunction with any medical plan, but it may not be sold as a stand-alone product.
- The FSA product can only be offered on the customer's anniversary date.

Multiple options within the FSA product are not permitted. The customer is limited to one FSA plan.

BlueSaver℠ Health Savings Account (HSA-qualified HDHP)

- New Business: 2+ (eligibles)
- Existing Business: 2+ (enrolled by line of business)
- A Heath Savings Account (HSA) is only available with a federally qualified high-deductible health plan (HDHP).
- HSA-qualified high-deductible health plans are only offered with integrated drug as of October 1, 2010.
- For groups adding an HSA-qualified HDHP product for the first time, the HSA-qualified HDHP product will be considered a downgrade from all current product offerings, and can be offered off-cycle as of January, 1, 2011 on a contract year basis only. The HSA-qualified HDHP product will renew upon the customer's current renewal date with any other product offerings.
- Groups adding or changing to an HSA-qualified plan with a contract year benefit period will be permitted to change anniversary. The anniversary change is applicable to all products under the group and the group will receive a re-rate at the time of the anniversary change.
- An HSA-qualified HDHP may be offered along with other products as long as the customer does not exceed the maximum number of product offerings. For example, a customer can offer a standard HMO, a standard PPO and an HSA-qualified HDHP.
- Deductible/out-of-pocket credit will not be allowed/given for groups moving from an existing HSA-qualified HDHP with a calendar year deductible/out-of-pocket accumulation to a contract year deductible/OOP accumulation basis.
- Fourth-quarter deductible carryover credit is not included with HSA-qualified HDHP offerings.
- Subject to benefit exception approval, prior carrier deductible credit may be given to an HSA-qualified HDHP when the prior carrier coverage was also an HSA-qualified HDHP. Prior carrier deductible credit will not be permitted when prior group coverage was not an HSA-qualified HDHP.

Consumer-driven Health Care Toolkit

For additional information on HRAs, FSAs, and HSAs, the link below will connect to the Consumer-Driven Health Care Toolkit at www.ibx.com/broker_group.

Section 6 — National accounts

A *national account* is a non-KHPE group that has employees located in more than one plan area but chooses to cover its employees through a single national contract executed with a control (home) plan. Businesses that qualify for national account consideration must be domiciled in the Greater Philadelphia five-county area of Philadelphia, Delaware, Montgomery, Bucks, and Chester counties.

Underwriting and participation requirements for national accounts:

- Minimum enrollment. A national account must have a minimum of 1,000 enrolled contracts for their PPO and HMO medical products.
- Out-of-area location. A national account must have at least one location outside of the IBC service area.

Key rating characteristics — PPO and HMO/POS lines of business:

- Excess claims provision. Inpatient/outpatient pooling points based on group size.
- Provider discount. For all national account claims, regardless of where incurred, discounts are based on the actual IBC contractual savings or as reported by participating plans for the account. For all HMO/POS claims, discounts are based on the actual IBC contractual savings. Discounts for those members who are located outside IBC's service area are based on the actual contractual savings reported by participating plans for the account.
- At least 75 percent of all eligible in-area, as well as 75 percent of all eligible out-of-area, contracts *in each location* must enroll in an IBC or subsidiary product.

Section 7 — When a rate quote is not available through ROAM

There are situations where the type of quote you are requesting is not available through the ROAM system, and you will need to submit a rate request through an IBC account executive. This section will identify those situations and provide you with a list of the documentation that may be required at the time you submit a request.

When must a rate request be submitted?

Small employer groups (new business groups with 2 – 50 eligible employees, or existing groups with 2 – 50 enrolled contracts)

A rate request is required when the following types of quotes are requested:

- a change in anniversary date;
- a material change in the census (e.g., purchasing new entity, total takeover, or combining with another entity); requires approval by Underwriting and will be quoted as New Business via ROAM (the dropped to paper) for under 51 employees and via GUS as PAMID for over 51 employees.

Mid-size groups 51 - 99. A rate request is required for all 51 - 99 new business and any non standard requests not viewable as alternatives to renewals on ROAM.

Traditional groups and all groups 100+ and cost-plus. A rate request must be submitted regardless of funding arrangement.

What documentation is requested when ROAM quote is not available?

Existing IBC groups:

- requested plan design
- marketing strategy (if applicable)

Note: For existing IBC groups adding new contracts, if the number of new contracts is greater than 10 percent of the existing population, refer to "new business group" requirements outlined on the following page.

Section 7 — When a rate quote is not available through ROAM (continued)

New business groups (including existing IBC groups adding new contracts totaling more than10 percent of the existing population):

- name of existing insurance carrier;
- length of time with current carrier;
- claims data — if available, three years of claims data is preferred;
- enrollment for the claims period (breakdown of contracts by month);
- shock claims information (individual claims in excess of $50,000);
- diagnosis and prognosis for excess claims;
- summary of current plan design (source documentation);
- current renewal, including premium rates (source documentation);
- employee contribution (the amount of premium contributed by the employee toward his or her benefits program; it can be expressed as a percentage or dollar value);
- detailed census — in spreadsheet format. The census must include the following:
  - employee name
  - date of birth (month, day, year)
  - current program enrollment (i.e., HMO, PPO, Rx, Vision)
  - number of insured lives during experience period (contracts by month)
  - ZIP code of current residence
  - employee gender
  - coverage status (i.e., enrollment by coverage tier)
  - waivers — eligible employees not electing coverage because they are covered under another plan (i.e., spouse's coverage)
  - opt-outs — eligible employees not electing coverage and who are *not* covered under another plan
  - date eligible for coverage if employees are in a probationary period

Additional required information, where applicable, would include:

- request for proposal (RFP) request and attachments;
- union agreement (if applicable).

The right to decline to quote

Subject to applicable law, Underwriting reserves the right to decline to quote any group deemed to be an unsatisfactory risk. However, such a decision will not be based in any way on the medical condition of the group's members.

Section 8 — Group terminations and reinstatements

Termination of coverage

The terms and conditions of coverage termination are as follows:

- Generally for fully insured PPO or HMO customers, the group may terminate coverage on the contract anniversary date by giving the other party no less than 30 days' advance written notice. IBC or KHPE may terminate the group's coverage for nonpayment of premium upon written notice effective the last day of the 30-day grace period.
- For self-insured/cost-plus groups, IBC/KHPE may terminate the ASO agreement immediately upon prior written notice for nonpayment. Either party may terminate the ASO agreement on 90 days' prior written notice for any reason.
- Upon termination of coverage, the group is responsible for all due but unpaid premiums. IBC will not be responsible for collecting any premium dollars from individual group members, even if the group members were responsible for the cost-sharing of the premium with the group.
- Upon termination of the group's coverage, all COBRA groups must be terminated by IBC / KHPE. COBRA-only groups are not allowed.
- If an account that is on a special premium payment schedule (such as contingency, delayed premium, or staggered premium arrangement) cancels either on-anniversary or off-anniversary, the unpaid premiums are due immediately.
- If a group account terminates in order to purchase nongroup coverage, it will not be eligible for group benefits or rates for 12 months from the date of the termination.
- IBC reserves the right to cancel a group's coverage off-anniversary if the group fails to meet.
- IBC's underwriting guidelines, including but not limited to minimum participation requirements.
- If a group that currently has Blue Cross (hospitalization), Blue Shield (medical/surgical), and Major Medical coverage decides to cancel either the Blue Cross or Blue Shield component, or both, it must also cancel the Major Medical program.
- If a group cancels freestanding prescription drug coverage and has Major Medical coverage, the Major Medical rates must be adjusted to include drug coverage unless the group furnishes proof of purchasing a freestanding prescription drug program from another carrier.
- Vision, prescription drug, and dental programs (except for those offered as an HMO rider) may continue to be offered to the group on a freestanding basis.

Section 8 — Group terminations and reinstatements (continued)

Reinstatement of coverage

Whenever a previously enrolled group wishes to return to active coverage under IBC, this restoration is termed a *reinstatement*. Often, this reinstatement occurs after a termination from coverage due to failure to promptly pay premiums. In order to maintain continuity of coverage and avoid exposure to preexisting condition waiting periods, groups may seek to regain their active status through a reinstatement. Some points to consider are:

- The reinstatement must occur within 60 days of the effective date of the cancellation, and the reinstatement must be retroactive to the cancellation date;
- Any past-due premium must be collected prior to reinstatement.

When the above conditions have been met and a reinstatement form has been completed by Marketing, Underwriting will review the case and make a final determination as to whether the group should be reinstated, and what the rate level will be.

Section 9 — Individual medically underwritten products

Individual HMO

For more than 70 years, Independence Blue Cross has offered quality health care products and services designed specifically to meet the changing health care needs of its customers.

With Individual HMO from Keystone Health Plan East, members select a primary care physician from IBC's expansive network to coordinate all of their care.

These are medically underwritten programs, so coverage is not guaranteed and some applications may not be approved based on medical conditions. As a medically underwritten product, acceptance and rates are based on an applicant's health status. There is no automatic transfer from any existing Keystone Health Plan East, Personal Choice, or other Independence Blue Cross plan into the individual medically underwritten programs.

In addition, the HMO plans are subject to a preexisting condition exclusion. Coverage for any preexisting condition, illness, or injury for which medical advice or treatment was recommended or received within the 90-day period that precedes the effective date of coverage is excluded for the first 12 months.

There is no waiver of the preexisting exclusion provision. Certificates of Creditable Coverage from a group plan are not applicable for these products. Even if an applicant has been continuously insured under another plan prior to applying with us, the preexisting exclusion provision will apply to any approved application.

For more information, please view the Individual Broker Toolkit at www.ibx.com/broker_individual.

Section 10 — Group Medicare products

Medicare Advantage

What is Medicare Advantage?

Medicare Advantage plans are health plan options that are part of the Medicare program. When someone joins one of these plans, he or she generally gets all Medicare-covered health care through that plan. This coverage may include prescription drug coverage.

To be eligible and join a Medicare Advantage plan, the applicant must have Medicare Part A and Part B. An applicant will have to pay the monthly Medicare Part B premium to Medicare. In addition, he or she might have to pay a monthly premium to the Medicare Advantage plan for the extra benefits that are offered.

When someone joins a Medicare Advantage plan, his or her Medigap policy will not work. Medigap will not pay any deductibles, copayments, or other cost-sharing under the Medicare health plan. Therefore, the applicant may want to drop his or her Medigap policy when joining a Medicare Advantage plan. However, the applicant has a legal right to keep the Medigap policy.

What Medicare Advantage products are offered by Independence Blue Cross?

Independence Blue Cross offers Personal Choice 65℠ and Keystone 65 as Medicare Advantage products.

Underwriting guidelines

Eligibility. In order for Personal Choice 65 and Keystone 65 to be sold on a group basis, the group customer must be located, and the members of the Personal Choice 65/Keystone 65 group must reside, in the IBC service area (counties of Bucks, Chester, Delaware, Philadelphia, or Montgomery). National accounts may elect to offer Personal Choice 65/Keystone 65 to their members residing in the IBC service area. No out-of-area contracts may enroll.

Minimum group size. An account must have a minimum of two contracts (Medicare and commercial combined) in order for Personal Choice 65/Keystone 65 to be offered.

Multiple retiree products per customer. Underwriting rules allow an account to offer all four types of Medicare products at the same time: Security 65® (Medicare Supplement), Personal Choice 65 (PPO), Keystone 65 (HMO) or one of the Keystone 65 Point-of-Service plans, and Keystone 65 Direct (Open Access POS).

75-percent rule. Personal Choice 65 and Keystone 65 members will be counted toward meeting the 75-percent participation requirement for the entire customer.

Section 10 — Group Medicare products (continued)

Retiree-only accounts. Retiree-only accounts will not be permitted. If the group's active contracts cancel, coverage for early retirees, as well as Medicare coverage, may not remain in force. In such accounts, dependents may be offered one of our individual community-rated products.

New accounts — Medicare Advantage only (no commercial coverage). New Medicare Advantage groups may be sold without the requirement of having a commercial plan in place.

Early-retiree-only accounts. Coverage for *early-retiree-only* group accounts (under age 65 non-Medicare eligible retirees) will not be offered. Early retirees may not represent more than 10 percent of a commercial group.

Rating status. For Personal Choice 65 and Keystone 65 — Community-rated for all new business. For renewals, groups with an average of 50 or fewer enrolled contracts in the 12 months preceding the renewal preparation will be community-rated. Groups with an average of 50 or more enrolled contracts in the 12 months preceding the renewal preparation will be experience-rated. For Medicare Supplemental plans, all programs are community-rated.

Tier structure. Single rate only.

Rate renewal period. Rates will be published and adjusted annually, subject to approval by CMS (Centers for Medicare & Medicaid Services). Rates are expected to be adjusted on January 1 of each year. A group's Personal Choice 65/Keystone 65 rate change date may not match its commercial anniversary date. (If the group has commercial drug, dental, or vision coverage, those rates will change on the group's commercial business anniversary date.)

Medicare supplement. For Medicare supplement coverage, there must be an active under-65 population in order to set up this coverage line, and there must be at least one enrolled life to set up the group coverage. Traditional Major Medical may be offered with Personal Choice 65 (as has been permitted with Security 65® and 65 Special).

Section 10 — Group Medicare products (continued)

Ancillary products

Personal Choice 65:

- Rx – Part D, freestanding (rating follows commercial), or PDP
- Vision – community-rated plan (when no commercial coverage is offered) or a freestanding plan (rating follows commercial)
- Dental – no IBC coverage is available

Keystone 65:

- Rx – Part D rider, freestanding (rating follows commercial), or PDP
- Vision – rider or freestanding (rating follows commercial)
- Dental – rider

Personal Choice 65 and Keystone 65:

- 75 percent participation requirements apply to all freestanding ancillary coverage programs.

Section 11 — IBC/KHPE underwriting guidelines summary

Reference chart

Market segment	Available benefits	Number of allowed options	Participation requirements	Employment contribution requirements	Rate tiers	Submission guidelines	Off-anniversary benefits changes
2 – 50 eligible employees	The Blue Solutions for small employers portfolio of plans integrate medical, Rx, and vision benefits. Choose from copay, deductible, and HSA-qualified** plans.	2 – 4 lives: 1 complete benefits plan package 5 – 50 lives: 2 complete benefits plans packages	2 – 19 lives: 100% participation. Minimum group size is 2 enrolled. 20 – 50 lives 75% participation required	50% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier	New business quotes will be handled through the account installation (AI) process	Only 1 benefits downgrade will be permitted off anniversary
51 – 99 eligible employees	The Blue Solutions Plus portfolio for mid-market employers portfolio features medical plans with optional Rx, and vision. Choose from copay, deductible, and HSA-qualified** plans.	3 total benefits plan packages. Combine up to 3 medical, 2 Rx riders, and 1 vision plan	75% participation required	50% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier	New business quotes will be through the account installation (AI) process	Only 1 benefits downgrade will be permitted off anniversary
PPO 100+ eligible employees	Medical: Underwriting discretion, Rx: Underwriting discretion. For benefits plan details please see page 17.	3 total benefits plans packages. Combine up to 3 medical, and 2 Rx riders. *Exceptions with Underwriting approval	75% participation required	50% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier	New business quotes will be through the account installation (AI) process	Only 1 benefits downgrade will be permitted off anniversary
HMO/POS/ DPOS 100+ eligible employees	Medical: Underwriting discretion, Rx: Underwriting discretion. For benefits plan details please see page 17.	3 total benefits plans packages. Combine up to 3 medical, and 2 Rx riders. *Exceptions with Underwriting approval	75% participation required	50% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier	New business quotes will be through the account installation (AI) process	Only 1 benefits downgrade will be permitted off anniversary

Guidelines within this chart apply for the quotation of new business. For applicable guidelines for existing business, assume enrolled employees instead of eligible.
Refer to guidelines for details on benefits plan restrictions and requirements.
* Quotes for religious exclusion and elective abortion exclusion riders must be submitted via the benefit exception process when they are to be offered in conjunction with a POS program.
** The HSA option must be offered with a Blue Solutions Deductible Series Medical.

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