2017 UNDERWRITING COMPLIANCE GUIDELINES

EFFECTIVE 1.1.2017

Capital BLUE

Capital BlueCross
Group Underwriting Compliance Guidelines
Effective January 1, 2017

- The guidelines within this document apply to all group health, dental, vision, and prescription drug coverages offered by Capital BlueCross, as well as our wholly-owned subsidiaries, Keystone Health Plan® Central, Inc. (KHP Central), Capital Advantage Insurance Company® (CAIC), and Capital Advantage Assurance Company® (CAAC).

- For the purpose of this document, all programs offered by Capital BlueCross, CAIC, CAAC, and KHP Central shall be collectively referred to as "Capital." Any guideline(s) specific to KHP Central will be referenced as HMO.

- Capital Underwriting Compliance Guidelines specific to our consortium and Medicare offerings are available as separate documents to our internal Account Executives.

- As allowed by law, Capital may reject or adjust the rates for any group that does not meet Underwriting guidelines using the eligibility criteria stated on the initial Group Application. The group will have to reapply with no retroactive effective dates permitted. Eligibility criteria may not be changed merely to meet Underwriting requirements. (See additional details throughout these guidelines for differences in market segments.)

- All paperwork for new groups or benefit changes must be received by the deadline stipulated for the requested effective date found within this booklet.

- For definition under the Patient Protection and Affordable Care Act (PPACA): Small Group shall be defined as a group with fewer than 51 employees. Mid-Market Group shall be defined as a group with more than 50 employees and fewer than 105 expected enrollees. Large Group shall be defined as a group with more than 50 employees and 105 or more expected enrollees. Underwriting Compliance reserves the right to make limited exceptions. Capital will initially define group segment based on enrollment data available unless a Certification of Group Size attestation form has been submitted.

- Capital reserves the right to change these guidelines at any time.

- Capital reserves the right to request additional and/or satisfactory documentation to verify a group and its employees or subscribers meet the eligibility criteria, and to reject an application when such documentation is not provided.

- **The information contained within this communication is considered proprietary and should not be shared with anyone other than the intended recipient**. This information is intended only for personal and confidential use of the individual to whom it is issued and may contain information that is privileged, confidential, and protected by law. If you are not the intended recipient, you are hereby notified that any use or disclosure of the information contained herein is strictly prohibited. If you have received this information in error, please notify Capital BlueCross immediately. Your compliance is appreciated.

- **All questions regarding the information contained within should be directed to the Director of Actuarial Operations**.

Capital BlueCross
Group Underwriting Compliance Guideline Index

I. PPACA REGULATIONS AND IMPACTS

A. Defining Group Size Segments

PPACA—The Patient Protection and Affordable Care Act—is a federal statute aimed at improving the access of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mandates, subsidies, and tax credits to employers and individuals.

In 2017, under the law, Large Groups are considered to be any group that has over 50 employees.

Capital defines group sizes for product availability in the following three segments:

1. A Small Group is a group of fewer than 51 employees. This size segment is only permitted to enroll in standard benefits (no customization of benefits). These groups are not eligible for MCC (multi-coverage credit) when purchasing dental and/or vision with their medical coverage. In addition, only the groups that have at least ten enrolled contracts may enroll in ASO (self-insured) products. Capital private exchange products require a minimum of 20 enrolled contracts. (These products are explained in Section III of these guidelines.)

2. A Mid-Market Group is a group of 51 or more employees, with an expected enrollment of fewer than 106 enrollees. This size segment is only permitted to enroll in standard benefits. ASO products and Capital private exchange products are available, as well.

3. A Large Group is a group of 51 or more employees with 105 or more expected enrollees. This size segment is permitted to customize benefits (some limitations apply) or choose from a standard product list. These groups are eligible for MCC when purchasing dental and/or vision with fully-insured medical coverage. ASO products are available. Capital private exchange products are available, as well, however, cannot be customized.

For new groups, Capital will use the enrollment census information and Certification of Group Size form, if provided during prospect quoting, to determine group size for rating purposes. For existing customers, current enrollment information and Certification of Group Size or Medical Loss Ratio (MLR) will be used to determine the group size for rating purposes. If, under PPACA regulations, a group should be in a different segment than they received on the quote, they will have the ability to attest to their group size by completing a Certification of Group Size form. The sales representative will need to follow internal processes to have the group size updated accordingly in the system. After they receive confirmation the update has been made, a new quote can be run.

B. FF-SHOP

1. FF-SHOP stands for Federally-facilitated Small Business Health Options Program. It is a federally-run website that offers Small Group employers an opportunity to purchase health insurance products. Capital group products are not available through FF-SHOP beginning January 1, 2017.

2. FF-SHOP groups are defined as groups that choose to purchase products through the FFM (Federally-facilitated Marketplace).

3. All groups that applied and are enrolled on a 2016 Capital SHOP product, will be transitioned to direct Capital products upon their renewal period in 2017. The renewal sent will instruct the group that they need to do nothing if they agree to the new benefits. Should they wish to remain on FF-SHOP, they will need to cancel the direct coverage and reapply on the FF-SHOP website for another carrier.

C. Per Member Rate Calculation (PMRC)

PMRC is applicable to fully-insured Small Groups. Small Group rates will be determined by the age and tobacco-use status of each member and the geographic location of the group. This means that every person covered by the group, including dependents, may have a different rate applied to him/her. Those rates will then be added together to determine the rate for the entire family. Additionally, each employee will be listed with his or her unique rate on the monthly premium statement.

D. Annual Special Open Enrollment Period

Small Group group/member participation requirements will be waived during an annual special open enrollment period for employer groups that runs from November 15 and extends through December 15 of each year for coverage effective the following January. Any Small Group applying during the special enrollment period as described herein does not need to meet the participation requirements. All other audit criteria must still be met (eligibility, common-law employee, the group is a legal entity with an active EIN located within our 21-county service area, etc.). Small Groups enrolling outside the special enrollment period are required to meet participation requirements, including the 25 percent residency requirement and 75 percent of their eligible employees enrolled as subscribers for the group contract to be issued or renewed. This participation requirement may be met by enrollment in Capital (to include KHP Central, CAIC, and CAAC) products.

E. Pediatric Dental and Vision

Small Groups (groups with fewer than 51 employees) are required under PPACA to enroll in both a pediatric dental and pediatric vision program.

All Small Groups must purchase PPACA-compliant pediatric dental and vision products, regardless if they have any applicable members under age 19 enrolled through the group. All members enrolling in medical must also be enrolled in a pediatric dental and vision product. All Capital medical packages include embedded pediatric dental and vision benefits.

F. Senior℠ Product Eligibility

Effective December 1, 2014 for all new groups and existing groups at renewal: the Senior products will only be open to Medicare-eligible, not actively-working employees. True retired or otherwise not actively-working employees such as COBRA eligibles, may continue to be enrolled in Senior medical or remain enrolled in the Senior Rx if they are already enrolled in the prescription Rx plan. Senior products will not grandfather any current, actively-working, Medicare-eligible enrollment. Please note, the Senior Rx plans are not creditable.

Actively-working, Medicare-eligible employees will be allowed to enroll in the group commercial medical and drug plans offered by the group (must enroll in both medical and drug if the group elects this option) or may enroll in BlueReliance, BlueJourney, SecureRx® PDP, and/or an individual Medicare Supplement program (this product contains no drug offering). Please note, if the group offers an HSA, actively-working, Medicare-eligible employees enrolled in Medicare Part A or B cannot contribute to an HSA due to IRS regulations. The group is also not permitted to make contributions to an HSA or pay for the individual plan for a Medicare enrollee.

Existing groups wishing to add the Senior product or new Senior enrollees will need to confirm the enrollees are not actively-working and eligible to be enrolled in the Senior product. Both existing groups and new groups will be required to confirm member eligibility for the Senior product (via completion of a Certification of Employment Status for Senior form).

G. Guaranteed Availability

Capital offers the same small group products approved for sale to any small group that applies and accepts any small group that applies for any of these products, provided the group meets all UW Compliance guidelines.

H. Guaranteed Renewability

Capital is required to renew or continue in force the coverage at the option of the plan sponsor (with certain exceptions, such as nonpayment of premiums, fraud, termination of product, or not meeting all UW Compliance guidelines). This does not mean that the premiums or fees cannot be increased or decreased. If one product is offered to a group at renewal that product MUST be made an option for ALL groups with similar eligibility at renewal.

II. GROUP ELIGIBILITY

A. Defining an Eligible Group

1. An eligible group is a collection of eligible employees or subscribers who are employed by a single employer. The account must be a legal entity, which has the legal capacity to execute a contract. A group cannot be formed for the express purpose of purchasing insurance.

An eligible group must reflect current, full-time business activity. Dormant or inactive companies will not be viewed as eligible for group health insurance.

2. An eligible group must contain at least one common law employee. Owners/partners/officers, spouses, and/or dependents of owners/partners/officers are excluded from the definition of common law employees. Owner-only groups are not eligible for group coverage.

3. Capital reserves the right to deny, cancel, or rerate any group that does not meet Underwriting guidelines. (Subject to restrictions as identified through PPACA)

An existing group will be given at least 60 days notification of cancellation if found to be noncompliant.

B. Location

1. The business must be physically located within Capital's 21-county service area to be eligible for group coverage. If the group is headquartered outside our 21-county service area, Capital can only insure those locations within our territory with notification to the BlueCross BlueShield Home Plan (the BlueCross BlueShield plan which services the area where the business is headquartered). Any group which is headquartered outside our area and applying for group coverage must be accompanied by a cede agreement before consideration will be given to the application. If the group is headquartered in our service area, we can insure all locations.

2. Participation rules require that Small and Mid-Market Groups have a residency requirement of at least 25 percent of the enrolled employees must reside within our service area, with a 30-mile border leniency applied. All HMO subscribers must reside within our service territory (30-mile leniency is applied) and they must use an HMO network provider in order to receive reimbursement.

C. Common Ownership

IRS aggregation rules will apply when reviewing requests to combine multiple entities for the purposes of applying for health insurance coverage. If a group is part of a controlled group or commonly owned group and is subject to aggregation rules under Internal Revenue Code IRC section 414, the group should be applying for coverage based on the aggregated group size. Proof of aggregation will need to be supplied in order to be approved. Groups must also complete and submit a Certification of Group Eligibility to Combine form and a Certification of Group Size form. There must be only **one** Policymaker legally authorized to make contractual agreements for the entire group population. Capital BlueCross Underwriting Compliance reserves the right to grant final approval on multiple-entity groups.

In the absence of the Policymaker, a signature may be accepted by any C-suite officer or senior executive of the Group (e.g., CEO, CFO, or owner) or any group employee previously authorized on form C-591 (Contract Signing Authority Form).

D. Investment Income

Business that generates only investment income will not be considered a basis for group health coverage. Business that generates only rental income will not be considered eligible unless ancillary services are provided to multiple units and/or the group has at least one eligible employee.

E. Employee Class

A group may set their probationary period, premium contributions, or products offered by type or class of employee within the limitations of PPACA, provided this is applied uniformly to all employees meeting the same criteria.

A group should be discouraged from offering a different level of required hours per week for eligibility. If a group does offer health coverage to a type or class of employee that varies in hours worked per week to be eligible, the audit and compliance determination will be based on the lesser of the hourly requirements.

F. Multiple Options

Capital Enrollment Requirements

For Health and Rx Lines of Business Sold/Renewed Effective January 1, 2017

PPO, CMM, POS, HMO, Traditional, Rx, Senior
(This includes Capital private exchange products.)
(Example: Single option = one PPO, one Rx, one Senior
Dual option = one PPO, one HMO, two Rx, one Senior)

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Small Group (1–19)	Up to three options	**Option mix can contain only one Rx program for each medical option offered.** **Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **No MCC available on dental and/or vision.**	• **Fully-insured—at least 75 percent participation. *** • **ASO ONLY available with ten or more enrolled—at least 75 percent participation. *** • At least 25 percent of enrolled subscribers must reside within our service area.* HMO residency requirement is 100 percent. A 30-mile border leniency will be applied. • A **minimum** of at least **one contract** enrolled in **EACH** option offered. **CareConnect℠ Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured ONLY for this group size. Group must be headquartered in Dauphin, Cumberland, or Perry County. Exceptions can be considered with UW approval if a minimum of 25 percent of the enrolled employees reside within or in immediate proximity of these three counties.

***Except during Special Enrollment period of November 15th through December 15th for a January 1st effective date.**

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Small Group (20–50)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. **Option mix can contain only one Rx program for each medical option offered.** Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **NO MCC available on dental and/or vision**.	• **Can be sold fully-insured or ASO**. • Fully-insured—at least **75** percent participation. * • ASO—at least **75** percent participation. * • At least **25** percent of enrolled subscribers must reside within our service area.* HMO residency requirement is 100 percent. A 30-mile border leniency will be applied. • A **minimum** of at least **one contract** enrolled in **EACH** option offered. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. Exceptions can be considered with UW approval if a minimum of 25 percent of the enrolled employees reside within or in immediate proximity of these three counties.

***Except during Special Enrollment period of November 15th through December 15th for a January 1st effective date.**

Product Segment (number of enrolled subscribers)	Options	Option Mix	Option Enrollment Requirements
Mid-Market Group (up to 105)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. **Option mix can contain only one Rx program for each medical option offered.** Noncompliance with multiple-option guidelines will be addressed at renewal for existing groups. **Note: NO MCC available on dental and/or vision**.	• **Can be sold fully-insured or ASO**. • Fully-insured or ASO—Groups without at least **75** percent participation will be subject to rerating. • At least **25** percent of enrolled subscribers must reside within our service area. • A **minimum** of at least **one contract** in **EACH** option. Exceptions can be made in relation to PPACA regulations. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. Exceptions can be considered with UW approval if a minimum of 25 percent of the enrolled employees reside within or in immediate proximity of these three counties.
Large Group (106+)	Up to five options	**Note: If group elects multiple products at initial enrollment and any of those receive no enrollment, the products without enrollment will be removed from the option mix**. Noncompliance issues will be addressed at renewal for existing groups. These programs can be offered with Prospective or ASO arrangements.	• Fully-insured—Groups without at least **75** percent participation will be subject to rerating. • ASO—at least **25** percent participation. • A **minimum** of at least **one contract** in **EACH** option. Exceptions can be made in relation to PPACA regulations. **CareConnect Gatekeeper PPO** Product can be sold as a full replacement or as a multiple-product offering. Can be sold as fully-insured or ASO. Group must be headquartered in Dauphin, Cumberland, or Perry County. Exceptions can be considered with UW approval if a minimum of 25 percent of the enrolled employees reside within or in immediate proximity of these three counties. Other counties may be considered on a case-by-case basis by Case UW. **PPO Choice Product Suite** Group must be headquartered in Berks, Lancaster, York, or Adams County. Product was designed to be offered as full replacement. Rerating will be applied if any other medical product is offered along with the PPO Choice product. A group may choose to move to a PPO Choice product off renewal; however, they would have to wait until their next renewal to select a non-Choice product.

Note—All Capital medical products offered must have the **same funding arrangement**. In addition, all Capital drug products must have the **same funding arrangement.** All products must be self-insured, or all products must be fully-insured.

Note—All Capital medical products offered must have the **same financial arrangement**. In addition, all Capital drug products must have the **same financial arrangement** (e.g., PPO, Traditional, and HMO must all be Prospective vs. retro credit).

G. Calendar Year vs. Plan Year

A group may elect either a Plan Year or a Calendar Year program design for medical and prescription drug coverage.

This decision to move from one to the other should be made after considering all the facts at the time of renewal. The group should consult their Account Executive and/or producer to understand the impact to their employee's claim payments.

This change can only be made one time. Any group moving to a Plan Year from Calendar Year will not be able to move back to Calendar Year and vice versa.

Please note: Dental is always administered on a calendar year basis, and Vision is always administered based on date of service.

III. PARTICIPATION REQUIREMENTS

A. Fully-Insured Groups (FI)

75 percent participation is required for all fully-insured Small Groups applying for group coverage with Capital outside the annual special open enrollment period for employer groups. Please refer to Section I, Part D. Mid-Market and Large fully-insured groups are required to either meet the 75 percent participation requirement or be subject to rerating.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be counted as enrolled for participation calculation purposes. Employees with other coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage by any carrier and those with public coverage such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. If an employee does not check a line of business on the waiver, Compliance will not assume they are waiving coverage for that product (e.g., if the employee signs the waiver and checks the "medical" box but not the "dental" box, Compliance will only apply the waiver to the medical participation). Capital may verify true and active coverage during any audit activity.

B. Self-Insured Groups (ASO)

Small Business ASO Groups—75 percent participation is required for all self-insured Small Business ASO Groups applying for coverage with Capital outside the annual special open enrollment period for employer groups. Specific and aggregate stop loss coverage is required for all groups. Proof of active stop loss coverage, including aggregate, is necessary upon initial enrollment, as well as subsequent renewal.

Paperwork to enroll must include all new group paperwork as defined in Section IX of this booklet along with the following completed forms: NYHCRA Payor Election application, NYHCRA Electronic Filing application, **signed ASO proposal rate sheet, and signed rate illustration exhibit sheet**.

Large Group ASO—Large self-insured groups are required to either meet a 25 percent participation requirement or be subject to rerating. Specific and aggregate stop loss coverage is required for groups with fewer than 300 contracts. Proof of active stop loss coverage, including aggregate, is necessary upon initial enrollment, as well as subsequent renewal. This requirement of proof applies only to those groups where stop loss coverage is mandatory and is not provided by Capital or Consolidated Benefits, Inc. Required Stop Loss coverage may apply separate participation guidelines. Please reference your Stop Loss carrier's requirements (for Avalon®, please reference the Avalon Stop Loss sales guidelines).

C. 1–19 Contracts

For groups having between one and 19 contracts (excluding Senior), the following participation requirements determine eligibility*:

Total Eligible Employees	Minimum Participation Requirements**
1	1
2	2
3	3
4	3
5	4
6	5
7	6
8	6
9	7
10	8
11	8
12	9
13	10
14	11
15	11
16	12
17	13
18	14
19	14

***Except during Special Enrollment Period of November 15 through December 15 for a January 1 effective date**.
****Total enrolled employees plus valid other insurance waivers**.

D. Capital Private Exchange

Groups with 20 or more enrolled subscribers may apply to use the private exchange tool. Every eligible employee will need to log on to the enrollment tool and either enroll in coverage or waive coverage.

The group must take at least one of the products offered in the Capital private exchange portfolio and cannot alter the benefit design in any way. A group may not offer the same medical plan with different Rx plans. There will also be no ancillary-only contracts or MCC available with the Capital private exchange portfolio for either dental or vision products. The minimum monthly employer funding amount per employee must be 75 percent of the total monthly single-person premium for the lowest priced medical/prescription plan that the group offers to all eligible employees in order for the group to not have to meet a participation requirement. If a group should choose to fund less than 75 percent, the group will then be required to meet the participation rule that applies to their group size. Complete other insurance information will be required when a member waives coverage on the tool. (Please see Section IX, Part E of this document for definition of a complete waiver.)

Paperwork to enroll must include all new group paperwork as defined in Section IX of this booklet along with the Capital private exchange setup form and an open enrollment load file of those employees enrolling. Individual paper applications and waivers are not required (except under special circumstances). **Checks/eChecks for Capital private exchange groups will require the medical and Rx premium amount, on the lowest tier rate of the least-expensive product times the number of eligible employees submitted on the open enrollment file**.

E. Enrollment Minimum

1. All participation guidelines are applied at the employee/subscriber level and not at the dependent level of the contract.

2. If an existing fully-insured Group or an existing Small Business ASO Group falls below the required 75 percent participation level but exceeds 50 percent participation, a one-year grace period may be given to enable the group's participation level to increase. If the group does not reach the required participation level during the next audit, the group coverage will be canceled with at least 60 days notification.

3. Eligible employees who choose to waive coverage and provide a signed waiver with other insurance coverage will be counted in the calculation towards the total participation percentage required. Employees with other group coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage and those with public coverage, such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. Capital reserves the right to verify the presence of active coverage with other carriers.

IV. EMPLOYEE/EMPLOYER CONTRIBUTION

For Capital private exchange products the *employer* can choose to either fund 75 percent of the total monthly single-person premium for the lowest-priced medical/prescription plan that the group offers to all eligible employees or less than 75 percent with the understanding that they are required to meet the participation rule that applies to their group size.

For all other products, there are no contribution limits at this time.

V. EMPLOYEE/SUBSCRIBER ELIGIBILITY

A. Group Subscriber Eligibility

1. An eligible employee is defined as a common-law employee who works a minimum of 20 hours each week for at least nine months a year and receives a regular wage, reportable on a W-2. If an employer chooses to stipulate a higher number of hours required for eligibility, we adhere to that number for audit purposes to determine eligibility. The maximum number of hours a group can set for eligibility purposes is 40 hours (groups must consider their own potential penalties under PPACA if over 30).

2. The definition of what a group considers "full-time" and "part-time" is determined by the group. All employees that are working the required number or eligibility hours set by the group will be considered eligible for coverage, regardless if they are full-time or part-time.

3. Owners/partners that are employees and are actively participating in their business are considered to be eligible and are included in the participation calculation. Owners/partners who only have a financial interest are not considered eligible. Groups cannot be comprised of owners/partners only enrolling. A group must have at least one common-law employee enrolled.

4. Independent contractors receiving a 1099 form are not eligible for group coverage.

5. Members of the Board of Directors cannot be enrolled unless they meet the same criteria as an eligible employee.

6. For the purposes of health care reform, the spouse and/or dependent(s) of a sole proprietor are NOT considered common-law employees. A sole proprietor/business owner and his/her spouse and/or dependent(s) are not considered an eligible group. However, once the sole proprietor/business owner(s) has an average of one common law employee (that is not his/her spouse and/or dependent[s]) and has that employee on the first day of the plan year, then it will be considered an eligible employer group. The common-law employee and the owner(s) can obtain group coverage. The spouse and/or dependent(s) of a business owner may work for the company and (if meeting eligibility requirements) enroll in group coverage, but cannot be used to satisfy group eligibility requirements.

7. Capital does not acknowledge the continuation of group health insurance coverage as part of a severance agreement or personal agreement made between buyer and seller. Former owners of a business are not eligible to remain on group coverage. Former employees determined not eligible for COBRA or mini-COBRA and who do not meet the established retiree policy are not eligible to remain enrolled.

8. An existing subscriber found to be ineligible for group enrollment would be given at least a 30-day notification of cancellation. It is the group's responsibility to inform the subscriber of this termination.

B. Dependent Eligibility

1. An eligible dependent is the spouse and/or child(ren) of an eligible employee/subscriber. This will include legally-married same/opposite-sex spouses, newborn children, children legally placed for adoption, legally-adopted children, stepchildren, or children of a legal guardian. A child is eligible and covered until the age limitation specified in the contract. Certain exceptions may apply if a disability is present. Effective October 1, 2010 at renewal, the dependent age increased to 26 regardless of student status in accordance with health care reform.

2. Divorced/ex-spouses are not eligible to remain on the subscriber's contract, nor are they viewed to be an eligible subscriber unless they are employed by the same group and meet eligibility guidelines.

3. Domestic partnership coverage is available to all group sizes. An affidavit and supporting documentation is required for all Small and Mid-Market Group domestic partner enrollment. An affidavit may be required for Large Group domestic partner enrollment. A group can add this coverage on or off-renewal.

4. Widows/widowers of deceased employees are eligible to remain on the group provided a written policy exists, which is applied uniformly. Such policy may be requested in writing during an audit.

5. Product selections are dictated by the group and the employee. The employee and the dependents may only select products offered by the group.

   Dependents of an enrolled employee can only enroll in products selected by the employee.

   Child-only contracts may be permitted under certain circumstances.

C. ACT 4

On June 10, 2009, Governor Rendell signed legislation expanding insured group health insurance coverage to adult, unmarried children up to age 30. The new Pennsylvania law (Act 4 of 2009) requires health insurers to continue coverage of unmarried children through age 29 at the option of the employer. This law went into effect for group policies renewing on or beginning January 1, 2010.

To be eligible for coverage under Act 4, the adult dependent must meet the following criteria:

1. Is not married.

2. Has no dependents (see definition) of his or her own (regardless of whether or not the dependent lives with or is claimed on a tax return of the adult dependent).

3. Is a resident of Pennsylvania, or enrolled as a full-time student at an institution of higher education.

4. Is not covered under another group or individual health insurance policy or entitled to benefits under any government program.

The employer group should inform Capital, at the time of their contract renewal, if they wish to offer this additional coverage. If so, it is the employer's responsibility to notify Capital when an employee wants to add an eligible dependent to its policy.

Capital will bill the employer a single contract subscriber rate for the coverage of the additional dependent. Since the law states that the employee is responsible for the full cost of the coverage for the dependent, the employer group may wish to collect the cost of the additional premium from the employee.

The dependent must enroll in the same coverage as the employee, except in the case where the employee is over 65.

Note: Groups can only add this on their renewal date. **NO EXCEPTIONS WILL BE MADE**.

D. Retirees

Please note—Capital's Medicare Advantage products are not covered by these Underwriting guidelines. The following applies to our Medicare Complementary products only.

1. Retirees are eligible to remain on the group coverage provided the business has an established retiree policy, which is applied uniformly to all employees. There are no stipulations as to who must pay the premium. A retiree affidavit may be requested from the employer during an audit. Capital does not endorse any policy set by the employer which is discriminatory in nature.

2. Retirees cannot be used to help satisfy participation requirements.

3. Any group having more than 100 Medicare eligibles (active or retired) enrolled will have some flexibility in their product design and should contact their Account Executive to obtain information.

4. Participation rules require that any group having more than 20 percent retirees enrolled is subject to review by the Vice President, Actuarial Services.

   The 20 percent ratio is determined by the total enrolled active employees combined with the number of retirees on the group program.

5. With limited scenarios, Capital will allow retiree-only groups with a minimum of two contracts when no active employees are covered through Capital. The employer group must be an active business with 20 or more actively-working employees, even if they are not covered through Capital. The business must have an established retiree policy, which is applied uniformly to all employees. A retiree affidavit may be requested during an audit or at enrollment of new contracts. Retiree-only groups will be able to enroll in the standard Senior medical product only (no Senior drug coverage).

6. Medicare Secondary Payer (MSP) rules and guidelines should always be referenced prior to assisting our groups with product selection and eligibility.

7. Senior products are not available for enrollment through the Capital private exchange platform. Retirees needing Senior products will be handled outside of the Capital private exchange platform.

E. COBRA

1. Capital does not administer COBRA, and therefore, we do not determine COBRA eligibility. The group's legal counsel should advise the group in conjunction with their COBRA administrator. Eligibility for COBRA may be questioned if no qualifying event is evident.

2. Participation rules require that a group cannot exceed more than 20 percent COBRA continuants based on total enrollment.

3. COBRA continuants cannot be used to help satisfy participation requirements.

4. A group cannot be comprised of COBRA continuants only with no active contracts enrolled.

5. COBRA enrollment through the Capital private exchange platform must be discussed with Sales Administration.

   Mini-COBRA Law

   The mini-COBRA Law allows eligible employees and dependents to purchase health insurance for a period of nine months after their employment ends. It applies to medical and drug coverage and does not include dental and vision coverage.

   Note: The Medicare Secondary Payer (MSP) code on our system will be used to determine whether a group falls into the Small Group classification for existing groups. New group business will have to complete the Group Application in order to provide the information necessary to determine eligibility for mini-COBRA.

VI. RATING METHODS/PRODUCT CHANGES

A. Rating Methodology and Limitations

1. Quotes for new prospect groups should be submitted using the following guidelines:

a. Fully-insured Small Groups should be quoted using PMRC-based rates and Small Group products.

b. Small Groups expecting to enroll 10–50 contracts as self-insured should be quoted using demographic base rates with ASO products.

c. Mid-Market Groups expecting to enroll as fully-insured or self-insured should be quoted using demographic base rates and Mid-Market products. Groups with fewer than 51 on the census submitted will require a Certification of Group Size form that attests that the group has more than 50 employees.

d. Large Groups expecting to enroll more than 105 contracts should submit a quote request to Case Underwriting using normal procedures and supplying required documentation.

e. Underwriting Compliance will have the final determination as to whether a new group will be deemed Large, Mid-Market, or Small at the time of the initial audit prior to enrollment based on actual enrollment received.

2. SIC Code Determination:

For all new groups, the primary SIC Code shown on the Dunn & Bradstreet website will be used. There are no exceptions to this policy.

B. Group Termination—Small and Mid-Market Groups

When a Small or Mid-Market Group voluntarily terminates coverage with Capital and reapplies for coverage after a lapse in coverage of any amount of time, they will be considered a new business. New member applications will be required to obtain rates. Please refer to Account Administration policies surrounding additional requirements for groups requesting cancellation and reinstatement.

C. Preliminary Rate Process

Underwriting Compliance will provide preliminary rates for all ASO Small Groups upon receipt of the Service Request. Sales/Producers will be required to collect a group application and a member level census file from the group. The census file must include member level information of first and last name, gender, contract type, date of birth, employment status, ZIP Code, and Medicare eligibility. This information should be attached to a Service request and submitted to Underwriting Compliance.

The preliminary rates are provided to the group and, if accepted, full paperwork and deposit check are required. Once the prospect group is submitted for the final audit, final rates will be based upon actual enrollment.

D. Quoted Rate vs. Actual Rate

The rates presented to a new prospective group will be confirmed through the audit process. The actual enrollment reflected on the individual applications (combined with any necessary risk assessment—for ASO Small Groups only) will be the basis for the final rate. If the rate must change, the representative will be notified and given two working days to return a decision from the group stating they approve or reject the new rates. A new signed rate sheet is required.

All Large Group quotes will be quality checked to assure all caveats initially presented to the group are fulfilled.

For Mid-Market Group business, all quoting activity is considered complete once the paperwork is received at Capital. No further changes will be made to the quote, and the final group rates will be run in Underwriting Compliance based on actual enrollment received.

E. Product Change—Off-Renewal

1. A Small or Mid-Market Group may choose to change products or add products within the first eight months of their contract period. These product changes will only be considered if moving to a lesser benefit design program. Both Medical and Rx benefits must be considered when comparing value/richness of benefits.

2. All product change activity for Small and Mid-Market Groups will be frozen 120 days prior to the renewal date.

3. A Small or Mid-Market Group must be fully paid to date prior to requesting any benefit change.

4. A Large Group may choose to change products or add during their contract period. These product changes are group-specific and will be considered on a case-by-case basis by the Director of Case Underwriting.

5. "Material" benefit change paperwork should be submitted 75 days in advance of the effective date requested to meet the PPACA Summary of Benefits and Coverage (SBC) requirement of 60-day notice to employees when off-renewal changes are made.

VII. REPOOLING EXISTING GROUPS

Each group is evaluated annually prior to their renewal to determine if they are in the appropriate market segment for rating and product selection purposes. Criteria considered may include: PPACA-guaranteed renewability regulations, enrollment in Capital products (excluding Senior) during the prior 12-month period, group size based on reported average number of employees for the calendar year immediately preceding their renewal date, anticipated change to an account's corporate structure, and other historical fluctuations:

A. Capital Small Groups Moving to Mid-Market

If the average total enrollment for all health options over a 12-month period is more than 50 contracts, the group may be repooled on their next anniversary date. A Mid-Market Group renewal is generated and delivered to the group approximately 75 days prior to their anniversary. Benefits are changed to reflect benefits offered to Mid-Market Groups. Due to guaranteed renewability regulations, a group may elect to keep their existing product (only their existing product, no benefit changes are allowed) unless the product is no longer offered. Should a group elect to keep their current product, rating impacts may apply.

B. Capital Mid-Market Groups Moving to Small

If the average total enrollment for all health options over a 12-month period is fewer than 51 contracts and we do not have a prior attestation on file from the group, the group may be repooled on their next renewal date. If the group has fewer than 51 employees, a Small Group renewal is generated and delivered to the group approximately 90 days prior to their anniversary. Benefits must be changed to reflect PMRC and benefits offered to Small Groups. If the group feels they did not receive the correct renewal, Underwriting Compliance will send a Group Size Attestation to the group for completion in order to verify the total employees. If the group completes the attestation indicating they have more than 50 employees, the renewal will be reprocessed.

C. Capital Mid-Market Groups Moving to Large

If the average total enrollment for all health options over a 12-month period is more than 105 contracts, the group may be repooled on their next anniversary date. A Large Group renewal is generated and delivered to the group approximately 60 days prior to their anniversary. Due to guaranteed renewability regulations, a group may elect to keep their existing product (only their existing product, no benefit changes are allowed) unless the product is no longer offered. Should a group elect to keep their current product, rating impacts may apply.

D. Capital Large Groups Moving to Mid-Market

If the group's average total enrollment for all health options during the Base Experience Period (BEP) is fewer than 90 contracts when the renewal is calculated, the group may be repooled. Benefits are changed to reflect benefits that are offered to Mid-Market Groups. Due to guaranteed renewability regulations, a group may elect to keep their existing product (only their existing product, no benefit changes are allowed) unless the product is no longer offered. Should a group elect to keep their current product, rating impacts may apply.

E. Groups Changing Risk Pools

Existing groups changing risk pools are processed differently than new groups. All groups changing risk pools (e.g., fully-insured Small or Mid-Market Group moving to ASO) should be quoted using the existing enrollment. In addition, groups may only change risk pools at the time of their renewal. Requests to move risk pools received off renewal will be denied. Groups can leave consortiums off renewal to quote direct business.

F. Groups Falling Below Minimum Requirements

If a Small Business ASO group would drop below 10 contracts upon renewal, they will not be permitted to stay in the ASO product. They will be automatically mapped into fully-insured plans at renewal.

VIII. OTHER UNDERWRITING COMPLIANCE GUIDELINES

A. Audit Selection Criteria

1. The following actions require a full audit to be completed:

a. All new fully-insured groups. All products will be audited.

b. All new Small Business ASO groups. All products will be audited.

c. All existing groups falling below three active contracts enrolled.

2. The following groups may be subject to an audit:

a. Any existing groups with an enrollment variance of ten percent or more.

b. Any existing groups that are suspected of fraud or activity resulting in noncompliance with Underwriting guidelines.

c. Any existing groups moving from one risk pool to another where an audit is normally required (e.g., large group to mid-market, ASO to fully-insured). Exceptions can be made if a full audit was conducted within 1–2 years prior.

d. Any Small and Mid-Market Groups where an audit has not been completed in two years.

e. Any Large fully-insured groups where an audit has not been completed in four years.

f. Any group not responding to reporting requirements, regulatory mandates, or legal issues.

3. Underwriting Compliance will notify the Account Executive and/or producer within 15 days in advance of any audit taking place for all existing group business. The group will be notified by mail with instructions regarding necessary documentation, and the time frame to comply will be clearly communicated with the audit request. Failure to respond to repeated requests for audit documentation may result in termination of group coverage.

4. Underwriting Compliance reserves the right to randomly audit any group to assure continued compliance with our guidelines. This includes, but is not limited to, verification of correct product selection, such as group size and Senior eligibility.

B. Termination of Group Policies

Capital may terminate any products, members, or group contracts based on noncompliance with the contribution/participation rules found within these Underwriting Compliance Guidelines. All group level cancellations will be given with at least 60 days notice prior to cancellation. All membership specific cancellations will be given to the group with at least 30 days prior notice to the member's cancellation.

C. FSA Enrollment Requirements

The Flexible Spending Account (FSA) product can only be sold when a group also purchases a Medical product. Capital does not allow FSA-only group contracts.

The FSA product is not available for Small fully-insured groups. Any Small Business ASO or Mid-Market group that selects a FSA product must note that employees MUST enroll in the medical in order to take the FSA product. There is no FSA-only subscriber option. For Large groups, employees can elect to enroll in the FSA-only, but there is an additional fee assessed when not accompanied by the medical plan.

IX. NEW GROUP ENROLLMENT PAPERWORK

A. Group Application—Must be completed in full by the group. Missing information may delay the audit process and may result in a later effective date. In some cases, this document serves as the group contract and, as such, must be completed by the Policymaker. The group will be contacted to provide any missing information prior to enrollment, ID card issuance, or benefit change activity. Electronic signatures are not permitted.

B. Signed Rate Acceptance Pages—Groups in each size segment will be required to sign the applicable rate page. Small Groups must include the signed Age Band rate sheet. Mid-Market Groups must include the composite rate sheet. Large Groups must include the Underwriting rate sheet. In addition to the signed rate acceptance, groups that enroll in Small Business ASO will be required to submit the signed rate illustration exhibit page.

C. Group Attestation Forms (as applicable)—Multiple groups combining as one entity must complete a Group Certification of Group Eligibility to Combine form with all EINs listed. Any groups that have over 50 employees, but have enrollment below 51 subscribers, must complete a Certification of Group Size form.

D. Individual Applications—Original applications must be presented and completed entirely by the subscriber. Missing information will delay the enrollment process. Capital also accepts a standard electronic enrollment Excel template. Electronic signatures are permitted on individual applications from approved vendors (FormFire and Easy App) **only**.

Capital private exchange products: Applications not required; however, the Open Enrollment file is required.

E. **Waiver Forms**—All eligible employees must complete a waiver form if they are choosing not to enroll. Electronic signatures are permitted from approved vendors (FormFire and Easy App) **only**. Capital also accepts a standard electronic waiver Excel template.

All eligible employees who complete a waiver in its entirety (including which products they are waiving) will be counted in the calculation towards the total participation percentage required. Employees with other coverage (e.g., from a spouse, parental coverage where the employee is a dependent, individual coverage—including individual Marketplace coverage by any carrier and those with public coverage, such as Medicare and Medicaid) will be calculated as enrolled. Employees covered as the subscriber on group coverage with another carrier offered by the same employer group will NOT be considered valid waivers for purposes of meeting participation guidelines. If an employee does not check a line of business on the waiver, Compliance will not assume they are waiving coverage for that product (e.g., if the employee signs the waiver and checks the "medical" box but not the "dental" box, Compliance will only apply the waiver to the medical participation). Capital may verify true and active coverage during any audit activity.

Waiver forms are not necessary for a spouse or children who are not enrolling.

Capital private exchange products: Every eligible employee will need to log on to the shopping tool and either enroll in coverage or waive coverage. The shopping website will collect the other insurance waiver information.

F. **Sales Paperwork**—All required sales paperwork should be complete and presented as a *packet* with the enrollment/audit documents. Paperwork should NOT be presented in pieces, to avoid delays and/or loss (e.g., NYHCRA Payor Election application and NYHCRA Electronic Filing application for Small Business ASO groups, HRA set-up form, eGEMS® service agreement).

G. **Premium Deposit (must be received in Cash Processing)**—**All new Small and Mid-Market Group applications must be accompanied by a one-month premium deposit (check or eCheck)**. **Capital will not accept a postdated check**. **All deposit checks for Small and Mid-Market Group coverage must be made payable to "*Capital BlueCross*." Underwriting will verify the funds have been received in Cash Processing when they receive the new group paperwork**. ***Special payment arrangements can be made for billing agents with signed agreement forms.**

Capital private exchange groups will require the medical and Rx premium amount, on the lowest tier rate of the least-expensive product times the number of eligible employees submitted on the open enrollment file.

Capital reserves the right to request additional deposit monies when a delinquent payment history exists.

H. **Employee Tax Documentation**—The most recent tax documentation available must be presented to verify the eligibility of all owners and employees enrolling/enrolled for group coverage. These include, but are not limited to:

1. UC-2—most recent unemployment compensation report (should be marked by the group indicating each employee's eligibility status, e.g., eligible, termed, seasonal).

2. W-2 for any current employee that does not appear on the UC-2.

3. Pay stubs for all newly hired employees not yet appearing on the UC-2.

4. A list of anyone not on the UC-2 or receiving a pay. Also must include a reason of eligibility (e.g., retired, COBRA).

Note: Underwriting Compliance will follow up for the first available UC-2 when applicable (e.g., for a new start-up company, new hire verification).

I. **Ownership Tax Documentation**—The most recent tax documentation filed yearly with the Internal Revenue Service must be presented for the following:

1. All groups choosing to combine multiple business entities for rating purposes, regardless of group size. (All companies wishing to combine must submit tax documents along with a Certification of Group Eligibility to Combine form.)

2. All groups where the owner(s) is enrolling and does not appear on the UC-2.

3. Any groups where fewer than four applicants are enrolling.

These forms include, but are not limited to:

Schedule C, 1065 U.S. Return of Partnership Income (including all K-1s), 1120 U.S. Corporation Income Tax Return, 1120S U.S. Income Tax Return for an S-Corp (including all K-1s), or 990 Return of Organization Exempt from Income Tax.

*If group is a brand new entity, we will require them to submit the following:

1. SS-4 or PA-100.

2. Letter signed by the Policymaker listing all eligible employees.

3. At least one pay stub for each employee enrolling.

4. If a group has been recently purchased, documentation demonstrating proof of new ownership will be required (e.g., signed Sales Agreement).

Note: Underwriting Compliance will follow up for the first available corporate tax docs.

Underwriting Compliance reserves the right to request ownership tax documentation for all other group coverage applications when deemed necessary. The necessity will be determined by the Director of Actuarial Operations.

**Please note to CBC internal users ONLY—Paperwork Checklists are maintained on Salesforce in the content library.

X. BLUE CROSS DENTAL℠ ENROLLMENT REQUIREMENTS

Market Segment (Enrolled Subscribers)	Minimum Participation Required	Product Selection	Additional Requirements
Small Group (1–19)	75%	**Standard products only**.	• Single-option dental only up to nine enrolled contracts. • Dual option available to ten+ enrolled contracts with a minimum of three enrolled in each option. • No other dental carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • **Vision Value Plan is available at no cost with the purchase of a Dental product for Small ASO groups. No other MCC available.**
Small Group (20–50)	75%	**Standard products only**.	• Single or dual-option dental is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other dental carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • **Vision Value Plan is available at no cost with the purchase of a Dental product for ASO groups. No other MCC available.**
Mid-Market (51–105)	75%	**Standard products only**.	• Single or dual-option dental is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other dental carrier can be offered. • Eligible employees choosing to waive medical can still enroll in the dental product. • **Vision Value Plan is available at no cost with the purchase of a Dental product. No other MCC available.**
Large Group (106+)	75%	Product design can be customized.	• Single or dual-option dental is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • Eligible employees choosing to waive medical can still enroll in the dental product. • MCC may be available for fully-insured groups ONLY. • Select products are not eligible for MCC.
Voluntary (10–105)	25%	**Standard product only.**	• Cannot be sold as dental only. • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as dental only.
Stand-Alone Dental Only	75%	1–105 standard products only. 106+ products can be customized.	• Single-option dental up to nine contracts enrolled. • Dual-option dental is allowed for ten+ enrolled. • Not eligible for Voluntary dental product.

Please note—All dental products offered as a dual option must differ by more than simply adding orthodontic or major services.

Underwriting Compliance must approve exceptions.

Note: Existing customers will have two years to meet all dental-compliance guidelines.

Dental product changes can be made ONLY at renewal (except at initial purchase of the BlueCross Dental product).

Voluntary dental product can only be offered at the group level and billed at the group level.

Voluntary dental cannot be sold as dental only (i.e., can only be sold in conjunction with medical).

No MCC allowed for Small PPACA fully-insured groups, Select products, or any size ASO groups.

Fully-insured groups that offer the Dental PPO Value 75 Plan with Multi-Coverage Credit (MCC) MUST also offer a buy-up plan, and the minimum enrollment must be met for each plan based on the group size described in the chart on the previous page.

MCC requires minimum of 75 percent participation in both medical and dental plans.

Small Business ASO medical plans that purchase Dental, must note that the dental product is fully-insured. There are no self-insured dental plans available to small business.

Standard portfolio dental benefits are administered based on calendar year. Large groups may have calendar year or contract year plan designs.

There will be no SIC Codes excluded.

A group may not split products across risk pools. For example: XYZ Consortium does not offer dental but group within XYZ Consortium wants to enroll directly with BlueCross Dental. This would not be allowed. If a group wants to offer dental, in this case, they would have to leave XYZ and enroll directly with Capital for all products. Limited exceptions may apply.

XI. BLUE CROSS VISION[SM] ENROLLMENT REQUIREMENTS

Market Segment (Enrolled Subscribers)	Minimum Participation Required	Product Selection	Additional Requirements
Small Group (1–19)	75%	**Standard products only**.	• Single-option vision only up to nine enrolled subscribers. • Dual option available to ten+ enrolled contracts with a minimum of three enrolled in each option. • No other vision carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • **Vision Value Plan is available at no cost with the purchase of a Dental product for ASO groups. No other MCC available.**
Small Group (20–50)	75%	**Standard products only**.	• Single or dual-option vision is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other vision carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • **Vision Value Plan is available at no cost with the purchase of a Dental product for ASO groups. No other MCC available.**
Mid-Market (51–105)	75%	**Standard products only**.	• Single or dual-option vision is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • No other vision carriers can be offered. • Eligible employees choosing to waive medical can still enroll in the vision product. • **Vision Value Plan is available at no cost with the purchase of a Dental product. No other MCC available.**
Large Group (106+)	75%	Product design can be customized.	• Single or dual-option vision is allowed. • Each option must have a minimum of five contracts enrolled/enrolling. • Eligible employees choosing to waive medical can still enroll in the vision product. • MCC may be available for fully-insured groups ONLY.
Voluntary (10–105)	25%	**Standard product only.**	• Cannot be sold as vision only. • Minimum ten contracts enrolled at all times to maintain voluntary product.
Voluntary (106+)	25%	Product design can be customized.	• Cannot be sold as vision only.
Stand-Alone (Vision Only)	75%	1–105 standard products only. 106+ products can be customized.	• Single-option vision up to nine contracts enrolled. • Dual-option vision is allowed for ten+ enrolled. • Not eligible for Voluntary vision product.

Underwriting Compliance must approve exceptions.

Note: Existing customers will have two years to meet all vision-compliance guidelines.
Vision product changes can be made ONLY at renewal (except at initial purchase of the BlueCross Vision product).

Voluntary vision product can only be offered at the group level and billed at the group level.

Voluntary vision cannot be sold as vision only (i.e., can only be sold in conjunction with medical).

No MCC allowed for Small PPACA fully-insured groups or any size ASO group.

Fully-insured groups that offer the Vision Value Plan with Multi-Coverage Credit (MCC) MUST also offer a buy-up plan, and the minimum enrollment must be met for each plan based on the group size described in the chart on the previous page.

MCC requires minimum of 75 percent participation in both medical and vision plans.

Small Business ASO medical plans that purchase Vision, must note that the vision product is fully-insured. There are no self-insured vision plans available to small business.

Vision benefits are administered based on date of service.

There will be no SIC Codes excluded.

A group may not split products across risk pools. For example: XYZ Consortium does not offer vision but group within XYZ Consortium wants to enroll directly with BlueCross Vision. This would not be allowed. If a group wants to offer vision, in this case, they would have to leave XYZ and enroll directly with Capital for all products. Limited exceptions may apply.

XII. PAPERWORK DUE DATES

2017 Effective Dates

Effective Date	All Group Paperwork Due Date (new and change)*	Ten Day Cancel Date**
January 1, 2017	12/12/2016	12/19/2016
January 15, 2017	01/01/2017	01/02/2017
February 1, 2017	01/12/2017	01/18/2017
February 15, 2017	02/01/2017	02/01/2017
March 1, 2017	02/12/2017	02/15/2017
March 15, 2017	03/01/2017	03/01/2017
April 1, 2017	03/12/2017	03/20/2017
April 15, 2017	04/01/2017	04/03/2017
May 1, 2017	04/12/2017	04/17/2017
May 15, 2017	05/01/2017	05/01/2017
June 1, 2017	05/12/2017	05/18/2017
June 15, 2017	06/01/2017	06/01/2017
July 1, 2017	06/12/2017	06/19/2017
July 15, 2017	07/01/2017	07/03/2017
August 1, 2017	07/12/2017	07/18/2017
August 15, 2017	08/01/2017	08/01/2017
September 1, 2017	08/12/2017	08/18/2017
September 15, 2017	09/01/2017	09/01/2017
October 1, 2017	09/12/2017	09/18/2017
October 15, 2017	10/01/2017	10/02/2017
November 1, 2017	10/12/2017	10/18/2017
November 15, 2017	11/01/2017	11/01/2017
December 1, 2017	11/12/2017	11/17/2017
December 15, 2017	12/01/2017	12/01/2017

***** Paperwork is due in to Sales Services by this date (New Group mailbox= New Group Paperwork, CBC; Renewal/Changes mailbox= Small Group Paperwork, CBC)—any groups submitting after this date will need to submit signed late letter (must be signed by both the group and, if applicable, the producer). Receipt of ID cards by effective date is not guaranteed if submitted after this date.

It is the group's responsibility to provide the SBC document to their employees within the timeframes required by PPACA. If the group fails to meet the PPACA notification requirements, penalties may be incurred.

****** Termination requests must be received by Capital prior to the end of business on this date. Producers may submit requests from groups to: cbcgrptermreq@capbluecross.com.

- 15th of the month effective dates are not available to medical HMO Products.

- All Preliminary rate requests must be submitted by the 12th of the month prior to the effective date requested. Any preliminary rate request submitted after the 12th will be denied, and the group will need to submit full final paperwork to obtain rates.

XIII. FREQUENTLY ASKED QUESTIONS

What if I do not have all the paperwork needed? Can I submit what I have?

No. Underwriting Compliance cannot complete an audit unless all the needed documentation is submitted. Paperwork should not be received in pieces.

How long will the audit process take for a new group?

If all necessary paperwork is received, the audit for a new group will be completed in five business days or less. Missing paperwork could delay the process.

How does the group get enrolled?

Underwriting Compliance forwards all new group paperwork and applications to Account Administration where the group is enrolled and ID cards are generated. Certain groups may have electronic enrollment and will not require paper applications. The spreadsheet is forwarded to the Account Administration mailbox. The need for hard-copy individual enrollment applications for any group activity is determined by our Account Administration department.

What if the group does not complete all fields on the Application for Group Benefits?

An updated group application will be requested by the UW Compliance Specialist working the group audit. All the information requested on the group application is imperative to the processing of the group paperwork.

Which employees should be entered into the census to obtain a quote?

For fully-insured groups sized fewer than 51: all employees expected to enroll should be entered into the census, as well as all of their dependents, COBRA contracts, dependents through age 29 (Act 4—need enrolled as own single contract), and retirees. Medicare primary indicator and current employment status should be marked appropriately.

For Small Business ASO and Mid-Market groups: all active enrolling employees, COBRA contracts, and retirees. Medicare primary indicator and current employment status should be marked appropriately. *Dependents through age 29 (Act 4) will be enrolled as a single contract; however, they should NOT be included in this census for quoting.

It is important to note that the census used to produce a quote very often varies from the actual enrollment. As a result the rates may change for ASO groups and fully-insured groups of 51 or more, however, the group will always have the opportunity to reject the new rates and pull the application prior to actual enrollment.

Why does Underwriting Compliance contact a group directly to ask questions?

Capital's contract is with the group and, specifically, the Policymaker. Underwriting Compliance very often has the need to verify information or obtain more clarity surrounding notations found on tax documentation, etc.

The Account Executive and producer will be informed when this has occurred, but the audit process will not be delayed to gain permission. This would only result in further delays to the enrollment process.

Who is responsible for indicating eligibility on the UC-2?

This function can and should ONLY be done by the Policymaker or someone with specific knowledge concerning employee status at the group. The information pertaining to eligibility which is marked on the UC-2 is vital to the audit process, and that information must be credible.

The UC-2 should be clearly marked with notations for each employee listed stating eligible, terminated, not eligible, waiving, etc. This will be used for audit purposes and, in some cases, could impact the approval or denial of the group application. Account Executives and/or producers should never assume responsibility for this task.

Who can be the Policymaker of a group?

The role of Policymaker should always be clearly defined to a potential new group customer. The Policymaker **must** be an individual directly employed by the group or an owner of the business who has the legal authority to sign a contract, as well as make health program decisions on behalf of the employees at that location. There can only be ONE Policymaker. The Policymaker may designate a Group Leader/Group Administrator, who will handle the daily operation and employee issues of a group program. In the absence of the Policymaker, a signature may be accepted by any C-suite officer or senior executive of the Group (e.g., CEO, CFO, or owner) or any group employee previously authorized on form C-591 (Contract Signing Authority Form).

Tax documents contain confidential information. How can I be sure this will not be shared?

Capital has very strict Human Resource policies concerning the confidentiality of our customer information. Capital is also very aware of the need for compliance with all Health Insurance Portability and Accountability (HIPAA) regulations.

Although a group's tax documentation is **always** required to prove eligibility and compliance, these documents never leave the Underwriting Compliance files. The documents are filed within this department's locked filing cabinets or in access-restricted electronic folders. At Capital, we take our customer's privacy very seriously.

How does a group know if they are required to have pediatric dental and vision coverage?

All fully-insured Small Groups (groups with fewer than 51 employees) are required under PPACA to purchase pediatric dental and vision coverage. All 2017 Small Group products include both the pediatric dental and vision coverage within the medical product.

capbluecross.com