SMALL EMPLOYER GROUP

Underwriting Guidelines 2024

Medical, Dental, Vision

of Tennessee

Contents

Eligibility Guidelines 6
- Group Size Definition 6
- Counting Employees to Determine Group Size 6
- Employer Eligibility 7
- Employee Eligibility 8
- Dependent Eligibility 9
- Other Eligible Participants 10

Assignment of Eligibility and Coverage Effective Dates 12
- Assignment of Eligibility and Effective / Termination Dates 12
- Group Coverage Effective Dates 12
- Employee Coverage Effective Dates 12
- Dependent Coverage Effective Dates 13
- Late Applicants 13
- Employees Returning from Military Service/Reinstatement of Coverage 14
- Open Enrollment Period 15
- Rehire Provision 15
- HIPAA Special Enrollment and Qualifying Events 15

Benefit and General Underwriting Guidelines for New and Existing Business 17
- Medical, Dental and Vision Benefits 17
- Benefit Exceptions 17
- COBRA Administration Services 17
- Grandfathered Health Plans 18
- 24 Hour Coverage 18
- Carve Outs/Class Outs 18
- Different Benefits by Class of Employee 18
- Employee Only Coverage 19
- Underwriting Guidelines for Employee Only and Employee/Child Only Coverage 19
- Multi Options 19
- Plan Year Administration 20
- Contraceptive Services Exclusions 20
- Contribution and Participation Requirements 20
- Rate Tier Structure 21
- Bankruptcy / Poor Payment History 21

Common Ownership / Single Employer Verification 22
Coverage Continuation 22
State Continuation Coverage 24
Leave of Absence 25
Benefits after Coverage Ends 25
Companion Life GAP Plans 26
Quoting Guidelines for New Business 28
Required New Business Quote Information 28
Sale Submission Checklist 29
Guidelines for Existing Business 31
Renewals and Renewal Notices 31
Adding Coverage to Existing Business 31
Benefit Changes for Existing Groups 31
Client Reporting 32
Existing Groups with Name, Address, Ownership and/or Census Changes including Group Splits 32
Requests to Change Renewal Date 32
Group Failure to Comply with Underwriting Guidelines 32
Rating Guidelines for New and Existing Businesses with EHB Plans with Composite Rating 34
DentalBlue Multi Option Guidelines 36
Contribution and Participation Requirements for 2024 38
Required Tax Documentation for Sales and Group Splits 40
Level Funding for Small Employers 45
General Info 45
Administrative Expenses include the following: 45
Stop Loss Protection 45
Claims Funding 45
Benefits 46
Medical 46
HRA 46
Dental and Vision 46
Underwriting Guidelines 46
Continuation Coverage 47
Audit 47
Billing 48

Reporting..... 48
Standard Interactive Reporting (IR)..... 48
ERISA 5500..... 48
Settlement Process..... 48

Eligibility Guidelines

Group Size Definition

Counting Employees to Determine Group Size

Employer Eligibility

Employee Eligibility

Dependent Eligibility

Other Eligible Participants

Eligibility Guidelines	
Group Size Definition	For rating and benefit purposes, a small employer group is defined as an employer who employed an average of at least one employee but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Rates and benefits offered by BlueCross are based on employer attestation of group size (i.e. small or large employer per Affordable Care Act (ACA) guidelines). For existing groups, the most recent ACA/Medical Loss Ratio (MLR) employer size certification will be used to determine group size. For existing groups that do not respond to the certification, the average number of total subscribers over the prior calendar year will be used to determine the group size. For prospect groups, employer size should be disclosed during the quoting process. For sales, employer size is confirmed via the Employer Group Application (EGA).
Counting Employees to Determine Group Size	All employees issued a W-2 are considered employees, regardless of hours worked or eligibility for or enrollment in the health plan. This would include full-time, part-time and seasonal employees. Independent contractors (i.e. 1099 workers) should only be counted as an employee if they meet the common law employee standard. A sole proprietor and his/her spouse are not considered employees. Partners in a partnership and their spouses are not considered employees unless the partners are bona fide partners pursuant to 45 CFR 146.145(c)(2) and both work for the partnership. Corporation shareholders are not considered employees unless they meet the common law employee standard and are issued a W-2. Some employers own multiple businesses. If the businesses are treated as a single employer under Internal Revenue Code section 414 (b), (c), (m) or (o), they should be combined for purposes of counting employees. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

Employer Eligibility *Associations, Professional Employer Organizations (PEOs), leasing companies, Multiple Employer Welfare Arrangements (MEWAs) and unions require approval prior to quoting.*	**A small employer group must meet the following requirements to be eligible for BlueCross group coverage:** • The group must be a valid employer group and actively conducting business as a going concern. • The group must have a primary business location and employees in Tennessee *(or Walker, Dade Catoosa counties in north Georgia for level funding)*. • If covering out-of-state employees, branches, locations and/or subsidiaries, the group must have a Tennessee headquarters *(or a north Georgia headquarters for level funding)* as confirmed by Dun & Bradstreet financial reports and wholly own the out of state branches, locations and/or subsidiaries. • The group must have a minimum of two employees eligible for coverage and one common law employee enrolled in the coverage at all times*. *Sole proprietorships must have at least one non-spouse common law employee enrolling for coverage.* 1065 *partnerships must also have at least one non-spouse common law employee enrolling for coverage unless the partners are bona fide partners pursuant to 45 CFR 146.145(c)(2). Corporation shareholders are not considered common law employees unless they are issued a W-2. 1099 workers are generally not considered a common law employee.* **For stand-alone dental and vision groups, a minimum of five subscribers (including one common law employee) is required.* • If including more than one business under a single policy, the group must attest that they are a single employer as defined under Section 414 (b), (c), (m) or (o) of the Internal Revenue Code. ***To verify compliance, groups should submit the Single Employer Verification Form.***

Employee Eligibility	**Employees/owners considered eligible for coverage are listed below. Employees/owners must be actively at work and have satisfied all eligibility requirements of the employer including any eligibility waiting period to be eligible for coverage. All employees/owners listed below must also be paid by the policyholder or one of its subsidiaries approved for coverage under the group plan.** **Employees Eligible for Coverage:** • Full-time employees who work at least 30 hours per week • Part-time employees who work at least 20 hours per week • Corporate Officers and Owners who work at least 20 hours per week • Leased employees that meet the requirements of either a full or part-time employee and are considered the common law employee of the policyholder • Seasonal/Temporary employees who meet the requirements of either a full-time or part-time employee • Minors (i.e. employees less than 18 years of age) may be eligible for coverage only if they meet the requirements of a full-time or part-time employee and still comply with all Tennessee and U.S. Department of Labor child labor laws • Expatriates (i.e. U.S. citizens working at a U.S. company's foreign location) may be covered under the U.S. company's group health plan if they meet the requirements of a full-time or part-time employee • Foreign Nationals (i.e. non-U.S. citizens who come to live and work in the U.S. for a U.S. company for a specified period of time) may be covered if they meet the requirements of a full or part-time employee **Employees Not Eligible for Coverage:** • Commission employees, temporary/seasonal employees, of counsel employees, consultants, stockholders and prior owners are not eligible unless they meet the requirements of a full or part-time employee listed above. • Elected or appointed officials including board members are not eligible unless they meet the requirements of a full or part-time employee or serve a rural co-op or public utility. For a rural co-op or public utility, board members may be offered coverage if: (1) coverage is offered to all board members as well as employees, (2) board members make up less than 10% of total enrollment and (3) the group submits a copy of their charter confirming compliance with underwriting guidelines. • Employees who are not U.S. citizens, do not reside in the U.S. and who work at an employer's location not located in the U.S. • Illegal immigrants • Employees on severance that is not state continuation or COBRA

Dependent Eligibility

**If a group desires to exclude dependents from coverage, please refer to the Employee Only Coverage section.*

***Domestic partners are only eligible to enroll at the initial effective date of a sale or at open enrollment of an existing group.*

Divorced spouses and dependents who permanently reside outside of the U.S. are not eligible for coverage.

Grandchildren are not eligible for coverage unless they meet the eligibility requirements listed in this section.

Dependents eligible for coverage are listed below*.

- Spouse - An employee's current spouse (opposite or same sex or common law) as defined by the employer which may include a domestic partner**. Spousal eligibility is based strictly on an employer's internal personnel policies.

- Children - The employee's or employee's spouse's natural child, legally adopted child (including children placed for the purpose of adoption), stepchild(ren) or children for whom the employee or employee's spouse are legal guardians; who are less than 26 years of age

- A child of the employee or employee's spouse for whom a Qualified Medical Child Support Order has been issued

- Incapacitated Over Age Dependent - An employee's or employee's spouse's incapacitated child that is age 26 or older that is unmarried, incapable of self-sustaining employment by reason of intellectual disabilities or physical disabilities and is chiefly dependent upon the employee or employee's spouse for economic support and maintenance. **Certification of Dependency form required.**

  For incapacitated dependents of existing subscribers of existing groups – the child must already be covered by BlueCross when he/she reaches the plan's limiting age. Once the child reaches the limiting age, he/she may enroll within 31 days of reaching the limiting age. If the child was not previously covered by the employee prior to reaching the limiting age, he/she is not eligible to enroll as an incapacitated dependent.

  For incapacitated dependents of newly eligible subscribers of existing groups: The incapacitated child is eligible for coverage only if he/she was covered under the subscriber's or subscriber's spouse's previous plan and has less than a 63 day break in coverage from the prior plan.

  For incapacitated dependents of subscribers of new groups: The incapacitated child is eligible for coverage only if he/she was covered under the subscriber's or subscriber's spouse's previous plan and has less than a 63 day break in coverage from the prior plan.

- Dependents of an Expatriate - The employee's dependents that meet the eligibility criteria outlined above may also be covered under the group health plan whether they remain in the U.S. or relocate with the employee.

- Dependents of a Foreign National who meet the eligibility requirements outlined above are only eligible for coverage if they reside in the U.S. Dependents are not eligible for coverage if they remain in residence outside of the U.S. However, BlueCross will consider a move to the U.S. a qualifying event for such dependents and allow them to enroll within 31 days of the event.

Other Eligible Participants	• State Continuation/ COBRA beneficiaries (Only groups with 20 or more employees or who otherwise must comply with COBRA law are eligible to offer COBRA continuation coverage) • Employees on a military leave of absence and their dependents • Employees on an approved leave of absence and their dependents if the approved leave meets the following criteria: o The employer continues to consider the subscriber as an employee and all other group benefits are continued as well as the medical benefits. o The leave of absence is for a specific period of time established before the leave of absence began. o The purpose of the leave of absence is known. o The leave of absence does not last longer than six months. If the leave lasts longer than six months, the employee should be offered COBRA or State Continuation coverage. • Retirees Retirees and their dependents may be eligible with BlueCross approval if the following conditions are met: o Had group coverage through their employer before and upon retirement o Have had continuous group coverage since retirement o The employer treats all retirees the same in regards to eligibility o Employer contributes the same amount towards retiree coverage as for employee coverage o The employer has a written retirement plan available to employees o Retiree enrollment does not exceed 10% of total group enrollment **The Retiree Coverage Attestation Form and/or copy of group's retiree plan are required to confirm compliance.** • Independent Contractors (i.e. 1099 workers) Independent contractors are eligible for coverage only if they are considered common law employees of the employer per IRS guidelines and meet the normal employee eligibility criteria (i.e. actively at work and working at least 30 hours per week). The group must offer coverage to all independent contractors meeting the above criteria and the employer must contribute the same amount towards their coverage as they contribute towards coverage for w-2 employees. **The 1099 Verification form (and/or additional tax documentation) may be required to confirm eligibility.** If the employer does not consider their independent contractors to be their common law employees per IRS guidelines, then the independent contractors are not eligible for coverage.

Assignment of Eligibility and Coverage Effective Dates

Assignment of Eligibility and Effective / Termination Dates

Group Coverage Effective Dates

Employee Coverage Effective Dates

Dependent Coverage Effective Dates

Late Applicants

Employees Returning from Military Service/Reinstatement of Coverage

Open Enrollment Period

Rehire Provision

HIPAA Special Enrollment and Qualifying Events

Assignment of Eligibility and Coverage Effective Dates	
Assignment of Eligibility and Effective / Termination Dates	Groups are responsible for making eligibility determinations and setting effective dates for new employees, employees who have qualifying events and employees whose coverage is terminating. This applies to all BlueCross products. **Groups should base all eligibility criteria as well as effective/ termination dates in accordance with state and federal regulations and BlueCross underwriting guidelines. Per our group agreement, BlueCross may conduct employee and dependent eligibility audits to ensure compliance with underwriting guidelines. Any ineligible employees or dependents will be termed from the group policy.**
Group Coverage Effective Dates	In accordance with ACA provisions, small employer groups may only purchase and renew coverage with a first of the month effective/renewal date.
Employee Coverage Effective Dates	Employees may enroll within 31 days of initial eligibility after successfully completing the eligibility waiting period assigned by their employer, during open enrollment or if he/she incurs a qualifying event. Employee waiting periods typically lasts 0, 30, 60 or 90 days from the new employee's initial date of employment. Waiting periods exceeding 90 days are prohibited per ACA regulations. Below are explanations of the three eligibility options and their impact on coverage: • First billing date following eligibility period: New hires become eligible for coverage on the first day of the following billing cycle after completing their eligibility waiting period. Consequently, the group is billed for the entire month for new hires. If the effective date falls on the bill cycle date, the effective date will be that date, unless otherwise requested. • First day immediately following eligibility (i.e. give and take): New hires become eligible for coverage the first day after completing their eligibility waiting period, which is not necessarily the first day of the normal billing cycle. • Date of hire eligibility: New hires become eligible for coverage the first day of hire, which is not necessarily the first day of the normal billing cycle.

Dependent Coverage Effective Dates	Dependents are eligible to enroll with the employee at the time of initial eligibility or open enrollment. In addition, the following special enrollment periods apply: • Spouse If an employee marries and wants to cover the new spouse and any children acquired as a result of the marriage, he or she has 31 days from the marriage to apply for coverage. If the employee has dependents who could have been covered before the marriage but were not covered, all dependents are eligible through the 31-day special enrollment period. • Domestic Partners If eligible for coverage, domestic partners may only enroll at the time of initial eligibility or during the open enrollment period. Employee status changes such as marriage and divorce would not apply to a domestic partner because there is no legal marriage. Acquiring a domestic partner is not a qualifying event that constitutes a special enrollment. These same rules apply to the children of a domestic partner that are not also the employee's children. • Children Newborn children are automatically covered for 31 days after the date of birth unless waived by the group agreement. This applies to all subscribers, including those with employee only coverage. However, the subscriber must enroll the child within 31 days from the date of birth. If the subscriber does not and an additional premium is required to cover the child, the plan will only cover the child after 31 days from the date of birth on an exception basis. If the subscriber adds the child to the policy on the date of birth and additional premium is required to cover the child, the premium will be charged for the first 31 days. See information in the Spouse section above for children acquired as a result of a new marriage. For children acquired via adoption or guardianship, the children must be enrolled within 31 days of when the child is legally placed in the subscriber's home. For children whom health coverage is required via a qualified medical child support order, the children must be enrolled within 31 days of when the order is issued.
Late Applicants	Employees and dependents applying for coverage more than 31 days after the initial effective date, open enrollment or date of a qualifying event are considered late applicants. For most group agreements, late applicants must wait until the next open enrollment period to obtain coverage.

Employees Returning from Military Service/Reinstatement of Coverage	When a member returns from military service, the Uniformed Services Employment and Re-employment Rights Act (USERRA) requires the employer to reinstate his or her medical coverage without a waiting period. In addition, reinstatement must be administered without regard to give & take rules, rehire provisions, etc. USERRA also sets varying periods of time, based on length of military service, in which the employee must return to employment after military duty in order to qualify for uninterrupted benefits, including health care coverage. Here are those time frames: • Service under 31 days Those who served fewer than 31 days must report to the employer on the first day of the first regularly scheduled work period following completion of service. If reporting that soon is "impossible or unreasonable through no fault of (the returning employee)," the law requires them to report "as soon as possible." For military service of fewer than 31 days, health care coverage is provided as if the service member had remained employed. • Service of 31 to 180 days Returning employees who served 31 to 180 days are allowed 14 days to return to work, or "as soon as possible" if meeting that deadline is impossible through no fault of the employee. Their coverage will be reinstated back to the date of discharge, if the request for coverage reinstatement is received within 30 days of the discharge. If the request is received more than 30 days from the date of discharge, and documentation of "as soon as possible" is not submitted, the effective date will be the next open enrollment. • Service of more than 180 days Employees who serve more the 180 days are allowed 90 days to apply for reinstatement with their employer, or "as soon as possible" if meeting that deadline is impossible through no fault of the employee. Their coverage will be reinstated back to the date of discharge, if the request for coverage reinstatement is received within 30 days of the discharge. If the request is received more than 30 days from the date of discharge, and documentation of "as soon as possible" is not submitted, the effective date will be the next open enrollment. • Disabled persons Returning employees who are hospitalized for or recovering from injuries sustained or aggravated by military service are allowed two years to apply for employment after recovering from those injuries.

Open Enrollment Period	Employers have the responsibility to provide an annual open enrollment period. During this 31-day period, eligible employees may apply for coverage for themselves and eligible dependents. Generally, the open enrollment period should be conducted 30 – 60 days prior to the group's renewal date.
Rehire Provision	Groups may include an employee rehire provision in their eligibility policies. A rehire is any full-time or part-time employee who left the company for any reason and was allowed to return to his/her position. If this provision is included, the eligibility waiting period is waived for eligible rehires that are rehired within a certain time period (i.e. rehire period) if the application is received within 31 days of the rehire date. In addition, the rehire will be considered as having continuous coverage for the purpose of administering the deductibles and out of pocket amounts. Underwriting approval required if the rehire period is more than 180 days.

HIPAA Special Enrollment and Qualifying Events	In order to comply with HIPAA provisions, BlueCross allows qualifying employees/subscribers to enroll or change their coverage (including move to a different benefit option if a multi option arrangement is offered) other than during open enrollment. In general, the employee must request the change within 31 days of the change in status. Some examples of a qualifying event or change of status include the following:
	• Marriage or divorce*
	• Death of the employee's spouse or dependent
	• Change in dependency status
	• Medicare eligibility
	• Coverage by another payor
	• Birth or adoption of a child of the employee*
	• Termination of employment or commencement of employment
	• Switching from part-time to full-time, or from full-time to part-time by the employee or the employee's spouse
	• Loss of previous health coverage when:
	  ○ Employee was enrolled in another health coverage plan at the time he or she was initially eligible for group coverage through the employer group plan; and
	  ○ He or she stated in writing at that time why he or she chose not to enroll through the employer group plan
	
	**When an employee gets married or has a child (birth or adoption), this constitutes a special enrollment period for not only the employee; but for everyone covered under the employee's plan. Similarly, if a dependent loses previous coverage, the employee and everyone covered under the employee's plan may enroll for coverage outside the open enrollment period.*
	
	Additional special enrollment periods may also apply. Please refer to the BlueCross Evidence of Coverage (EOC) for complete information.

Benefit and General Underwriting Guidelines

for New and Existing Business

Medical, Dental and Vision Benefits

Benefit Exceptions

COBRA Administration Services

Grandfathered Health Plans

24 Hour Coverage

Carve Outs/Class Outs

Different Benefits by Class of Employee

Employee Only Coverage

Multi Options

Plan Year Administration

Contraceptive Services Exclusions

Contribution and Participation Requirements

Rate Tier Structure

Bankruptcy / Poor Payment History

Common Ownership / Single Employer Verification

Coverage Continuation

Limited Medical Benefits

Benefit and General Underwriting Guidelines for New and Existing Business	
Medical, Dental and Vision Benefits	BlueCross offers small employers a range of fully insured medical plans (also known as Essential Health Benefit or EHB plans) as well as dental and vision supplemental plans (designed to coordinate with medical EHB plans) that meet Affordable Care Act (ACA) requirements. Please refer to the Group Product Guide, Ancillary Product Guide or contact your Sales/Account Executive for complete product information. Except for groups with a grandfathered health plan, EHB plans are the only medical plans available to small employer groups. BlueCross also offers to certain qualifying groups a special self-funded arrangement called level funding. For detailed information, please refer to the Level Funding section.
Benefit Exceptions	Benefit exceptions are not allowed for small employer groups.
COBRA Administration Services	BlueCross offers a complete range of COBRA administration and billing services available to employers purchasing BlueCross products, including an initial notification option. For more information about these services, please refer to the Group Product Guide or the Group Administrator Reference Manual. Third Party COBRA Administration BlueCross also offers third party COBRA administration for non-BlueCross products. If purchased, all standard COBRA administration services are provided. COBRA Initial Notification services may also be purchased for an additional charge. Non-BlueCross benefits include the following: • Dental benefits provided by another insurance carrier • Medical ancillary benefits (ex. pharmacy and vision) provided by an outside vendor Group Eligibility Requirements New or existing groups of any size that maintain medical benefits through BlueCross are eligible for this service. The group must purchase COBRA administration services as part of the BlueCross medical benefits in order to purchase COBRA administration services for the non-BlueCross benefits. The COBRA administration services purchased for the BlueCross medical and non-BlueCross benefits must be the same. Premium Due The premium due for COBRA administration of non-BlueCross benefits will be calculated on a case-by-case basis and billed monthly in conjunction with the BlueCross medical fully insured premium. Termination If a group terminates their medical benefits with BlueCross, COBRA administration services for any non-BlueCross benefits must terminate on the same day.

Grandfathered Health Plans	A grandfathered plan is a group health plan that has maintained enrollment since March 23, 2010 and has made limited changes to its benefits and employer contributions as permitted by federal regulations. A grandfathered plan is not required to comply with certain ACA small employer provisions including EHB benefits and modified community rating. Because of this, existing small employer groups with grandfathered health plans are not required to convert to EHB plans at renewal, as long as the group maintains their plan's grandfather status. Prospect groups, even if they had a grandfathered plan with another carrier, must choose an EHB plan if moving to BlueCross. <u>Maintaining Grandfather Status</u> Certain benefit changes as well as increasing the employer contribution by more than 5% will cause a group's plan to lose its grandfather status. For more information on maintaining a plan's grandfather status, please discuss with your Account Executive. Each year at renewal, a group with a grandfathered plan must submit the **Premium Contribution Certification Form** to confirm that the group has not made a contribution change that would cause their plan to lose its grandfather status. BlueCross will conduct annual audits to ensure a grandfathered plan has maintained its grandfathered status. **An existing small employer group whose plan loses its grandfather status must convert to an EHB plan.**
24 Hour Coverage	In general, BlueCross group policies exclude coverage for work related illness or injury. However, benefits for work related illness or injury are covered for the following individuals: • Sole-Proprietor of a group • Partner of a group including a partner of an LLC or PLLC • Corporate Officer of a group who has filed an election not to accept Workers' Compensation with the appropriate government department
Carve Outs/Class Outs	A carve out or class out where only certain classes of employees are offered coverage (ex. management only carve out) is allowed; however **it is the group's responsibility to make sure that any carve out/class out plans comply with applicable Internal Revenue Code non-discrimination rules.** The carve out/class out group of employees should be easily identified by a clear class designation that is reasonable, non-discriminatory and uses objective business criteria for identification. Reasonable classifications include specific job categories, nature of compensation (i.e. salaried or hourly), geographic location and similar bona fide business criteria. In general, valid classes of employees should have a minimum of two employees (with the exception of an owner class).
Different Benefits by Class of Employee	Different benefits offered based on employee class is allowed; however **it is the group's responsibility to make sure that any carve out/class out plans comply with applicable Internal Revenue Code non-discrimination rules.** Employees should be easily identified by a clear class designation that is reasonable, non-discriminatory and uses objective business criteria for identification. Reasonable classifications include specific job categories, nature of compensation (i.e. salaried or hourly), geographic location and similar bona fide business criteria. In general, valid classes of employees should have a minimum of two employees (with the exception of an owner class).

Employee Only Coverage	Small employer groups may exclude dependent coverage and provide coverage only for employees or for employee/children only. **Please note that the administrative burden for this eligibility change is on the employer. They are responsible for monitoring adherence to the employee only or employee/child only eligibility for coverage. Applications that do not meet their eligibility criteria should not be submitted by the employer.** No special forms are required for this eligibility change. Employees should complete a standard enrollment form excluding dependent information. Underwriting Guidelines for Employee Only and Employee/Child Only Coverage • For EHB plans, requests for employee or employee/child only coverage or to add back dependent coverage, does not require Underwriting approval. However, these eligibility changes may only take place at initial effective date or renewal. • For grandfathered plans, requests for employee only or employee/child only coverage or to add back dependent coverage requires Underwriting approval and a possible rate adjustment. • Employee only class outs are permitted (i.e. employee and dependent coverage for management but employee only coverage for non-management). Separate subgroups for each class are preferred for ease of administration. • In a fully insured multi option arrangement where employees may choose from among more than one option, employee and dependent eligibility must be the same for all options. • Continuation of Coverage **-** If a group has dependent coverage and later chooses to discontinue dependent coverage, enrolled dependents are not eligible for continuation coverage such as COBRA and State Continuation because this type of loss of insurance does not meet the definition of a qualifying event. In addition, if dependents are not eligible for coverage, COBRA and State Continuation participants may not add their dependents to their coverage.
Multi Options *For all products, subscribers may only change options at open enrollment or if they incur a HIPAA qualifying event.*	**Medical:** Small employers may offer up to three EHB benefit options with any benefit/network combination to their employees regardless of the rate differential between the options. Small employers in the Knoxville, Nashville and Memphis regions may offer up to four EHB benefit options if at least one of the benefit options includes Network L. The same metal plan offered on different networks is allowed; but counted as separate options. *For example, a silver plan offered on both networks P and S would count as two options.* Out of state subscribers may enroll in any available option regardless of the network. **Dental & Vision:** Small employers may only offer one dental and one vision supplemental plan to their employees. For groups with grandfathered medical plans or stand-alone DentalBlue coverage, please refer to the DentalBlue multi option guidelines grid. For VisionBlue, only one option is available to small employer groups.

Plan Year Administration	Plan year administration is an option for groups that want benefits (i.e. deductible, out of pocket and any benefit limit accumulators) in sync with their renewal date, instead of on a calendar year basis. The following guidelines apply: • Available for all size new groups and existing business at renewal only. • Effective/renewal date must be 1st of the month. • Groups may switch between Calendar Year and Plan Year if requested. • Accumulators will start over when a group moves from Calendar year to Plan year Administration or vice versa (i.e. deductible, out of pocket and any other benefit limit accumulators reset to zero). Accumulators will also start over if a group with Plan Year changes their effective date in the same plan year. • Groups with third party vendors must be evaluated on a case by case basis by BlueCross. • If multi options are offered, all options must be on the same basis (i.e. all calendar year or all Plan Year). • 4th quarter deductible carry over not allowed with Plan Year administration • Medical and Dental are generally required to be on the same administration basis (i.e. Medical cannot be Plan Year and Dental be Calendar Year). Exceptions must be approved by BlueCross. • EHB groups with plan year administration and HRAs – EHB HRAs must have plan year administration. If the HRA is set up to pay first, the EHB medical may be calendar year or plan year administration. If the HRA is set up for the member to pay first, the EHB medical must be plan year or calendar year with a January 1st effective/renewal date.
Contraceptive Services Exclusions	Certain small employer groups such as religious employers and other eligible organizations are allowed per ACA to exclude contraceptive services. Please contact your Sales/Account Executive for details.
Contribution and Participation Requirements	For employer contribution requirements for new and existing business for medical, dental and vision coverage, refer to the Contribution & Participation reference chart.

Rate Tier Structure	EHB Plans EHB plans are available with member level rating or composite rating. For member level rates, the premium rate for the employee and any dependent age 15 and older varies by age. One premium rate that does not vary by age applies to dependent children under age 15. The premium rate for family coverage is determined by adding the premium rate of each family member. EHB medical rates are subject to a three child cap for children under age 21. This cap does not apply to dental and vision rates. Employees and dependents are billed according to their age at the group's effective/renewal date. Composite rates are provided on a four tier basis (i.e. employee only, employee/spouse, employee/child (ren) and family). Composite rates are developed using the monthly premium based on member level rates including the three child cap. Special rating guidelines apply to EHB plans with composite rating. Groups may elect either composite or member level rates only at initial sale or renewal. Off renewal rate type changes are not permitted. If a group has more than one EHB benefit option within a product (i.e. two medical benefit options), all benefit options must have either composite rates or member level rates. A mix of composite and member level rates between EHB options is not allowed. Grandfathered Plans Grandfathered health plans include composite rating. Plans with less than 26 subscribers are required to have a four-tier composite rate structure (i.e. employee only, employee/spouse, employee/child(ren) and family). Plans with 26+ subscribers may also request two-tier (employee only and family) and three-tier (employee only, two person for employee and one dependent, and family) composite rates. Renewals are produced with the plan's current rate tier structure unless the group has dropped below 26 subscribers. If this happens, the renewal will be produced with a four-tier rate structure. Plans with 26+ subscribers may change rate tier structure at renewal. Rate tier changes are not allowed off renewal. Dental and Vision Plans Supplemental dental and vision plans (compatible with EHB medical plans) are available on a composite or member level basis. The rate type (i.e. composite or member level) is not required to match the medical rate type (i.e. medical may have member level rating and dental has composite rating). DentalBlue/VisionBlue plans (available with grandfathered medical plans or stand-alone) are available on a composite basis. BlueCross reserves the right to recalculate the composite rates if employer contribution falls below required levels.
Bankruptcy / Poor Payment History	BlueCross must be notified if any existing or prospect group has filed for bankruptcy or is in bankruptcy. For groups in bankruptcy or with a poor payment history, an advance deposit or ACH Debit billing may be required.

Common Ownership / Single Employer Verification	Establishing common ownership when quoting more than one business/group together under a single policy is essential in order to establish premium liability with a valid contract and to comply with the ACA, ERISA and Internal Revenue Code (IRC) definitions of a single employer, as well as BlueCross BlueShield Association marketing/national account guidelines *(i.e. out of state locations, subsidiaries, etc. must be wholly owned by the policyholder.).* In order to include more than one business on a single policy, the combined group must meet the requirements of a single employer as defined by section 414 (b), (c), (m) or (o) of the Internal Revenue Code (IRC). These regulations are also referred to as the aggregation rules. The aggregation rules are very complex. *Groups must consult their own tax/legal advisors regarding whether or not they qualify as a single employer. BlueCross cannot make this determination for them.* To verify compliance with the aggregation rules, any new small employer group who wants to include more than one business under a single policy, as well as any existing small employer group who wants to add a business to their policy, should submit the Single Employer Verification Form. This form should be completed and signed by the group administrator, owner or officer. Additional information may also be required for groups wanting to include an out of state business on their policy.
Coverage Continuation *For questions regarding COBRA, please contact your BlueCross representative.* *COBRA Administration Services are available for groups with 20 or more employees.*	**COBRA** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides employees (or former employees), their spouses and dependents with a temporary extension of group health insurance when coverage is lost due to certain qualifying events. Generally, COBRA Continuation Coverage must be identical to the coverage provided to current employees. COBRA Continuation applies to all employer groups (with the exception of church and federal government groups) with 20 or more employees on a typical business day regardless of their eligibility for your group health plan. For purposes of determining employee count, include part-time employees as “fractional” employees. Example: Two part-time employees working 15 hours per week would be counted as one full-time employee if 30 hours per week is considered full-time employment. COBRA continuation gives employees and their eligible dependents who are covered on the date coverage would otherwise end (qualified beneficiaries), the option, under certain conditions, of continuing their group health care coverage beyond the date they would otherwise be ineligible under the group agreement. This provision includes health coverage as well as dental, vision and prescription drug coverage (if these coverages are offered).The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added employees’ COBRA rights. If an employee loses his or her job because of import competition or shifts of production to other countries, he or she may have a second COBRA continuation election period. <u>Qualified Beneficiary</u> A qualified beneficiary is an employee, his or her spouse, or dependent child who is covered under the employer’s group health plan and who has had a qualifying event. The qualified beneficiary must be covered under the plan on the day before the qualifying event. Any child born to or placed for adoption with a qualified beneficiary during the period of continuation coverage will also be eligible for continuation coverage.

Coverage Continuation (cont.)	Qualifying Events Qualifying events are instances that would cause individuals to lose health coverage if COBRA Continuation Coverage were not available. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that you must offer the coverage to them under COBRA. Qualified beneficiaries have 60 days from the date of the qualifying event, or the date they are notified of their rights (whichever is later), to elect continuation coverage. Domestic Partners Because a domestic partner is not the legal spouse of an employee, domestic partners are not considered qualified beneficiaries for COBRA continuation coverage. If an employee elects COBRA, BlueCross will allow a currently covered domestic partner and children to continue on the employee's COBRA coverage. However, a domestic partner and their children (that are not also the employee's children) may not make an independent election for COBRA. Duration of Coverage Qualified beneficiaries must be offered continuation coverage for up to 18 months after coverage would otherwise end because: • Employment is terminated for any reason other than gross misconduct. • Hours of employment are reduced. Continuation coverage must be provided for up to 29 months if the member is considered disabled under Title II or Title XVI of the Social Security Act (within 60 days of the qualifying event) and coverage would otherwise end because: • Employment is terminated for any reason other than gross misconduct. • Hours of employment are reduced. Continuation coverage must be provided for up to 36 months for: • Surviving legal spouse or children. • A separated or divorced spouse, and/or dependent children who are ineligible for Medicare. • Children who have reached the limiting age or who no longer meet the definition of an eligible dependent as stated in the group agreement. End of Coverage COBRA Continuation Coverage begins on the date that coverage would otherwise have ended due to a Qualifying Event and will terminate: • At the end of the applicable 18, 29 or 36-month period. • If and when all health plans you provide to all of your employees are canceled. • Generally, if the Qualified Beneficiary stops paying the premiums. • If the Qualified Beneficiary becomes eligible for Medicare (after COBRA continuation has begun). • If the Qualified Beneficiary obtains other group coverage and satisfies the pre-existing condition limitations, if any, which apply to the other coverage. • If the Qualified Beneficiary is no longer considered disabled for Social Security purposes (if coverage was continued due to disability). Paying for Coverage If a Qualified Beneficiary elects COBRA Continuation Coverage, he or she is responsible for paying for such coverage. The group is, however, responsible for billing the Qualified Beneficiary. On a monthly basis, COBRA participants may be billed up to 102 percent of their premium. Qualified Beneficiaries continuing coverage based on disability may be billed up to 150 percent of the applicable premium for such coverage (after the first 18 months of continuous COBRA Continuation Coverage).

Coverage Continuation (cont.)	Qualified Beneficiaries have 45 days after the date on which they chose COBRA Continuation Coverage to pay the initial premium. A group health plan is not required to provide coverage to a potential Qualified Beneficiary until after the individual elects and pays for the coverage. If the individual does not immediately elect COBRA Continuation at the time of the Qualifying Event, the first payment must be made retroactive to the Qualifying Event. Most employers collect the COBRA Continuation premium in advance. However, at least a 30-day grace period for a COBRA Qualified Beneficiary to pay the premium must be allowed. If payment due from the Qualified Beneficiary is late, please code the Qualified Beneficiary as canceled due to nonpayment until payment is received in order to prevent claims from being paid. **State Continuation Coverage** BlueCross is required by law to offer State Continuation Coverage to all members of a fully insured group of any size. A qualified beneficiary may elect State Continuation Coverage instead of COBRA, but typically, members who want State Continuation Coverage are those who do not have access to COBRA – those employed by a group with fewer than 20 employees or who were covered under a church plan. BlueCross is not required to offer State Continuation Coverage to self-funded groups. Administrative Procedures The member must notify the employer of the change in status within 31 days of the date their coverage would otherwise end, or the date they were notified of this, whichever is later. The member must remit the full month's group premium payment to the employer in advance, on or before the beginning of each month's coverage, for the coverage. Eligibility Requirements • Employees and Dependents An employee may elect to continue group coverage for three months when no longer eligible for coverage because of a reduction of hours or non-payment. To receive this three-month extension of group benefits, the employee must have been covered by the group plan for the three months immediately preceding termination of the coverage. Payment for such coverage must be made in advance to the employer within 30 days of the employee's ineligibility for coverage or was notified of the termination of such coverage, whichever is later. These payments may be made on a monthly basis. • Dependents of Employees When an employee dies, becomes divorced or legally separated, his or her dependents are eligible for continued coverage for 15 months. Only those dependents covered under the group plan for at least three months prior to termination and as of the qualifying event, are eligible. • Pregnant Members If a member (employee or dependent) is pregnant at the time her health coverage would otherwise terminate under the plan (for any reason other than replacement of group coverage), she may continue coverage through such plan for a period up to six months after pregnancy ends. Coverage continuation will cease if the member does not pay the premium, becomes eligible for another group plan or becomes eligible for Medicare.

Coverage Continuation (cont.)	**Leave of Absence** Coverage for an employee and dependents can be continued during a leave of absence if: • The employer continues to consider the subscriber as an employee and all other group benefits are continued as well as the medical benefits. • The leave of absence is for a specific period of time established before the leave of absence began. • The purpose of the leave of absence is known. • The leave of absence does not last longer than six months. If the leave lasts longer, the employee should be offered COBRA or State Continuation Coverage. • The leave of absence is for military service covered under USERRA. For detailed information on USERRA, refer to Employees Returning from Military Service/Reinstatement of Coverage section below. **Benefits after Coverage Ends** An employee or dependent may receive benefits after his or her coverage ends due to termination of an employer's group agreement and he or she is hospitalized on the day coverage ends. Under most EOCs, he or she will receive hospital benefits for up to 60 days or until the member is discharged, whichever occurs first.

Companion Life GAP Plans	BlueCross has partnered with Companion Life to offer a group sponsored gap plan that may be offered in conjunction with BlueCross HDHP medical coverage. The purpose of allowing this combined product offering is to help employees offset the financial burden of higher out of pocket expenses associated with higher deductible/out of pocket plans.
	
	<u>Underwriting Guidelines</u>
	• Pre-approved options for BlueCross medical groups with 5 – 250 employees, including EHB plans. No BlueCross medical underwriting review required.
	• Non-standard GAP plans require approval.
	• Minimum GAP deductible of at least $2,500 required.
	• Once the GAP deductible is set, the medical deductible must be twice that amount or more. For example:
	  ○ $2,500 GAP deductible must have a BlueCross medical deductible of $5,000 or higher
	  ○ $3,000 GAP deductible must have a BlueCross medical deductible of $6,000 or higher
	  ○ $4,000 GAP deductible must have a BlueCross medical deductible of $8,000 or higher
	  ○ Traditional and HSA compatible deductibles available
	  ○ Benefit amounts range from $500 to $10,000
	  ○ May be sold on an employer paid, voluntary or contributory basis
	  ○ Guaranteed issue with no pre-existing condition limitations
	  ○ Dual plan options available
	  ○ All employees and dependents are eligible if covered under the BlueCross medical plan
	  ○ Broker commissions are 10% flat on the GAP product

Quoting Guidelines for New Business

Required New Business Quote Information

Sale Submission Checklist

Quoting Guidelines for New Business

To request a quote, please submit a Quick Quote form to your Sales Executive and/or complete a quote request via SQS Blue. The following information is necessary to provide a quote:

Required New Business Quote Information	
Name and Address of Policyholder and All Other Businesses to be Included	Group must have a primary business location and employees in Tennessee. • If including more than one business, the Single Employer Verification Form is required. • If quoting on the Tennessee location of a group with an out of state headquarters or if quoting on out of state employees/branches/subsidiaries, please see your Sales/Account Executive.
Number of Average Employees Employed During the Previous Calendar Year	Required to determine whether the group is a small or large employer so the appropriate rating and benefits are offered. This information will be verified by the Employer Group Application. **** Please note that if the employer attests in the EGA that they are a large employer; but a small employer EHB quote was sold, the EHB sale must be voided and a Non-EHB quote issued. The reverse is also true. ****
Number of Total Eligible Employees	Total eligible employees should include anyone offered coverage (i.e. full-time employees, part-time employees, retirees *(see eligibility guidelines),* COBRA/State Continuation participants and 1099 workers *(see eligibility guidelines).* Employees who are currently in their waiting period but will have completed their waiting period by the effective date should be included as eligible. If the employee eligibility period will be waived on initial enrollment, include all new employees as eligible as well. For carve out quotes (ex. management only quotes), the number of total eligible employees should only include the particular class of eligible employees.
Number of Participating Employees (including retirees if any)	Participating employees include eligible employees that will be enrolling on the effective date. Employees who are currently in their waiting period but will have completed their waiting period by the effective date and are expected to enroll should be included as participating. If the employee eligibility period will be waived on initial enrollment, include all new employees expected to enroll on the effective date as participating.
Census *The same census should be used to rate all benefit options.*	For **Medical** quotes: Date of birth and relation to employee (i.e. spouse, child, etc.) for all participating members For **Dental** quotes: State of residence for all participating employees For **Vision** quotes: No census required
Tax Documentation for Groups with 2 – 5 Employees	Tax documentation is required for groups enrolling less than 6 employees to verify group and employee eligibility. Refer to the Required Tax Documentation section for detailed information.

Sale Submission Checklist

- Sold quote number(s) denoting selection of either composite or member level rates
- Employer Group Application
- Employee Enrollment (via the EEW form or spreadsheet template)
- Binder check for estimated first month's premium
- Waivers if enrolling less than 50% of total eligible for medical (for February – December effective dates only)
- Single Employer Verification form if including more than one business
- Tax documentation if enrolling less than 6 subscribers

Guidelines for Existing Business

Renewals and Renewal Notices

Adding Coverage to Existing Business

Benefit Changes for Existing Groups

Client Reporting

Existing Groups with Name, Address, Ownership and/or Census Changes including Group Splits

Requests to Change Renewal Date

Group Failure to Comply with Underwriting Guidelines

Guidelines for Existing Business	
Renewals and Renewal Notices	Small employer group renewals are released approximately 90 days prior to the renewal date. In addition to providing BlueCross customers with their group renewal, brokers should deliver any applicable renewal notices to their groups at least 60 days before the renewal date as federal regulations require. The small group renewal notice includes information about premiums, changes in coverage, other coverage options and contact information. This required notice must be sent to every small group that receives an EHB renewal and to grandfathered plans in the small group market. Account Executives will make the renewals and associated renewal notices available via SQS BLUE.
Adding Coverage to Existing Business	Existing small employer groups may add coverage for a new product (i.e. a group with current medical coverage wishes to add dental and vision coverage) on or off renewal up to five months before the next renewal date. All products should be set up with the same group number, billing cycle and renewal date.
Benefit Changes for Existing Groups	Groups with EHB Plans Small employer groups with EHB plans may make buy down changes (i.e. changing to a less rich benefit plan or adding a less rich medical plan) up to five months before the next renewal date as long as employees are given a minimum 60 day notice to comply with ACA/SBC regulations. Benefit buy ups (i.e. changing to a richer benefit plan or adding a new, richer benefit plan) are not allowed off renewal. Please note that if a group does make a permitted off renewal benefit change, only those employees currently enrolled may take advantage of the benefit change. The benefit change does not constitute an open enrollment for all employees. Multi option guidelines apply (i.e. a group may not have more than 3 medical options). Rating for off renewal benefit changes cannot take into account any census changes during the year. Rates for the off renewal benefit change will be based off the census used to prepare the most recent renewal. Network changes, rate type changes (i.e. switching from member level to composite rating) and changing to or adding a richer benefit plan are not permitted off renewal. These changes are permitted only at renewal. Groups with Grandfathered Plans Groups with grandfathered plans may make any available benefit and/or network change at renewal as long as the benefit change would not cause a loss of grandfather status. Small employer groups with grandfathered plans that choose not to maintain the plan's grandfathered status or make a benefit or contribution change that causes a loss of grandfather status must convert to an EHB plan. Small employer groups with grandfathered plans may not add new EHB options. A mix of grandfathered and EHB plans are not allowed for small employer groups.

Client Reporting	Renewal Reporting Packages BlueCross provides reporting packages to small employer groups along with their annual renewal as follows: • For groups with 2 – 25 subscribers: Package S with limited interactive reporting. • For groups with 26 – 99 subscribers: Package I with limited interactive reporting. ERISA Form 5500 Information Upon request only, BlueCross will provide groups with less than 100 employees information to help them complete Schedule A of the ERISA Form 5500 approximately four months after the end of the contract year. This information is available for medical, dental and vision coverage. Please contact your BlueCross representative for more information.
Existing Groups with Name, Address, Ownership and/or Census Changes including Group Splits	Please contact your Account Executive if an existing group incurs a name, address, ownership and/or census change. Changes such as these may require Underwriting review of benefits and rating to ensure ACA compliance. Underwriting approval is required to add new businesses/subsidiaries/locations, especially those out of state, to the policy. Underwriting also reserves the right to adjust the rates off renewal for census changes for groups with grandfathered plans.
Requests to Change Renewal Date	A group may request to change their renewal date. All products must move to the new renewal date. A change in renewal date should also correspond with the same change in the group's ERISA plan year anniversary date.
Group Failure to Comply with Underwriting Guidelines	BlueCross regularly reviews the enrollment of groups to confirm that underwriting requirements such as eligibility, single employer/control group, Tennessee headquarters and participation requirements are being followed. These requirements are in place to ensure compliance with state and federal regulations as well as to better control the cost of coverage we provide to our customers. Groups are required to comply with underwriting guideline requirements when they are first enrolled and to continue to remain in compliance for as long as their coverage remains in effect. If our records indicate that a group may not be in compliance, the group will be notified via certified letter and asked to provide documentation such as quarterly tax documentation and payroll to verify compliance. If the group does not respond to the audit request, their coverage with BlueCross will be termed as of the date indicated in the audit letter. If the group does respond to the audit request but is found out of compliance, their coverage with BlueCross will be termed as of the date indicated in the audit letter. Any ineligible subscribers identified in an otherwise compliant group will be termed as of the date indicated in the audit letter.

Rating Guidelines for New and Existing Businesses

with EHB Plans with Composite Rating

Rating Guidelines for New and Existing Businesses with EHB Plans with Composite Rating

For both EHB sales and renewals, the following rating guidelines apply:

- Small employer groups with EHB plans may elect either composite or member level rates at initial sale or renewal. Groups may change their rate type (i.e. move from composite to member level rates) only at renewal.

- For groups with both EHB medical coverage and EHB dental/vision coverage, the medical rate type (i.e. member level or composite) is not required to match the dental or vision rate type.

- For groups with multiple options per product, all options per product must have the same rating type (i.e. either composite rates or member level rates). For example, if a group has 3 medical options, all medical options must have the same rating type.

- EHB sales and renewals with composite rates should be submitted to BlueCross for processing **before** the effective/renewal date. **Final composite rates may need to be recalculated as outlined below.**

- After the start of a group's plan year, EHB composite rates may not be changed again until renewal (regardless of any census changes that occur during the year).

For EHB sales, the following rating guidelines apply:

- If a group plans to enroll dependents, a dependent census is required and must be used to produce EHB quotes with composite rates. If a dependent census was not provided for the sold quote prepared by the broker and the sale is submitted before the effective date, the composite rates must be recalculated with the dependent census. If a dependent census was not provided for the sold quote prepared by the broker and the sale is submitted after the effective date, the group must move to member level rates. A dependent census is not required to provide a quote with member level rates.

- If the enrolled employee count is within 15 percent of the employee count on the group's sold rates, the final composite rates will not need to be recalculated.

- If the enrolled employee count is outside 15 percent of the employee count on the group's sold rates, the actual enrolled census (including dependents) will be used to recalculate the final composite rates.

- If a sold group is submitted after the effective date and the actual employee enrollment is outside the 15 percent threshold outlined above, the group must move to member level rates.

For EHB renewals, the following rating guidelines apply:

- If a group is adding a new location or downsizing and the enrolled employee count is within 15 percent of the employee count on the group's initial renewal rates, the final composite rates will not need to be recalculated.

- If a group is adding a new location or downsizing and the enrolling employee count is outside 15 percent of the employee count on the group's initial renewal rates, the actual enrolled census (including dependents) will be used to recalculate the final composite rates.

DentalBlue Multi Option Guidelines

DentalBlue Multi Option Guidelines	
Group Eligibility	Multi options allowed for groups with 26+ enrolling employees
Number of Options	Maximum of two options allowed
Allowed Combinations and Reimbursement Options	Allowed Combinations Traditional Plans may be offered in a multi-option arrangement with the following exceptions: • HDDPs are not permitted. • Preventive/Deluxe combinations are not permitted. Select plans may only be offered with another Select plan. <u>Reimbursement Options (out of network)</u> Reimbursement options must be the same for all plans in a multi-option arrangement.
Orthodontic Benefits – Select Plans	If orthodontic benefits offered, benefits must be the same for each option. If orthodontic benefits are excluded, they must be excluded from both options.
Orthodontic Benefits – Traditional Plans	If orthodontic benefits offered, benefits must be the same for each option. If orthodontic benefits are excluded, they must be excluded from both options.
Rate Tier Structure	Must be the same for both options
Minimum Enrollment	Options must have at least one enrolled subscriber. At initial enrollment, any options offered that do not obtain minimum enrollment will not be processed and will not be available to new hires later during the policy year. At renewal, any option with zero enrollment will automatically be cancelled and renewal rates will not be produced for this option.

Contribution and Participation Requirements for 2024

Contribution and Participation Requirements for 2024

Medical	Contribution Requirement	Participation Requirement
Small Employer EHB New Groups with January Effective Date	0% [1]	No minimum requirement[1]
Small Employer EHB New Groups with February – December Effective Dates	0% [2]	50% of net eligible [5]
Small Employer EHB Existing Groups	0% [2]	50% of net eligible [5]
Large Employer NonEHB New Groups	0% [3]	No minimum requirement[3]
Large Employer NonEHB Existing Groups	50% of employee only rate [4]	50% of net eligible [5]
Small and Large Employer Groups with Grandfathered Plans	50% of employee only rate [4]	50% of net eligible [5]

Dental Plans	Contribution Requirement	Participation Requirement
Small Employer EHB Supplemental Plans for New and Existing Groups	25% of employee only rate for Non-Voluntary plans 0% for Voluntary plans	No minimum requirement
Large Employer DentalBlue NonEHB for New and Existing Groups	For Traditional plans, 50% of employee only rate for virgin groups and 0% for takeover groups. For Select plans, 0%.	For Traditional plans, 50% of total eligible and for Select plans, 20% of total eligible both with an absolute minimum of 2 subscribers (or 5 subscribers for standalone coverage)

Vision Plans	Contribution Requirement	Participation Requirement
Small Employer EHB Supplemental Plans for New and Existing Groups	50% of employee only rate for Non-Voluntary plans 0% for Voluntary Plans	No minimum requirement
Large Employer VisionBlue NonEHB for New and Existing Groups	50% of employee only rate for Non-Voluntary plans 0% for Voluntary plans	For groups with 10 or less employees, 50% of total eligible. For groups with 10+ employees, minimum of two subscribers. (For stand-alone coverage, an absolute minimum of five subscribers required)

[1]Since the Affordable Care Act (ACA) requires that all new small employer group business is guaranteed issue during an open enrollment period each year (November 15 – December 15), carriers may not impose contribution or participation requirements during this time.

[2]The ACA permits carriers to impose contribution requirements for small employer new groups with February – December effective dates and existing groups; however BlueCross has elected not to do so.

[3] The ACA requires that all new large employer group business is guaranteed issue. Carriers may not impose contribution or participation requirements.

[4]For groups with more than one medical plan, the contribution requirement is 50 percent of the employee only rate for the lowest priced plan.

[5] For Non-SHOP plans, valid waivers include group coverage through a spouse or parent, Medicare, TennCare, military coverage or individual coverage (on or off the Marketplace). For SHOP plans, individual coverage is not a valid waiver. New small employer groups with February through December effective dates should provide waivers at initial enrollment if enrollment is less than 50 percent of total eligible employees.

Example Participation Calculation:
30 total eligible employees
10 employees waive because of group coverage through a spouse
20 net eligible employees

20 x 50% = 10 Participation requirement: 10 employees

Required Tax Documentation

Required Tax Documentation for Sales and Group Splits

Which Groups Must Be Certified?

- New groups purchasing medical coverage with less than 6 enrolling employees
- Existing groups adding medical coverage with less than 6 enrolling employees
- Existing Group Splits – If an existing group splits (on or off renewal) and any of the "new" groups have less than 6 enrolled employees; the "new" groups must be certified if medical benefits are offered

Who Must Be Certified?

- All subscribers enrolling in medical coverage must be certified.
- For groups enrolling 2 or less subscribers, all eligible and enrolling employees/owners must be certified.

What Documentation is Required?

Groups Enrolling 2 or Less Subscribers

- Groups should submit the most recent business tax documents and quarterly wage and tax report for *all enrolling and eligible subscribers*. A complete list of required information is outlined below.
- Groups should submit the Employee Certification Form for any subscribers not listed on the quarterly wage and tax report or for new hires with less than full-time wages on the quarterly wage and tax report.

Groups Enrolling 3 – 5 Subscribers

- Groups should submit the Employee Certification Form for *all* enrolling subscribers.
- Groups should submit the most recent business tax documents and/or quarterly wage and tax report if only owners are enrolling.

For All Groups Enrolling Less than 6 Subscribers

- Signed waivers of coverage are required for small employer groups purchasing EHB plans if participation is less than 50% of total employees. *Only applies to February – December effective dates.*
- Groups with new hires not listed on the most recent tax documentation will be asked to complete a follow up audit at a later date to verify employee eligibility. New businesses who have not yet filed their annual business tax documentation at the time of sale may also be asked to complete a follow up audit at a later date, especially if only owners/partners/shareholders or husbands/wives enroll.
- If a payroll is required in addition to other documentation, the payroll must show all current employees and include the time frame of the payroll, wages and tax deductions. Handwritten payrolls or checks/check stubs are not acceptable. Handwritten quarterly wage and tax reports are also not accepted as the state of Tennessee requires electronic filing of all quarterly wage and tax reports.

Please note that our underwriting guidelines, in accordance with federal law, ***will require that a plan must have at least one common law employee (i.e. W2 employee) among its participants in order to be considered a group health plan.*** *Sole proprietors and his/her spouses, partners in a partnership (who do not qualify as a bona fide partner* pursuant to 45 CFR 146.145(c)(2)),and their spouses; as well as shareholders of a corporation (who do not also qualify as common law employees by also being considered a W2 employee), are not considered common law employees. Therefore, a plan whose enrollment consists only of sole proprietors, partners in a partnership (who do not qualify as a bona fide partner* pursuant to 45 CFR 146.145(c)(2), and their spouses; or shareholders of a corporation (who do not also qualify as common law employees by also being considered a W2 employee), is not eligible for group coverage.*

**A bona fide partner is a partner that performs services on behalf of the partnership.*

Tax documentation submitted should be the most recently filed information. Quarterly state wage and tax reports and federal 941 quarterly filings are due to the state/IRS as follows:

- 1st Quarter – Due April 30th
- 2nd Quarter – Due July 31st
- 3rd Quarter – Due October 31st
- 4th Quarter – Due January 31st

Business tax returns (including Schedule C for a sole proprietorship) are due by April 15th or March 15th depending upon the type of business. Six month tax extensions are generally available, which would extend the filing due date to September 15th or October 15th.

Confidentiality

All forms and tax documents submitted are considered confidential and proprietary and afforded the same protection and privacy as required by HIPAA for personal medical information. Tax information is reviewed only by Underwriting staff and used solely for verification of eligibility and participation guideline compliance. Documents are managed via a retention schedule developed and approved by BlueCross Legal department according to applicable state and federal laws. Documents are kept in secure storage facilities with limited access only by Underwriting. Once documents are no longer needed, they are destroyed. Duplicate copies of documents are destroyed prior to being placed in storage.

Required Tax Documentation Based on Type of Business/Employee	Existing Business *(In business one or more years)*	Newly Formed Business *(In business less than one year and not yet required to file tax documents)*
Employees *Employees must show earnings equivalent to 30 hours per week at minimum wage (or 20 hours per week if part-time employees covered) to be eligible for coverage.* *The Group Administer should mark employees as full-time, part-time, termed, etc. Job titles/classifications should also be listed for each employee for carve out/class outs.* *After all required notations are made; the Group Administrator should sign and date the tax form.* *Employer identification number / Federal Tax I.D. required.*	**One** of the **most recently filed** following documents required: • **Quarterly wage and tax report filed with the state** • **Outside vendor (ex. ADP) quarterly tax and payroll summary** • **IRS Form 941 *with matching payroll***	• **Employee Certification Form** *A follow-up audit is required to verify eligibility of employees of new businesses unable to provide tax documentation at time of sale.*
New Hires (W2 employees) *A follow-up audit is required to verify eligibility of new hires.*	• If not listed on the quarterly wage and tax report or 941 or if not showing full-time wages on these forms, **Employee Certification Form**	• **Employee Certification Form**
Sole Proprietor or Single Member LLC . ***A non-spouse W2 employee must enroll for business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	• **Employee Certification Form** **and** • **Schedule C, E or F of IRS Form 1040** *The most recently filed tax form should be submitted. After April 15t, prior year's tax information must be accompanied by a copy of the filed IRS Form 4868 Application for Automatic Extension of Time to File.*	**Employee Certification Form and one** of the following documents: • **Business License** *(certain businesses may be exempt from obtaining a business license)* • **State of Tennessee or IRS letter assigning account/Employer Identification number** • **Cancelled business check** with the business name and address • **Copy of most recent bank statement with business name and address** *(account balances may be marked through for privacy)* • **Signed/dated LLC Operating Agreement** listing each owner and percentage of ownership *A follow up audit may be required to verify eligibility of owners of new businesses unable to provide tax documentation at time of sale.*

Required Tax Documentation Based on Type of Business/Employee	Existing Businesses *(In business one or more years)*	Newly Formed Businesses *(In business less than one year and not yet required to file tax documents)*
Partner of a Partnership (including LLC member treated for tax purposes as a Partner of a Partnership) ***If only partners are enrolling, the partners must qualify as a bona fide partner pursuant to 45 CFR 146.145(c)(2)). Otherwise, a non-spouse W2 employee must enroll for business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	• **Employee Certification Form** **and** • **IRS Form 1065 with Schedule K-1** *The most recently filed tax form should be submitted. After April 15th, prior year's tax information must be accompanied by a copy of the filed IRS Form 7004 Application for Automatic Extension of Time to File.*	**Employee Certification Form and one** of the following documents: • **Signed/dated Partnership Agreement or LLC Operating Agreement** listing each partner and percentage owned • **Filed/stamped one page State of Tennessee Partnership form and a letter** on the group's letterhead listing each partner and percentage owned *A follow up audit may be required to verify eligibility of partners of new businesses unable to provide tax documentation at time of sale.*
Shareholder of a Corporation (including an LLC member treated for tax purposes as a shareholder of a corporation) *The most recently filed tax form should be submitted. After April 15t, prior year's tax information must be accompanied by a copy of the filed IRS Form 7004 Application for Automatic Extension of Time to File.* ***If only shareholders are enrolling, shareholders must also be W2 employees. Otherwise, a W2 employee must enroll for the business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	**Employee Certification Form and one** of the following forms depending upon how the business files: • **<u>If a C corporation:</u> IRS Form 1120** *(If owners/officers with percentage of ownership not listed on Schedule E, include Articles of Incorporation or filed/stamped State of Tennessee Charter listing owners and percentage of ownership*) • **<u>If an S corporation:</u> IRS Form 1120-S with Schedule K-1** • **<u>If only shareholders enrolling,</u> shareholders should be listed on the quarterly wage and tax report filed with the state** or outside vendor (ex. ADP) quarterly tax and payroll summary	**Employee Certification Form and one** of the following documents: • **Signed/dated Articles of Incorporation** listing each owner and percentage of ownership • **Filed/stamped one page State of Tennessee Charter** and letter on the group's letterhead listing each shareholder/member and percentage owned *If only shareholders are enrolling, they must attest on the Employee Certification Form that they are also W2 employees and a follow up audit will be conducted to verify eligibility.*
Independent Contractor Must be considered a common law employee. *Must show earnings equivalent to 30 hours per week at minimum wage to be eligible for coverage.* ***A W2 employee must also enroll for the group to be eligible for coverage.***	• **Employee Certification Form** **and** • **IRS Form 1099-NEC**	**Employee Certification Form and one** of the following documents: • **Current payroll** • **Copy of work contract/agreement** *A follow up audit may be* required *to verify eligibility of 1099 workers unable to provide Form 1099-NEC at time of sale.*

The following special groups are required to submit the **same** information as a new or existing business listed above EXCEPT as noted below:

Farms	Groups with Leased Employees	Section 501(c)(3) Organizations
Farms may submit IRS Form 943 **with current payroll** in lieu of quarterly wage and tax report or IRS Form 941.	If a group with leased employees is unable to provide standard tax documentation for these employees, a letter on company letterhead explaining the employer/employee relationship and a current payroll should be submitted. The employer must be the common law employer of the leased employees. *A follow up audit is required to verify eligibility of employees of new businesses unable to provide tax documentation at time of sale.*	Groups should submit IRS Form 941 **with matching payroll** since they are exempt from unemployment taxes. Churches that are also exempt from FICA taxes as well as unemployment taxes should submit the most recent quarterly payroll *and* a copy of the filed IRS Form 8274. **If enrolling pastors only, pastors *must* be common law/W2 employees.**

Husband/Wife Group Eligibility and Required Tax Documentation

Husband/wife groups (i.e. a group with only a husband and wife enrolling) require approval from BlueCross prior to quoting. A follow up audit may be conducted for a new business. In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.

		If group is eligible, what tax documentation is required?	
How does the husband/wife business file its taxes?	**Is the group eligible for BlueCross group medical, dental and/or vision coverage?**	**If business has been in existence 1+ years**	**If business has been in existence less than 1 year and not yet required to file tax documents**
Sole Proprietorship	**No**	na	na
Partnership (including an LLC treated for tax purposes as a Partnership)	Yes, if both spouses are bona fide partners	**IRS Form 1065 and Schedule K1** **Employee Certification Form**	**Partnership Agreement** listing partners and percentage owned *or* filed/stamped state of TN partnership form and letter listing partners/percentage owned **Employee Certification Form**
	Yes, if one spouse is a bona fide partner and one spouse is a W2 employee	**IRS Form 1065 and Schedule K1** **Employee Certification Form** **Most recent quarterly wage and tax report filed with state**	**Partnership Agreement** listing partners and percentage owned *or* filed/stamped state of TN partnership form and letter listing partners/percentage owned **Employee Certification Form** *A follow up audit will be conducted for the most recent quarterly wage and tax report.*
Corporation (including an LLC treated for tax purposes as an S or C Corporation)	Yes, if both spouses are also W2 employees	**Most recent quarterly wage and tax report filed with state**	**Articles of Incorporation** listing each owner and percentage owned **Employee Certification Form** *A follow up audit will be conducted for the most recent quarterly wage and tax report.*

Level Funding for Small Employers

General Info

The following information provides a general overview of the level funding arrangement for small employers. For complete information regarding level funding, please refer to your BlueCross Sales or Account Executive.

Level funding is a special financial arrangement offered to healthy groups that meet certain criteria established by Actuary and Underwriting and the following eligibility requirements:

- For employer groups located in Tennessee: level funding is available to ACA small employer groups with a minimum of 10 enrolling employees

- For employer groups located in Walker, Dade and Catoosa counties in north Georgia: level funding is available to ACA small employer groups with a minimum of 5 enrolling employees

Level funding, which applies to medical and pharmacy coverage only, combines the advantages of being self-funded (i.e. less premium taxes and fewer benefit mandates) with the stability of a fully insured plan. Groups will pay one fixed payment each month that incorporates all the components required for self-funded (i.e. administrative expenses, stop loss protection and claims funding). If the group elects an HRA, HRA claims will be billed as usual. Groups may also purchase ancillary coverage such as dental or vision coverage; but those coverages must be on a traditional fully insured arrangement. With level funding, groups have the potential to share in a surplus at the end of the contract period if the group renews with BlueCross.

Administrative Expenses include the following:

- Claims and Billing Administration
- COBRA Administration (if applicable)
- Network Access
- Medical Management
- 24/7 Nurseline
- Physician Now powered by MDLive
- Health Maternity
- NICU Care Management

Stop Loss Protection

Stop loss protection is required through BlueRe and includes the following:

- Specific stop loss protection for a catastrophic claim from a single employee or dependent. Attachment point varies based on the number of enrolling employees (i.e. $20,000 for groups with 10 – 20 employees and $25,000 for groups with 21 – 50 employees)
- Aggregate stop loss protection against group level claims that exceed 120% of expected annual claims

Claims Funding

As noted above, with level funding, groups pay one fixed payment each month that incorporates claims funding. If at the end of the contract year, actual claims are less than expected, the group will share in the savings and receive money back after renewing. If actual claims are higher than the group's monthly payments, BlueCross will pay the difference. Please refer to the settlement section below.

Benefits

Medical

BlueCross offers many different medical plans to choose from ranging from HSA Compatible plans to plans with copays. All plans are available with networks P or S. Level funding benefits include medical, pharmacy and wellness coverage with the same access to clinical management programs and consumer tools as our fully insured plans. Please note that level funded plans do not include pediatric dental and vision coverage or lifestyle health coaching.

Plan year or calendar year benefit administration available. Multi option guidelines apply – a maximum of 3 benefit/network combinations allowed. Pharmacy benefits may not be carved out. Benefit customization is not allowed.

HRA

All standard HRA options are available to pair with a level funded plan including the BlueCross in-house solution, with access to all the standard options, and the BlueCross integrated solutions.

If the group elects an HRA, HRA claims will be billed as usual. For BlueCross' in house solution, claims will be billed for ACH Debit on a weekly basis (for the claims paid the prior week). Our preferred vendors offer HRA replenishment options that will be discussed during onboarding, and the most popular option is weekly replenishments. The vendors will bill for all HRA administration fees and claims per the agreed upon schedule.

Dental and Vision

Tennessee employers who desire to purchase dental and vision coverage may purchase NonEHB DentalBlue and/or VisionBlue coverage on a fully insured arrangement. Standard underwriting guidelines such as participation, contribution, etc. apply. EHB supplemental dental and/or vision coverage may not be purchased if medical coverage is on the level funded arrangement. Fully insured dental plans are not available to Georgia employers.

Underwriting Guidelines

The following guidelines apply to level funded quotes:

- Underwriting approval is required before a level funding quote may be issued.
- Groups must meet the following eligibility requirements:
    - ACA small employer groups with a minimum of 10 enrolling employees for employers located in Tennessee
    - ACA small employer groups with a minimum of 5 enrolling employees for employers located in Walker, Dade or Catoosa counties in north Georgia
    - ERISA qualified plans only
    - Less than 10% COBRA enrollment
- Level funding quotes are not available to existing groups off renewal.
- Rates and benefits offered are based on the employer attestation of group size. Small employer level funded quotes are presented on the basis of the average number of all employees in the preceding calendar year being 50 or less.
- Underwriting will review groups each year at renewal to determine if the level funding arrangement may continue for the next plan year.
- Level funded groups will be rated based on the group's previous claims experience.
- Good candidates for level funding include healthy groups seeking lower premiums.

- No benefit customization allowed.
- Groups will be medically underwritten. New groups must submit a medical questionnaire. The questionnaire not required for renewing groups as current claims information will be utilized.
- **Underwriting may revise or withdraw the proposal if any of the information upon which these rates or benefits were based changes or is inaccurate. This includes Medical History and census changes (if the members who enroll are either 10% more or 15% less different than the members who were quoted)**
- ACH Debit billing required
- Broker commissions follow the standard ACA/EHB commission rate for the small group segment and is included in the group's monthly payment as part of the administrative fee.
- Groups may offer up to three different benefit/network combinations regardless of the rate differential. For groups offering multi network, out of state members must select the rates associated with Network P.
- No other carriers/coverage will be offered to employees. No supplemental or gap plans will be offered which reduce any portion of the member out of pocket liability.
- **Underwriting reserves the right to either decline to quote or revise the monthly rate if any of the following occur at initial enrollment of the level funding arrangement:**
    - **Less than the minimum number of employees enroll**
    - **A 10% or more increase in actual members when comparing the submitted members used to generate the level funded quote and the actual members who enroll**
    - **A 15% or more decrease in actual members when comparing submitted members used to generate the level funded quote and the actual members who enroll.**
- Participation requirements:
    - For Tennessee small employers - 50% of net eligible with a minimum of 10 enrolling employees
    - For Georgia small employers – 50% of net eligible with a minimum of 5 enrolling employees
    - Valid waivers of coverage include group coverage through a spouse or parent, Medicare, Tenncare, military coverage or individual coverage (on or off the Marketplace)
- Employer Contribution requirements:
    - For Tennessee and Georgia small employers – 50% of employee only rate for lowest priced plan

Continuation Coverage

For groups with 20+ employees who are required to provide COBRA continuation coverage, BlueCross COBRA administrative services are available for an additional fee.

Please note that for groups with less than 20 employees who do not qualify for COBRA coverage, State continuation coverage is not applicable for self-funded ERISA groups. Individual market coverage is available where COBRA is not an option.

Audit

All sold level funded plans will be audited by Underwriting Policy & Procedure staff to ensure compliance with all general and level funded specific underwriting guidelines. Underwriting reserves the right to either decline to quote or revise the monthly rate if any of the following occur:

(1) Less than minimum number of employees enroll
(2) A 10% or more increase in members when comparing the actual members used to generate the level funded quote and the actual members who enroll
(3) A 15% or more decrease in members when comparing the actual members used to generate the level funded quote and the actual members who enroll
(4) Any gross violation of underwriting guidelines as deemed necessary by Underwriting and Audit staff

Billing

A binder check is required for new groups. A binder check is not required for an existing group converting to the level funded arrangement.

ACH Debit billing required for both new groups and existing groups. BlueCross will generate the monthly bill around the 15th of the month for the following month due date. The ACH direct debit for the monthly payment will take place on the first business day of the following month. Along with the monthly bill, a YTD reconciliation of claims experience vs payments will be provided. If fully insured dental and/or vision coverage is purchased, these coverages will be set up on ACH debit billing as well. If the group elects an HRA, HRA claims will be billed as usual.

Reporting

Standard Interactive Reporting (IR)

IR will be available as outlined below as well as a new quarterly Financial Position Report that will allow groups to track and estimate a potential surplus.

- Demographic Breakdown of Members
- Enrollment by Group by Month (Group, Subgroup, Plan and Department Level)
- Group Member Listing
- Group Member Listing by Year
- Member Breakout by State
- Fitness Your Way
- Online Self-Directed Coaching
- Personal Health Assessment (PHA) Aggregate
- Personal Health Assessment (PHA) Participation List
- Wellness Activity

ERISA 5500

The employer must file a Form 5500 for an HRA with 100 or more participants. Several regulatory exemptions from the ERISA Form 5500 filing requirement for welfare benefit plans are available. Those most likely to be available for HRAs include exemptions for welfare benefit plans that: cover fewer than 100 participants and are unfunded, insured or a combination of insured and unfunded; are governmental plans; or are church plans under ERISA §3(3). Groups should discuss ERISA 5500 reporting with their tax/legal counsel.

Settlement Process

The final reconciliation process will occur during the fourth month after the end of the contract year (or during the 16th month after the coverage begin date). The group will receive an email notification after the 16th month indicating if they earned a surplus. The group must still be in force with BlueCross in order to receive the surplus, which will be in the form of a credit on their next monthly bill. The group will share in a percentage of the surplus amount (i.e. 50%) according to their contract. The group has no further obligations if they are not in a surplus position.

BlueCross will compare the group's total net paid claims and the groups total aggregate funding to determine if there is a surplus. After the three-month run out period, net paid claims will be adjusted by enrollment retroactivity and the terminal reserve fee.

Terminal reserves are calculated and retained by BlueCross to pay for claims that were incurred during the contract year but are not paid until after the settlement. The terminal reserve will be used to cover the run out claims from the 16th month onward so that the group has no further liability for runout claims for the contract year.

> *Example: If a hospital claim was incurred in June 2023, the last month of the contract period, and it was not processed until October 2023, the group will not be responsible for the claim. BlueCross assumes the liability and will use the terminal reserves to pay the claim.*