



HEALTHAMERICA
A Coventry Health Care Plan

**Small Group
Underwriting Guidelines**



Preface

- The purpose of these guidelines is to provide an outline of the information we collect and the minimum requirements to obtain a small group health insurance contract with HealthAmerica.
- The information provided in this document is intended for informational purposes and should not be considered all-inclusive. The HealthAmerica Underwriting department reserves the right to request additional information when necessary in order to verify group and member eligibility.
- HealthAmerica recognizes that documents collected for underwriting purposes contain sensitive and proprietary information. For this reason, the HealthAmerica Underwriting department follows strict confidentiality rules to protect the information contained in these documents.
- HealthAmerica reserves the right to update or change these guidelines at any time based on current regulations and changes in the insurance marketplace.
- Groups not meeting the Underwriting Guidelines or refusing to provide requested information will not be provided coverage under a HealthAmerica group contract.

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Group Eligibility

Defining a Group

An eligible group consists of a legal entity with a minimum of two enrolled employees and a maximum of 50 employees. The business must have legal authority to execute a contract on behalf of its employees, as well as meet the following criteria:

- ❑ Business must be actively engaged and full-time operational in its industry for a minimum of six months.
- ❑ Groups spinning off from existing companies may qualify for coverage before six months; Underwriting will review and approve on a case-by-case basis.
- ❑ Business must have Worker's Compensation insurance in-force, as required by state law.
- ❑ Business cannot be formed solely for the purpose of obtaining health insurance coverage.
- ❑ Investment or rental income-only groups will not be considered eligible for coverage. Exceptions will be considered for rental businesses owning and operating more than five units and maintaining full-time employees.
- ❑ Nonprofit and religious organizations, as well as government entities such as municipalities and townships, will be considered eligible for coverage.
- ❑ Groups previously termed for non-payment within the past 24 months may be required to pay two month's premium in advance of coverage.

Location

Businesses must be located within the state of Pennsylvania and select Ohio counties in order to be eligible for group coverage. Groups having their headquarters located outside of our defined Pennsylvania and Ohio in-area service region, but having an in-state office, may be eligible for coverage. Only employees working at the in-area location may be eligible for the group's coverage under their HealthAmerica plan.

Carve-outs

The current provisions within the Patient Protection and Affordable Care Act (PPACA) prohibit groups from carving out employees based on class. However, union/non-union groups may be established so long as the following conditions are met:

- ❑ The group must provide evidence of union/non-union employee segregation in which the union provides coverage to all union employees.
- ❑ Union bargaining agreement or carrier bill must be provided to verify current coverage for union members.
- ❑ Union and non-union employees are included in the total count of eligible employees to determine the case size (i.e., small or mid-market).

Common Ownership

Multiple businesses may be combined under one group contract so long as the following conditions are met:

- A single owner or husband and wife combination has controlling interest (greater than 50 percent) in each of the businesses intending to be combined; appropriate tax documentation will be required to verify ownership structure.
- The combined businesses have less than 50 total eligible employees.
- The businesses may have multiple SIC codes; however, rates for the combined group will be based on the SIC code from the business with the greatest amount of enrollment.
- Family members can not combine ownership amounts to total controlling interest.
- Groups combined under common ownership may only be separated based on a legitimate business reason (sale of business, etc.) verified by appropriate documentation.
- Groups deciding to split will require appropriate tax documentation to verify enrollment in each separate group at time of separation.
- Underwriting reserves the right to final approval/denial of multiple business groups.

Member Eligibility

Employees

An eligible employee is at least 18 years of age, actively employed on a permanent basis and meets the following requirements:

- Works a regular schedule of at least 25 hours per week or meets the employer's hourly requirement (whichever is greater) and is working at least nine months per year
- Receives a regular wage/salary supported by required tax documentation
- Meets the employer's set probationary period as outlined on the Group Application

Township supervisors may be considered eligible for coverage based on the Unconsolidated Pennsylvania Statutes for Municipal Corporations (Title 53), Second Class Township Code.

The following individuals are not considered eligible for coverage under the group contract:

- 1099/contract employees
- Directors, stockholders, trustees, absentee owners, board members
- Partners or other outside consultants who are not active, permanent full-time employees
- Seasonal employees working less than nine months per year and part-time employees working less than 25 hours per week
- Retirees, whether early or Medicare-eligible
- Elected officials

Dependents

Eligible dependents include spouses and children of enrolled subscribers. For the purposes of Underwriting, eligible children are newborn/biological, legally adopted, stepchildren and children placed under legal guardianship (proof of guardianship required). Children are eligible for coverage through the age of 26 (up to age 28 in Ohio); however, Act 4 of 2009 legislation permits a group to enroll eligible children up to the age of 30 as long as the following conditions are met:

- Not married
- Have no dependents
- Are Pennsylvania or Ohio residents or enrolled as a full-time student at an institution of higher education
- Are not provided private insurance coverage or enrolled in, or eligible for, government benefits

Note: A group may determine whether or not to elect Act 4 coverage; however, if elected, this coverage must be offered to all members. The employer will be billed a single subscriber rate for each dependent enrolled under Act 4. It is the employer's responsibility to coordinate payment from the employee for this additional subscriber. Coverage may only be elected at the new business or renewal date - exceptions to this policy will not be made.

Domestic Partners are not eligible for coverage in the Small Group market segment, but Common Law Marriages prior to January 1, 2005, will be honored in Pennsylvania, according to state laws. A common law marriage affidavit must be completed and notarized in order to process enrollment.

COBRA

It is the responsibility of the group to determine eligibility of COBRA applicants, but HealthAmerica may verify eligibility if a qualifying event is not apparent. COBRA enrollment should not exceed 10 percent of a group's total enrollment and may not be used to meet participation guidelines.

Late Applicants

All eligible employees, as defined in the Member Eligibility – Employees section, must complete either a waiver form or a medical application and enroll on the group's plan effective date. Eligible employees that waive coverage at the time of initial enrollment and decide to enroll at a later point must do so within 60 days of the effective date; their enrollment must be retroactive to the group's initial effective date. These individuals will be required to complete a medical application. Underwriting reserves the right to review all information and, if necessary, provide revised rates to the group based on demographic and risk changes upon additional enrollment. Beyond 60 days from the group's effective date, eligible employees must wait for the next open enrollment period to enroll, unless a qualifying event has occurred.

Probationary Periods

Probationary periods are determined by the employer group and must be applied consistently to all employees in accordance with state regulations. If a company is waiving its probationary period for an employee(s), Underwriting requires a letter on company letterhead citing this specific waiver from its standard policy. A group choosing to waive its probationary period for one employee must apply the same waiver to all employees to avoid discriminatory enrollment acts. Changes to the probationary period must be made at contract effective dates; off-cycle changes to this policy must be approved by the VP of Underwriting.

Product Availability

In-Area

Standard in-area products are available to members residing within the HealthAmerica service region. Members can use our online provider search to search for network providers based on product enrollment.

Out-of-Area

Groups having active subscribers outside of the HealthAmerica service area may choose to add an out-of-area product to their benefit options. Out-of-area enrollment is offered to groups with eight or more enrolled subscribers and is limited to no more than 30 percent of total enrolled subscribers. In order to maintain an out-of-area plan, a minimum of one subscriber must be enrolled in the product at the group's renewal. Groups falling below eight subscribers will be reviewed at the time of renewal and may be required to remove their out-of-area plan.

Dual Options

Dual options are available to groups with eight or more enrolled subscribers. Groups having out-of-area individuals may only choose one option for their out-of-area product. In this case, the high option should be matched, but the group has the flexibility to match to the low option, if desired. A minimum of one subscriber must be enrolled in each option in order to maintain this program at a group's renewal. Groups falling below eight subscribers will be reviewed at time of renewal and will be requested to move to single option benefit plan. For groups enrolled in more than one plan option, a multi-option load will most likely be applicable.

Participation Requirements

Contributions

The employer must contribute a minimum of 50 percent of the premium rates for each coverage tier (i.e., employee, employee/spouse, employee/children, family) or a minimum of 50 percent of the single premium towards the cost of each tier.

Participation Levels

The following participation guidelines will be followed for all small group products:

- At least 50 percent of the total eligible employees must enroll in the group's plan
- At least 75 percent of eligible employees must either enroll through the group's plan or be considered as a valid waiver. See Waivers section below for details.
- Dependent participation is not required
- COBRA applicants will not be counted towards total participation levels

*A participation chart is available in the Appendix.

Waivers

The following coverage will be considered as a valid waiver for the purposes of participation guidelines:

- Coverage under a spouse's medical plan
- Medicare (Part A and B)*
- Medicare Advantage Plan*
- Employees through age 26 (up to age 28 in Ohio) and younger currently enrolled on parent's plan
- V.A. or TRICARE Military Benefits
- Amish individuals covered under Amish Aid. These individuals may be required to submit a copy of Form 4029 (Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits) to satisfy this requirement.

* Must be accompanied by a copy of the individual's ID card for their alternate coverage plan.

Waivers completed for any other reason (e.g., Individual coverage, no coverage, etc.) are invalid and will not count towards the group's participation requirements.

Rating Methods

Medical Applications

Each individual subscriber is required to complete a medical application in its entirety and sign and date the document verifying the information they have provided is true and accurate to the best of his/her knowledge. The data collected from the medical applications is used by the HealthAmerica Underwriting department to determine a risk factor that will be assigned to each group.

Census Data

Census data entered into HealthAmerica's rating system BenefitExpress is used to gather demographic information to provide appropriate rates for each group. The HealthAmerica Underwriting department will verify all census data to ensure information in the rating system matches the information provided on the medical applications. Data accuracy is essential when providing census data as changes to demographics or enrollment may impact rates and product

availability. Necessary items to produce a quote include subscriber date of birth, gender, zip code, enrollment tier and number of dependents.

SIC Codes

Underwriting will use the SIC code that is registered with Dun & Bradstreet, Inc., in order to provide an industry factor for each group. Groups requesting a change in SIC code for rating purposes will be required to contact Dun & Bradstreet, Inc. to have their SIC code changed before Underwriting will adjust the group's file. Any exceptions to this practice will be at the discretion of Underwriting management.

Quoted Rates vs. Final Rates

Rates are not considered final until approved by Underwriting.

It is important to note that quoted rates received after medical underwriting are not considered final and are subject to change. Changes to a group's census (e.g., addition/subtraction of subscribers/members, correcting census errors), effective date, or product selection may result in a change to the group's rates. Additional medical information received from subscribers after medical underwriting is completed may also result in a change to rates. Once Underwriting has completed its review of the group submission, it will notify Marketing that final rates are available.

Benefit Change – Off-Cycle

Current groups have the option to request an off-cycle benefit change within the first nine months of each contract year. Benefit changes are only permitted to groups wishing to move to a lesser benefit design (e.g., higher deductible, etc.); upgrades must be made at renewal dates only. Benefit changes are not permitted within 90 days prior to a group's renewal date. A benefit change will result in the group's effective date being changed to the newly requested effective date, as well as any deductible level being reset for each subscriber/member. The off-cycle proposal will be valid for a 12-month contract period.

Enrollment Paperwork

Group Application

The group's decision maker must complete the HealthAmerica Group Application in its entirety in order to collect data for rating and underwriting purposes. If information missing, it may be requested during Underwriting review and may delay case processing and final rates until it is received.

Subscriber Applications

All eligible employees intending to enroll under the group's plan must complete the first and second page of a HealthAmerica medical application. Accuracy of the data provided is important as this is utilized in rate production and to verify enrollment.

All medical applications must be completed, signed and dated by the employee within 60 days of the group's effective date. If additional pages are included with the medical application, each page must be signed and dated by the employee.

All medical applications completed more than 60 days from the group's effective date must be:

- 1) Reviewed for any changes, including updates to medical conditions
- 2) Re-signed and re-dated (including any additional pages)

If medical applications are completed more than 75 days from the group's effective date, they are considered stale and employees will be required to complete entirely new medical applications.

All employee applications and revisions made to applications must be completed, signed and dated by the employee.

Any exceptions to the use of HealthAmerica medical applications or pre-approved forms must be approved by the VP of Underwriting.

Waivers

Eligible employees waiving coverage are required to complete Sections B and E of the medical application, as well as indicate the reason for waiving coverage.

All waivers must be signed and dated within the same timeframe requirements as indicated in the Subscriber Applications section.

Current Carrier Bill

Groups with current coverage will be required to submit a copy of its current carrier bill and census with their enrollment paperwork.

Tax Documentation

In order to verify employee eligibility, each group must submit a copy of its most recent PA Form UC-2A, Employer's Quarterly Report of Wages Paid to Each Employee. All pages, including the UC-2 and UC-2A portions, must be submitted for Underwriting review.

The UC-2A form must include the following information:

- Annotations for each of the employees listed should follow the UC-2A Annotation Guide provided in the Appendix.
- The group decision maker must sign and date the UC-2A form to validate accuracy of annotations for each employee.
- The UC-2A document must not have any data altered upon submission for Underwriting review and should include all appropriate wage information. UC-2As with white/blacked out wages will not be accepted; all information is required to verify eligibility.
- Groups combining multiple businesses will be required to submit a UC-2A for each business applying for coverage.

- ❑ Wages listed on UC-2A must support full-time eligibility for each employee. Part-time employees earning higher wages than full-time employees will require an explanation for wage disparity (i.e., highly compensated employee, seasonal, overtime etc.). Employee payroll records may be requested to provide further verification.
- ❑ Quarterly UC-2A documents must be submitted following the UC-2A Submission Date Guide in the Appendix.
- ❑ Underwriting may request additional documentation to support UC-2A annotations.

In certain situations an employee may not appear on a UC-2A, such as a new hire or a sole proprietor's spouse. These occurrences will require the group to submit a copy of the employee's most recently completed payroll register to verify eligibility. Newly hired employees should be handwritten at the bottom of the UC-2A form. The hire date, eligibility status, and the most recently completed payroll register should be included.

Religious or non-profit organizations that do not file a UC-2A will be required to submit a copy of its most recently completed payroll register and a copy of its most recently filed quarterly Form 941. The same guidelines for annotating the UC-2A apply for this payroll, and it must be signed and dated by the group's decision maker.

Husband and Wife Groups

Husband and wife group combinations are permitted to apply for coverage under a group contract provided the following conditions are met:

- ❑ Sole proprietorship – Must provide a copy of the most recent tax year's Schedule C document to verify ownership. If no UC-2A is filed, a copy of the most recent payroll register AND the previous year's W-2 form will be required for the spouse not appearing on the Schedule C.
- ❑ Corporations/Partnerships – Husband and wife groups formed as a corporation or partnership will be required to submit their main tax document, including the Schedule K-1s (depending on tax filing) to verify current ownership.
- ❑ Non-ownership spouses appearing on payroll must meet all eligibility requirements listed in the Member Eligibility – Employees section.
- ❑ If the business has additional part-time employees, a copy of the group's UC-2A will still be required to verify their status.

Ownership Documentation

Certain situations will require the submission of a company's ownership tax documentation, such as all ownership groups, owners not appearing on payroll/UC-2A, combining multiple businesses, etc. In these situations, applicable tax documents are as follows:

- ❑ C Corporation – First two pages of Form 1120 (must include ownership schedule)
- ❑ S Corporation – Form 1120S and Schedule K-1 documents for each shareholder
- ❑ LLC – Depending on filing with IRS, main tax document and/or K-1s for owners required
- ❑ Partnership – Form 1065 and Schedule K-1 documents for each partner
- ❑ Religious or non-profit – Form 990
- ❑ Sole Proprietorship – Schedule C or Schedule F

New Businesses

Although it is a requirement that businesses be in operation for a minimum of six months (as notated in the Defining a Group section), it is possible that a yearly tax return has not been filed. In these situations the following paperwork must be submitted for Underwriting review:

- A letter drafted on company letterhead detailing the start date of business operations, previous ownership experience, total number of employees, and a description of business activities. This letter is required to be signed and dated by the group's decision maker/owner.
- Copy of SS-4 document (application for Employer Identification Number) or PA-100 (PA Combined Registration) Form.
- Copy of the business' Operating Agreement, Partnership Agreement, or Articles of Incorporation.
- Most recently filed UC-2A form and/or payroll, meeting the same requirements as listed above.
- If an Underwriting exception to this guideline is made, an additional risk charge may apply.

Appendix

Participation Chart

Eligible Employees	Enrolled	Valid Waivers	Non-valid Waivers
2	2	0	0
3	2	1	0
4	2	1	1
5	3	1	1
6	3	2	1
7	4	2	1
8	4	2	2
9	5	2	2
10	5	3	2
11	6	3	2
12	6	3	3
13	7	3	3
14	7	4	3
15	8	4	3
16	8	4	4
17	9	4	4
18	9	5	4
19	10	5	4
20	10	5	5
21	11	5	5
22	11	6	5
23	12	6	5
24	12	6	6
25	13	6	6
26	13	7	6
27	14	7	6
28	14	7	7
29	15	7	7
30	15	8	7
31	16	8	7
32	16	8	8
33	17	8	8
34	17	9	8
35	18	9	8
36	18	9	9
37	19	9	9
38	19	10	9
39	20	10	9
40	20	10	10
41	21	10	10
42	21	11	10
43	22	11	10
44	22	11	11
45	23	11	11
46	23	12	11
47	24	12	11
48	24	12	12
49	25	12	12
50	25	13	12

UC-2A Annotation Guide

The following annotations shall be used for each employee appearing on the signed and dated quarterly filed UC-2A form or payroll register if applicable:

Annotation	Description
FT	Full-time Eligible (Enrolling)
PT	Part-time Not Eligible
W	Waiver (Full-time Eligible)
T	Terminated (include termination date and COBRA status)
Prob	Currently in probationary period (indicate hire date)
C	COBRA (indicate start and end dates of eligibility)
R	Retired
O	Other (indicate description as seasonal, owner, officer, owner's spouse etc.)

UC-2A Submission Date Guide

UC-2A reports are required to be submitted to the state on a quarterly basis; each report is due at the end of the month following the close of each quarter. Financial Underwriting will follow the guidelines below for accepting UC-2 reports for underwriting purposes:

Report filed	Reports due to state	Date required for Financial Underwriting
1st Quarter (January, February, March)	April 30	May 10
2nd Quarter (April, May, June)	July 31	August 10
3rd Quarter (July, August, September)	October 31	November 10
4th Quarter (October, November, December)	January 31	February 10