Small Group Underwriting & Enrollment Guidelines

The Highmark Small Group Underwriting & Enrollment Guidelines (in accordance with the ACA laws) document the requirements for new and existing small group employers enrolling/renewing with **January 1, 2014 and later effective dates** (revised 7/8/2014).

SMALL GROUP UNDERWRITING & ENROLLMENT GUIDELINES

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Highmark Small Group
Underwriting & Enrollment Guidelines

PREFACE

As an insurer, Highmark assumes financial risk (much like a bank or financial institution) when selling health care coverage. Therefore, to assess a group's eligibility and that of its members to be covered, groups are required to submit verifiable tax/wage and other documentation. Recognizing that this information is proprietary and extremely sensitive, it is used only for underwriting purposes to verify group and member eligibility and will be kept **STRICTLY CONFIDENTIAL**. Highmark's confidentiality statement can be found in the New Business Submission Guide and on the Sold Group Checklist.

Please note, Highmark will **not** provide (or renew) coverage for groups that refuse to provide employment and ownership tax documents or other requested information needed to validate the eligibility of the employees and owners.

In conjunction with the *Affordable Care Act* (ACA) laws, the goal of the underwriting guidelines is to provide clear and consistent policies and procedures relative to core issues affecting all **small group employers** that are applying for (or are renewing) Highmark off-exchange coverage.

Highmark reserves the right to revise the underwriting guidelines **at any time** and **to make final decisions regarding any situations or issues** that are not specifically addressed within the guidelines.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Defining an Eligible Group
Control Number: UC-101.1
Revision Date: July 8, 2014
Category: Group Eligibility Requirements

Definitions
An eligible group is defined as a business or other legal entity that is actively engaged in a **full time** enterprise which has the legal capacity to sponsor a group health plan for the benefit of **one or more** of its eligible employees (e.g., a corporation, partnership, sole proprietorship, union, religious and nonprofit organizations, municipalities/townships or other entities formed in accordance with applicable state and federal laws).

To be eligible for small group coverage under the ACA, **an employer-employee relationship must exist** between the individuals involved that satisfies the *common-law* definition of there being an employer-employee relationship. In addition, an employer must have had an average of **50 or less** common-law employees in the prior calendar year **AND** have at least one active common-law employee (may be full-time or part-time) when coverage commences.

To calculate the average number of employees for group/market size determinations, employers are to count all common-law employees (including full-time, part-time, seasonal/intermit-tent, and in and out of area employees for whom they issued a W-2) that were employed on **each of their business days during the PRECEDING calendar year**. Subsequently, they should then divide the total number employees by the total number of business days in that year. (Refer to UC-105.1 for more information regarding employee counts and group/market size).

An excerpt published by the IRS, defines a common-law employee as follows:

> *Employee (Common-Law Employee)*
>
> *Under common-law rules, anyone who performs services for you is your employee if you can control what will be done and how it will be done. This is so even when you give the employee freedom to action. What matters is that you have the right to control the details of how the services are performed.*

The IRS rules also indicate that the following individuals are NOT considered to be common-law employees and therefore, employers are to **EXCLUDE** these individuals when calculating their average employee count for the prior calendar year: independent contractors (including sole proprietors); partners in a partnership; shareholders owning more than two percent of an S corporation; owners of more than five percent of other businesses; family members of these owners and partners, including a child (or descendant of a child), a sibling or step-sibling, a parent (or ancestor of a parent), a step-parent, a niece or nephew, an aunt or uncle, or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or a sister-in-law. A spouse is also considered a family member for this purpose, as is a member of the household who is not a family member but qualifies as a dependent on the individual income tax return of an excluded individual.

In addition to the above ACA requirements, groups must provide current Unemployment Compensation tax (or payroll listing) and ownership tax documents as outlined in UC-103.2

and in the New Business Submission Guide and satisfy all applicable underwriting requirements.

Note: New groups applying for January 1st effective dates during the annual ACA guaranteed special enrollment period (which begins November 15th and ends on December 15th) are not subject to the minimum participation and employer contribution requirements. However, **enrollment is contingent upon receipt of all submission materials in that timeframe and all other underwriting requirements must be met**. Renewability of such groups is based on compliance with ALL underwriting requirements (including the minimum participation and contribution rules).

In addition to the above mentioned entities, rental businesses may also qualify for group coverage provided they have a minimum of six rental units or be a single dwelling with a minimum of 12,000 square feet verifiable through a Schedule E (Form 1040) or declaration page from their liability insurer.

New "start-up" businesses may also apply for coverage contingent upon receipt of ALL of the following documents at time of application:

- An annotated payroll register **showing at least 30 days** of payroll that identifies all employees and hours worked per pay period.
- A copy of the group's SS-4 application **and** the Employer Identification Number (EIN) assignment form from the IRS (or a PA 100 Form).
- Upon request, additional information may be requested to support group eligibility (e.g., sales invoices/materials, liability and/or worker's compensation policies etc.).

Former Groups canceled for nonpayment of premiums **must wait six (6) months from the cancellation letter date** before reapplying. Such groups may be quoted on the Producer Portal and additional financial safeguards may also be required.

Violations
Dormant businesses, "side and hobby" businesses, trust arrangements, investment entities and owner-only groups with no eligible employees do **NOT** qualify for group coverage.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Group Location/Residency Requirements
Control Number:	UC-101.2
Revision Date:	July 8, 2014
Category:	Group Eligibility Requirements

Definitions

To qualify for coverage, the **physical site** (street address) of a company or corporate headquarters must be located in Highmark's licensed service area. Separate mailing and post office box addresses may only be used for billing, correspondence and/or administrative purposes.

In addition, at least 50 percent of a group's enrolled subscribers (eligible employees/owners and COBRA continuants) must reside within Pennsylvania or in an out-of-state county that **is adjacent to Highmark's service area**.

Requirements for groups with multiple locations are as follows:

- If a company has headquarter and branch locations **within Highmark's Central and Western service areas**, the headquarter location will govern which Plan will write the combined locations (e.g., if the headquarters are in western Pennsylvania, the combined locations will be written by the western Plan).

- If a company is headquartered outside of Highmark's licensed service area but it has **branch location(s) within the service area**, Highmark may write the branch location(s) based on the following provisions:

  1. The headquarters must provide written authority to Highmark to negotiate coverage with the branch location(s).

  2. The group must have an authorized decision maker (contract signor) at the insured location.

- If a company's headquarter location is within Highmark's service area and its branch location(s) are out of area, the branch location(s) should **NOT** be quoted (or added to existing groups) **without PRIOR approval by Underwriting**.

Violations

Private residences do **not** qualify as branch offices and post office boxes cannot be used as physical locations.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Carve-Out Groups/Employee Classes
Control Number:	UC-101.3
Revision Date:	July 8, 2014
Category:	Group Eligibility Requirements

Definitions
All employees (regardless of class) that meet the eligibility requirements outlined in UC-103.1 are considered eligible for group coverage. That said, groups seeking to cover only nonunion employees may exclude their union employees from the eligibility and participation requirements provided the union employees have medical coverage through a separate union sponsored group health plan.

Groups seeking to exclude union employees **must provide evidence of current union coverage** (e.g., a copy of a union bargaining agreement and/or a health carrier invoice that identifies all covered union employees). The employer must also annotate the current unemployment compensation report to identify union/nonunion employees and their eligibility status.

Employee Classes – Groups may offer differing levels of coverage and contributions and apply different hourly and probationary period requirements to various employee classes (e.g., hourly/salary, union/nonunion, etc.) based on the following conditions:

- The employee classes must be verifiable and directly related to employment divisions and the segmentations must exist for purposes other than insurance coverage.
- Employee classifications must **not** violate any state or federal anti-discrimination laws.
- Group must have written human resources policies outlining the classifications and a year-to-date payroll register that identifies the employee classes.

Note: Separate group numbers may be established for accounting/cost allocations and to identify applicable waiting period requirements if they vary by employee class.

Violations
An employer's weekly hour requirements for employee eligibility **cannot** be less than 20 hours per week. In addition, the employer's waiting period requirements for new employees cannot exceed 90 calendar days as this is prohibited under the ACA.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: "Single Employer" Groups Involving Multiple Businesses

Control Number: UC-101.4

Revision Date: July 8, 2014

Category: Group Eligibility Requirements

Definitions

Multiple businesses may be quoted and written as **"single employer"** group provided all of the following requirements are met:

- The businesses must be aggregated and treated as a "single employer" under subsection (b) controlled group corporations, (c) partnerships, proprietorships, etc. under common control, (m) employees of an affiliated service group or (o) other regulations of the Internal Revenue Code (IRC) section 414 regulations.

- The employer must provide an aggregated average employee count **for all the businesses** for the purposes of determining group/market size (regardless of whether all businesses are applying for coverage).

- The employer must also provide a letter from its legal counselor or tax accountant citing the related entity names and applicable IRC regulation **as evidence of "single employer" status**.

- The combined businesses must have a common decision maker (contract signor) within the licensed service area that is legally authorized to make benefits/human resources decisions and contract on behalf of the combined businesses.

- Each business must be located **within Highmark's licensed service area**.

- For rating purposes, the address and county information for in-area headquarters must be entered as the lead group on the first page of the Small Group Business Application. For out of area headquartered businesses that have multiple in-area branch offices or aggregated businesses, the branch office or business that has **the most employees** must be entered as the lead group on the application.

- The combined enrollment for all the businesses must satisfy the minimum participation requirement as outlined in UC-102.1.

  Note: The minimum participation requirement does not apply to groups that apply for January 1st effective dates during the annual ACA guaranteed special enrollment period (which begins November 15th and ends on December 15th) provided all submission materials are received during that timeframe. However, **enrollment is contingent upon receipt of all submission materials in that timeframe and all other underwriting requirements must be met**. Renewability of such groups is based on compliance with ALL underwriting requirements (including the minimum participation and contribution rules).

Separate group numbers will be assigned to identify each business and the respective EIN, SIC code, physical location and enrollment information for audit/legal purposes. Existing

groups found to have multiple IRC aggregated businesses enrolled/embedded under the same group number will be separated and assigned individual group numbers provided they meet all underwriting requirements. If the businesses are not aggregated under the IRC rules, they will be separated and written individually.

Note: Existing groups may only enroll employees from other businesses (not currently insured by Highmark) provided they meet the requirements noted previously and they receive **approval by Underwriting**.

Violations
Multiple businesses written as part of a "single employer" group under the IRC aggregation rules do **not** have the option of breaking apart at a later date simply to obtain more favorable rates.

Exceptions
Multiple businesses written as a "single employer" group that experience ownership changes will be separated and rated as individual employer groups (e.g., some or all of the businesses are sold and are under new ownership). Such changes should be reported to Highmark in writing within 30 days from the change. (Refer to UC-106.2 and 106.3 for more information regarding ownership and group size changes.)

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Guideline Name:	Professional Employer Organizations
Control Number:	UC-101.5
Revision Date:	July 8, 2014
Category:	Group Eligibility Requirements

Definitions

Professional Employer Organizations (PEOs) are companies that provide human resource services to other employers (whereby the employers then become PEO clients). Subsequently, the PEOs hire the clients' employees alleviating the clients from their employer administrative responsibilities (e.g., recruiting, hiring/performance reviews, payroll, withholding of taxes, employee benefits, workers' compensation, application of complex state and federal laws, etc.).

In contrast, temporary employment agencies (also referred to as staffing or leasing agencies) hire employees and then lease the employees (known as "temps") to other employers/clients. PEOs and temp agencies have one thing in common. **They are both considered to be the employer of record for tax and insurance purposes**.

Employees of PEO's and temp agencies that meet the eligibility requirements (as outlined in UC-103.1) are considered eligible for group coverage.

Violations

Individuals that receive 1099 forms are **not** eligible for group coverage.

PEO clients cannot offer coverage to the outsourced employees as the clients are "host" groups and are not considered to be the employer of record. Likewise, groups that lease employees from a temporary agency **cannot** offer health coverage to the leased employees.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Employer (Group) Responsibilities
Control Number: UC-101.6
Revision Date: July 8, 2014
Category: Group Eligibility Requirements

Definitions
As the sponsor and contract holder of a group health plan, employers must:

- Administer coverage by uniformly offering enrollment opportunities to **ALL** eligible employees that meet the hourly and probationary requirements as stated on the group application (and the requirements outlined in UC-103.1). Hourly and probationary period requirements may only **be made at renewal and must be reported to Highmark in writing**.

- Contribute at least 10% of the total premium towards employee medical coverage and provide for payment of premium dues through authorized payroll deductions. (Refer to UC-102.2 for more information regarding contribution requirements.)

- Collect Highmark approved enrollment/waiver forms from ALL eligible employees that elect to enroll or waive **for themselves and/or their dependents** (for all product offerings at initial enrollment and annual open enrollment periods).

  Note: Exceptions may be made for groups that collect enrollment/waivers via an electronic process approved by Highmark.

- Report accurate employee counts at initial enrollment and annually in accordance with state and federal mandates (e.g., ACA group/market size and Medicare Secondary Payer purposes, COBRA, etc.). Groups are encouraged to seek advice from their legal counsel as state and federal mandates carry different definitions for counting employees.

- Notify their Sales contact of any **major enrollment changes** involving employee layoffs and/or ownership changes (e.g., business acquisitions/mergers or "sell-offs") and/or **business status and/or location changes** within 30 days of finalization. (Refer to UC-106.2 for more information.)

- **Provide a 30 day written cancellation notice** should the group decide to cancel any current coverage(s) as stated in the small group contract.

Highmark reserves the right to terminate group coverage at any time if the group performs an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact. In the event of cancellation, **it is the employer's responsibility to notify its subscribers of the termination of group coverage**. Conversion notices for individual coverage will be offered as options for replacing group **medical** coverage.

Violations
The employer's policies should **not** violate state or federal laws that prohibit unfair discrimination regarding eligibility standards for participation in employee benefits plans.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: 1 - 50 Medical/Vision Participation Minimums

Control Number: UC-102.1

Revision Date: July 8, 2014

Category: Group Participation/Product Requirements

The participation requirements outlined below and on the next pages apply to all small group employers that choose a single or dual medical/drug offering **and/or** vision coverage. The requirements also apply to the medical plans offered as part of *MyBenefits* defined contribution arrangements. However, please note that *MyBenefits* options are only available to employers that have **10 or more enrolled** employees.

Participation is based on each group's total number of active eligible employees and owners (as outlined in UC-103.1 and 103.2) that qualify for group coverage, regardless of whether they are enrolling in or waiving coverage. For multiple businesses that have certified they are to be treated as a "**single employer"** under applicable Internal Revenue Code section 414 aggregation rules, eligibility and participation requirements are based on the combined number of eligible employee counts **for all of the businesses**.

- Groups with **one or two** active eligible employees must have **100% participation**.
- Groups with **three or more** active eligible employees must have a **minimum of 50%** participation as noted on the group participation table on next page. For groups that elect a dual medical/drug offering, enrollment for both products is counted in aggregate. This allows up to 50% of the eligible employees to waive for any reason.

  Note: Minimum participation requirements for clients that elect a "slice" (Highmark narrow network product alongside a competitor) are adjusted to reflect a minimum of 50% participation in health insurance that qualifies as Minimum Essential Coverage (MEC).

- If an eligible employee (age 26 or younger) waives for parental coverage and the parent is also an eligible employee under the same employer, they are to be counted as two eligible employees in the participation calculation (regardless of the fact that they are enrolled under the same contract). The same premise applies for husband and wife employees that work for the same employer and enroll under one contract.

All eligible employees and owners must complete Enrollment/Waiver forms indicating their intentions to enroll and/or waive available coverage(s) for themselves **and/or** their dependents.

Violations

While COBRA continuants are considered eligible for group coverage, they **cannot** be used to satisfy the minimum participation requirements.

Exceptions

New groups enrolling with January 1st effective dates that do not meet group participation and contribution requirements may still enroll in coverage during an annual ACA guaranteed special enrollment period (that begins November 15th and ends December 15th) **provided all submission materials are received in that time frame and all other underwriting**

requirements are met. Renewability of coverage is contingent upon the group meeting all underwriting guidelines, including the minimum participation and contribution requirements.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: 1 - 50 Medical/Vision Participation Minimums *(continued)*

Control Number: UC-102.1

Revision Date: July 8, 2014

Category: Group Participation/Product Requirements

The following participation requirements apply to single and dual medical/drug offerings as well as vision coverage for employers (including owners) with **one or more** employees enrolling in a traditional group health plan. The requirements also apply to employers with **10 or more enrolled** employees for *MyBenefits* defined contribution arrangements.

Active Eligible Employees	Minimum Enrolled
1	1
2	2
3	2
4	2
5	3
6	3
7	4
8	4
9	5
10	5
11	6
12	6
13	7
14	7
15	8
16	8
17	9
18	9
19	10
20	10
21	11
22	11
23	12
24	12
25	13
26	13
27	14
28	14
29	15
30	15
31	16
32	16
33	17
34	17

Active Eligible Employees	Minimum Enrolled
35	18
36	18
37	19
38	19
39	20
40	20
41	21
42	21
43	22
44	22
45	23
46	23
47	24
48	24
49	25
50	24
51	26
52	26
53	27
54	27
55	28
56	28
57	29
58	29
59	30
60	30
61	31
62	31
63	32
64	32
65	33
66	33
67	34
68	34

Active Eligible Employees	Minimum Enrolled
69	35
70	35
71	36
72	36
73	37
74	37
75	38
76	38
77	39
78	39
79	40
80	40
81	41
82	41
83	42
84	42
85	43
86	43
87	44
88	44
89	45
90	45
91	46
92	46
93	47
94	47
95	48
96	48
97	49
98	49
99	50
100	50

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: 1-50 Product Offerings (Traditional Small Groups)
Control Number: UC-102.2
Revision Date: July 8, 2014
Category: Groups Participation/Product Requirements

No. of Eligible Employees	**Medical Product Offerings/Other Requirements**
1	• Groups with 1 **enrolled** employee must choose **one** medical/drug option.
2-50	• Groups with 2 – 50 **enrolled** employees may choose up to **two** medical/drug options. • The employer must contribute at least 10% of the total premium towards employee coverage. • If group is offering a "slice" (Highmark narrow network product alongside a competitor), employee contributions must correspond to the premium levels of the different offerings. **For example**: If the individual rate for the Highmark "slice" plan is less than that for the competitor plan, the employee contribution for the Highmark plan **must be less** than the employee contribution for the competitor plan.
No. of Eligible Contracts	**Vision Product Offerings/Other Requirements**
1-50	• Only one vision plan is allowed.

Refer to UC-106.1 for information regarding product additions and changes.

Violations
Groups electing coverage through a traditional group health plan **cannot** set up a product without enrollment.

Employees cannot change medical/drug options until the group's next open enrollment period.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: 10 - 50 *MyBenefits* Product Offerings (for Defined Contribution Arrangements)

Control Number: UC-102.3

Revision Date: July 8, 2014

Category: Group Participation/Product Requirements

Medical Product Offerings/Other Requirements
• Groups must have **10-50 eligible employees** and may only choose **one** of the family options available. • Each *MyBenefits* option includes several medical plans for employees to choose from and no minimum enrollment requirements apply between the medical plans. • Employees cannot change their level of coverage until the group's next open enrollment period.
Vision Product Offerings/Other Requirements
• Groups will automatically receive three vision plans for employees to choose from. • No minimum enrollment is required per plan.

Violations

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Eligible Employees
Control Number: UC-103.1
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Regardless of employee class, individuals that meet ALL of the following requirements will be considered eligible for group coverage:

- Work a minimum of **20 hours per week** (or higher number of hours as stated on employer's group application) at least **9 months per year** for the employer;

- Receive a regular verifiable hourly wage (or salary) and appear on the group's current unemployment compensation tax report (and/or year-to-date payroll listing) and wage/salary information must support the weekly hour requirement as stated on the group application;

  Note: Unemployment compensation reports/payroll listings must be signed and annotated (according to employee eligibility) **by the employer**. Wage and credit weeks should **not** be altered or omitted.

- Satisfy the minimum probationary period requirement (as stated on the group application).

Employees that voluntarily leave employment that are later rehired must satisfy the probationary period requirements before they can enroll in coverage.

Employers may apply different hourly and/or probationary period requirements for multiple employee classes (e.g., hourly/salary, union/nonunion, etc.) provided the classes are directly related to employment divisions and the segmentations exist for purposes other than insurance coverage. In addition, the classifications must be clearly defined in the employer's written human resources policies and **cannot** be in violation of any state or federal anti-discrimination laws.

Note: Changes to hourly and probationary period requirements may only be made **at renewal and must be reported to Highmark in writing**.

Violations
In accordance with the ACA laws, probationary period requirements **cannot exceed 90 calendar days** from the hire date.

Retired employees, stockholders, board members, professional associates, trustees, legal counsel, 1099 recipients, township supervisors and elected officials (that do not meet the above requirements) are **not** eligible for group coverage.

Exceptions
Union employees covered through a separate union group health plan may be excluded as ineligible **contingent upon proof of coverage** (e.g., a copy of a union bargaining agreement or its health carrier invoice that lists all union employees).

In addition, eligible employees waiving for religious beliefs may also be excluded as ineligible provided they submit a copy of an Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits (Form 4029) which has been filed with the government.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Eligible Owners
Control Number: UC-103.2
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Owners may only enroll in group coverage provided they are eligible to sponsor a small group health plan under the ACA. Specifically, the employer must have had an average of **50 or less** common-law employees in the prior calendar year **AND** have **at least one** active common-law employee (may be full-time or part-time) when coverage commences. (Refer to UC-101.1 and 105.1 for more information regarding employee counts and group/market size determinations.)

For example: If an owner had an average of three common-law employees in the prior calendar year and has one (full or part-time) common-law employee at time of application (or renewal), the owner would be eligible to enroll in the group health plan.

To validate that a business exists and to determine the number of eligible owners, the following tax documents are required (regardless of whether the owners are enrolling or waiving coverage):

- **Sole Proprietors** – Schedule C (Sole Proprietorship – Profit or Loss from Business), Schedule F (Profit or Loss from Farming) - OR - Schedule E (Form 1040 for rental businesses)

- **S Corporation or Partnership (e.g., LLC, LLP, etc.)** – First page of Form 1120S (U.S. Income Tax Return for an S Corporation) - OR - 1065 (U.S. Return of Partnership Income) **AND** Schedule K-1s (Partner's Share of Income, Deductions, Credits etc.) for **ALL partners**.

  Note: Limited liability companies or partnerships that have limited partners (investors not involved in the day-to-day business operations) may choose not to cover the limited partners. In this case, **only the general partners would be eligible for coverage**. Limited partner exclusions must be submitted **in writing** (either in the comments section of the Small Group Business Application or via a signed letter from the group on company letterhead). In addition, copies of Schedule K-1s for **ALL partners** are required as proof of partnership type.

- **C Corporations** - 1120 Form (U.S. Corporation Income Tax Return) first two pages only. Corporate officers/shareholders of C corporations will only be considered eligible for coverage provided **they appear as paid employees** on the group's current UC-2/UC2A form (or year-to-date payroll register) and wage/salary information must support the weekly hour requirement as stated on the Small Group Business Application.

Owners having multiple businesses may combine them together as one group for insurance purposes provided the related entities are treated as a **"single employer"** based on applicable section 414 Internal Revenue Code aggregation rules and evidence of aggregation. (Refer to UC-101.4 for more information.)

Note: Underwriting reserves the right to request additional legal/tax documentation when deemed necessary as further validation of owners and/or business/group eligibility.

Violations

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Disabled Employees
Control Number: UC-103.3
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
A disabled employee does not have to qualify for Social Security benefits and may continue under the active benefit program. Group coverage may be offered to disabled employees provided that **ALL** of the following requirements are met:

- The disabled employee was actively employed **and** covered under the employer's group health coverage **at the time the disability occurred** and employer-employer relationship currently exists.

- The employer must provide a copy of the unemployment compensation report (or payroll register) which identifies the disabled employee **as being actively employed at the time the disability occurred** (e.g., if the employee became disabled in November 2013, a third quarter unemployment compensation report for that year is required).

- The employer must have an established written human resources policy that uniformly offers **ALL** disabled employees the privilege of continuing on the group health plan.

- The employer must submit a Disability Verification Form (UC-103.3A) for **each** disabled employee enrolling.

Upon request, additional information may be requested relative to the eligibility of disabled employees.

Violations

Exceptions
The above definition does **not** include a qualified disabled individual who is entitled to protection from discrimination by the Americans with Disabilities Act ("ADA"). The ADA defines such an individual as "someone who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires". Individuals protected under the ADA are considered working employees and therefore, the employer is not required to complete the Disability Verification Form.

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UC-103.3A

DISABILITY VERIFICATION FORM

SECTION 1 (Please Print)

Group Name: _____

Employee Name: _____

Social Security No.: _____

Hire Date (mm/dd/yyyy): _____

Date of Disability (mm/dd/yyyy): _____

Benefits will be Extended Until: _____

SECTION 2

1. Was the disabled employee **actively** employed at the time of the disability? □ YES □ NO

   If "Yes", attach a copy of the relevant Pennsylvania Employer's Report for Unemployment Compensation (PA Form UC-2/UC-2A) that identifies the disabled employee as being **actively** employed at the time the disability occurred, (e.g., if the employee became disabled in November 2013, attach a copy of the third quarter 2013 UC2/UC-2A forms).

2. Is there and has there been a continuous employer–employee relationship from the time the disability occurred? □ YES □ NO

3. Does the Group have a uniform policy of offering **ALL** disabled employees the privilege of continuing on group health coverage? (Please attach a copy of policy.) □ YES □ NO

SECTION 3

I hereby certify that the information given in this form is true and correct. I understand that false statements made herein or fraudulent claims made hereunder are subject to the penalties of 18 Pa. C.S.A. § 4117 relating to insurance fraud.

_____ _____

Authorized Representative Name (Please Print) Title

_____ _____

Signature Date

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Dependent Spouse
Control Number: UC-103.4
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Eligible dependents may include an employee's spouse under a legally valid existing marriage between persons of the opposite sex or between persons of the same sex when entered into a state that sanctions such marriages by law that are valid pursuant to such law at time of the marriage. Spouses of **legally recognized** common-law marriage arrangements between persons of the opposite sex may also be considered eligible.

To establish the validity of a common-law spouse, a notarized Affidavit of Common-Law Marriage form (UC-103.4A) must be completed and at least three supporting financial documents are required (e.g., joint titles to property or automobiles, joint bank/credit account information, etc.).

Note: Upon request, Highmark may request copies of marriage certificates to validate eligibility of spouses. Legal/financial documents may also be required for common-law spouses in addition to the above affidavit as proof of eligibility.

Violations
Regardless of court decrees, ex-spouses are **not** eligible for group coverage unless they qualify as COBRA beneficiaries as defined by applicable state or federal law. If enrolling as a COBRA beneficiary, the group must provide a copy of the COBRA election notice.

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UC-103.4A

AFFIDAVIT OF COMMON-LAW MARRIAGE

We, _____and _____, the undersigned
(Husband's Name) *(Wife's Maiden Name)*

being duly sworn, do hereby state that on _____, being freely
(Date of Common-Law Marriage)

able to contract, entered into the relationship of marriage under common-law in

_____, holding ourselves out to the general public as husband and wife.
(State)

We currently reside at _____, _____ intending to be legally bound
(Street, City, Borough/Township) *(State)*

thereby in full recognition of the rights, duties, and obligations associated therewith. At that time we had the present intent to be married, evidenced by words in the present tense uttered with a view and purpose of establishing the relationship of husband and wife. As evidence that such a marriage exists, we have attached ***three or more*** *of the following documents to this Affidavit:*

- *Joint mortgage or lease;*
- *Designation of spouse beneficiary in a will;*
- *Durable property and health care "power of attorney" agreement;*
- *Joint title to an automobile, joint bank or credit account; or*
- *Such other proof as is sufficient to establish economic interdependency.*

We also acknowledge and understand that any person who knowingly and with the intent to defraud any insurer presents or conspires with another to present any statement in the support of an insurance claim that contains false information may be guilty of a criminal offense and subject to civil penalties to 18 Pa. C.S.A. § 4117.

_____ _____
Signature of Husband *Signature of Wife*

_____ _____
Date *Date*

_____
Policymaker Signature and Title

Sworn to and subscribed before this _____ day of _____, 20_____

_____
Notary Public

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Dependent Children
Control Number: UC-103.5
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Children may be covered as eligible dependents to the limiting age of 26 under the ACA regardless of their marital or student status or financial dependency. In certain instances, coverage may extend beyond that age pursuant to other applicable state or federal laws. Eligible dependents of a subscriber include:

- Natural children (including newborns)
- Stepchildren
- Children legally placed for adoption
- Adopted children of the subscriber or subscriber's spouse
- Children awarded coverage pursuant to an order of a court
- Children of a domestic partnership (as long as the domestic partnership exists and provided the employer elected domestic partner coverage)
- Children of a legal guardian who has assumed financial responsibility for the children

Pennsylvania based employers have the option to extend medical coverage for adult children (beyond the ACA limiting age) up to age 30 under Pennsylvania Act 4 of 2009. However, the employer must elect Act 4 coverage **at time of initial enrollment or at renewal**. To be eligible for coverage under Act 4, an adult child must:

- Be unmarried;
- Have no dependents;
- Not have coverage under any other group or individual health care policy or be **enrolled** in or **entitled** to benefits under any government health care program; **AND**
- Be a Pennsylvania resident or if not a resident, be enrolled as a full-time student at an institution of higher education.

To enroll an adult child, the attached Act 4 of 2009 Health Insurance Coverage for Adult Children Dependent Verification form must be completed, signed and attached to the subscriber's enrollment application.

Note: Health coverage for foster children is the responsibility of the appropriate social services agency.

Violations
Grandchildren are not considered eligible dependents (unless the contract holder has been awarded custody and can provide a copy of the legal custodial papers to support eligibility).

Exceptions
Eligibility may continue beyond age 26 if a subscriber's unmarried child is medically certified by a physician to be incapable of self-support due to mental retardation, physical disability, mental illness or developmental disability that started before age 26. Coverage is subject to review and approval by Highmark's Medical Review department.

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UC-103.5A

ACT 4 OF 2009
HEALTH INSURANCE COVERAGE FOR ADULT CHILDREN
DEPENDENT VERIFICATION

Date: _____

Covered Employee Name: _____ Group Number: _____

Identification Number: _____

Dependent Name: _____ Birthdate: _____

Identification Number: _____

Relationship to Covered Employee: _____

This form must be completed to continue to provide health care coverage for an adult child who no longer qualifies under the terms of the group's insurance contract as a part of the family coverage. Importantly, upon enrollment in this coverage, all deductibles, out-of-pocket amounts, visit limits and maximums will be reset, even if the adult child enrolls in this coverage in the middle of the benefit period and has previously incurred expenses while enrolled in the family coverage.

To be eligible for extended coverage up to the age of 30, the response to the following three questions must be "no":

1. Is the dependent married? □ YES □ NO
2. Does the dependent have dependents? □ YES □ NO
3. Is the dependent offered/provided private insurance or enrolled in, or eligible for government benefits? □ YES □ NO

Additionally, the adult child must respond "yes" to one of the following questions:

4a. Is the dependent a resident of Pennsylvania? □ YES □ NO

4b. If not a resident of Pennsylvania, is the dependent a full time student[1] at an institution of higher education? □ YES □ NO

[1] For the purposes of this Dependent Verification Form, full time student includes any individual who, pursuant to a federal law known as Michelle's Law, was a full time student, but within the past 12 months has taken a medically necessary leave of absence, or had another change in enrollment, due to a serious illness or injury. The adult child must have been covered under the group's insurance contract as part of the family coverage immediately prior to enrolling in this coverage. Additional information will be required to enroll an adult child who is on a Michelle's Law leave of absence.

I hereby certify that the information given in this form is true and correct. I understand that false statements made herein or fraudulent claims made hereunder are subject to the penalties of 18 Pa. C.S.A. § 4117 relating to insurance fraud.

_____ _____
Employee Signature Authorized Employer Signature

_____ _____
Date Date

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: COBRA Continuants
Control Number: UC-103.6
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group medical and/or supplemental coverage is available to eligible employees and dependents (that were covered at the time of the qualifying event) for employer groups with **20 or more** total employees. Length of coverage is up to 18 months for former employees and up to 36 months for former dependents.

Qualified employees and dependents enrolled in employer groups with **2 to 19** total employees may also continue medical coverage as COBRA continuants under Pennsylvania "mini-COBRA" law. However, unlike federal COBRA, covered individuals may only continue medical and prescription drug coverage **up to nine months**. Although the law does not extend to supplemental coverage, qualified continuants that were enrolled in supplemental coverage at the time of the qualifying event may continue that coverage.

For the purposes of determining which COBRA law applies, employers must calculate their full-time and full-time equivalent employees **for the preceding calendar years** (referring to the COBRA definition for counting employees and if applicable, the Internal Revenue Code aggregation rules for multiple businesses that are to be treated as a "**single employer"**). Employers are encouraged to seek legal counsel in making their determinations.

Note: When quoting new business, **ALL** qualified COBRA continuants enrolling in medical coverage must be included in the census. In addition, **the employer must submit copies of the COBRA election notices to validate eligibility** and COBRA continuants must be identified on tax documentation and enrollment applications.

Separate group numbers will be assigned for COBRA continuants for identification and audit purposes.

Violations
COBRA continuants **cannot** be used to satisfy the minimum participation requirements.

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Domestic Partners
Control Number:	UC-103.7
Revision Date:	July 8, 2014
Category:	Subscriber/Member Eligibility

Definitions

Domestic Partner coverage is only available at the employer's discretion and the election must be made known at time of **initial enrollment or at renewal**. Employers choosing to cover domestic partners must note the election on their group application (or submit the request in writing at renewal).

A Domestic Partner is defined as "a member of a Domestic Partnership consisting of two partners (of the same or opposite sex), each of whom has registered with a Domestic Partner Registry in effect in the municipality/governmental entity within which the Domestic Partner currently resides; or who meets the definition of a Domestic Partner as defined by the state or local government which the individual currently resides"; **or** meets **ALL** of the following requirements:

1. Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
2. Is not related to the other partner by adoption or blood;
3. Is the sole Domestic Partner of the other partner and has been a member of this Domestic Partnership for the last six (6) months;
4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
5. Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future.

Employees enrolling a domestic partner must complete a Domestic Partner Affidavit and submit **three or more** of the following documents along with their enrollment application.

- Domestic Partner agreement or proof of registry with a Domestic Partner registry;
- Joint mortgage or lease;
- Designation of one of the partners as beneficiary in the other partner's will;
- Durable property and health care "power of attorney" agreement;
- Joint title to an automobile, joint bank or credit account; or
- Such other proof as is sufficient to establish economic interdependency.

Violations

Exceptions

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UC-103.7A

DOMESTIC PARTNER AFFIDAVIT

The intent of this Affidavit is to certify that you and your partner meet the following Domestic Partnership requirements for the purposes of enrolling your partner as a dependent under your group health plan.

Employee Name_____ Identification Number _____

Group Name_____ Group Number_____

A Domestic Partner is defined as "a member of a Domestic Partnership consisting of two partners (of the same or opposite sex), each of whom has registered with a Domestic Partner Registry in effect in the municipality or governmental entity within which the Domestic Partner currently resides; or who meets the definition of a Domestic Partner as defined by the state or local government which the individual currently resides"; **or** meets **ALL** of the following requirements:

1. Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
2. Is not related to the other partner by adoption or blood;
3. Is the sole Domestic Partner of the other partner and has been a member of this Domestic Partnership for the last six (6) months;
4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and
5. Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future.

As evidence that a Domestic Partnership exists, please attach **three or more** of the following documents to this Affidavit:

- Domestic Partner agreement or proof of registry with a Domestic Partner registry;
- Joint mortgage or lease;
- Designation of one of the partners as beneficiary in the other partner's will;
- Durable property and health care "power of attorney" agreement;
- Joint title to an automobile, joint bank or credit account; or
- Such other proof as is sufficient to establish economic interdependency.

ATTESTATION

*The undersigned certify that they meet the requirements of a Domestic Partnership (as outlined above) and have provided **three or more** supporting documents as validation that a Domestic Partnership exists. In the event that the Partnership is dissolved, the employee agrees to immediately notify his/her employer of the change in status. Furthermore, the undersigned also acknowledge and understand that any person who knowingly and with the intent to defraud any insurer presents or conspires with another to present any statement in the support of an insurance claim that contains false information may be guilty of a criminal offense and subject to civil penalties to 18 Pa. C.S.A. § 4117.*

_____ _____

Employee Signature *Domestic Partner Signature*

_____ _____

Date *Date*

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: New/Late Entrants
Control Number: UC-103.8
Revision Date: July 8, 2014
Category: Subscriber/Member Eligibility

Definitions
Highmark reserves the right to verify the eligibility of new and late entrants **who are added to the coverage AFTER a new group's (initial) enrollment is complete**. Upon request, groups are required to supply information to support eligibility (e.g., copies of tax/payroll information, marriage licenses, birth certificates, adoption/legal custody papers, etc.). Members found to be ineligible will be canceled with a minimum **30-day written notice** and will be given the opportunity to re-enroll during the group's next open enrollment period (provided eligibility requirements are met at that time).

New Entrants include the following individuals (that meet the eligibility requirements and for whom Highmark received enrollment applications **within 30 days of their date of eligibility or the HIPAA life event)**:

- Newly hired employees that meet the hourly and probationary period requirements (and their eligible dependents).
- Rehired employees who were enrolled prior to a leave of absence of six months or less or a layoff status of less than one year (and their eligible dependents) may re-enroll in coverage upon return to active full-time employment.
- Employees that voluntarily leave employment that are later rehired must satisfy the probationary period requirement before they can enroll in coverage.
- Newly eligible dependents (resulting from marriage, birth, etc.) that are added to an **enrolled** contract holder's coverage. (Refer to other applicable guidelines in Subscriber/Member Eligibility section for more information regarding employee and/or dependent eligibility.)
- Employees and/or dependents that waived coverage at initial enrollment who later experience a life-changing event (as defined by HIPAA) which allows for special enrollment prior to the group's open enrollment/next renewal period.

Late Entrants include the following individuals:

- Eligible employees and/or their dependents that waived coverage when they first became eligible and that are added at a later date whereby there were no HIPAA life changing events that allowed for special enrollment (outside the group's normal open enrollment period).
- Eligible new hires and newly eligible dependents for which Highmark did not receive their applications **within 30 days from their date of eligibility**.
- Rehired employees who did **not** have coverage prior to a leave of absence or lay-off.

Violations

New and late entrant misrepresentations/omissions on applications may result in:

- Cancellation with a minimum 30-day written notice.
- Premium adjustments being retroactively billed back to the original effective date.
- Certain cases being referred to Highmark's Special Investigations Unit.

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Enrollment Documentation and Other Requirements
Control Number:	UC-104.1
Revision Date:	July 8, 2014
Category:	Enrollment Requirements

Definitions
Proper field underwriting is crucial during the new business process as the first step is to determine whether a business qualifies for small group coverage under the ACA. Specifics regarding necessary enrollment materials and other helpful information can be found in the New Business Submission Guide and Sold Group Checklist. Situations not addressed in the the guidelines or guide should be directed to the appropriate Sales contact or Underwriting **prior to submission of the sold group paperwork**.

Underwriting reserves the right to:

- Contact groups directly to clarify any discrepancies (involving ambiguous information) and/or to obtain additional information as deemed necessary **without prior notice to the writing agency**.
- Deny coverage to groups that refuse to provide all necessary employment and/or ownership tax documents or other requested information needed to validate the eligibility of the group and its employees.
- Deny coverage to groups that do **not** meet all applicable underwriting guidelines or that have self-set policies that have the appearance of discrimination.
- Change the requested effective date if all information is not provided by the group or writing agency within the requested time frame.

If approved, Underwriting will issue an Underwriting Approval and Premium Notice (UAP) to the writing agency to be presented to the group. The UAP must be signed and dated by an authorized group representative and a copy must be returned to Underwriting and the original UAP along with the group's initial deposit check must be returned to Sales. Upon receipt of this information, the enrollment process will commence.

Violations
Enrollment/Waiver Forms that are **more than 90 days old** (from the signature date) will not be accepted. In addition, substitute (or altered) tax documents should not be submitted (unless approved by Underwriting).

Exceptions
New groups enrolling with January 1st effective dates that do not meet group participation and contribution requirements may still enroll in coverage during an annual ACA guaranteed special enrollment period (that begins November 15th and ends December 15th) **provided all submission materials are received in that time frame and all other underwriting requirements are met**. Renewability of coverage is contingent upon the group meeting all underwriting guidelines, including the minimum participation and contribution requirements.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Group/Market Size and Rating Methodologies
Control Number:	UC-105.1
Revision Date:	July 8, 2014
Category:	Rating Requirements

Definitions
In accordance with the ACA, employers must report accurate employee counts for the purpose of determining applicable group/market size. That said, to sponsor a small group health plan, employers must have had an average of **50 or less** common-law employees in the preceding calendar year **AND** have at least **one or more** common-law employees (may be full-time or part-time) when coverage commences.

The definition of a common-law employee and how employers are to calculate their average number of employees are outlined in UC-101.1. For multiple businesses that are to be treated as a "**single employer**" under the Internal Revenue Code (IRC) section 414 rules, please refer to UC-101.4.

Based on the above requirements, the following examples illustrate small and large group/market size determinations and applicable rating methodologies:

- If a group's average employee count was **50 or less** (in the previous calendar year) and it currently has 65 enrolled employees, **the group will be rated in the small group market**.

- If a group's average employee count was **51 or greater** (in the previous calendar year) and it currently has 35 enrolled employees, the group **will be rated in the large group market**.

Employers of new "start-up" businesses (that were not in existence in the prior calendar year) should report the average number of individuals **"reasonably expected"** to be employed on the business days in the current calendar year.

Note: Under the ACA, the number of enrolled contracts has no bearing on group/market size determinations nor does it allow for flexibility to groups that experience enrollment changes from one year to the next. As such, groups may be rated in the small group market one year and the large group the next year **depending on the average number of common-law employees reported in the PRECEDING calendar year**.

Violations
Multiple businesses written as part of a "single employer" group under the IRC aggregation rules do **not** have the option of breaking apart at a later date simply to obtain more favorable rates.

Exceptions
Multiple businesses written as a "single employer" group that experience ownership changes (that no longer qualify as such) will be separated and rated as individual employer groups. Changes should be immediately reported to Highmark as outlined in UC-106.2 and 106.3.

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Rating Factors
Control Number: UC-105.2
Revision Date: July 8, 2014
Category: Rating Requirements

Definitions
The following rating factors will be applied to all small groups (that had an average employee count of **50 or less** in the preceding calendar year) and their members:

- **Age Bands and Tobacco Use** – Employees and dependents will be rated as separate members based on their respective ages and use (or nonuse) of tobacco. As a condition for enrollment, members age **21 and older** must attest to their use (or nonuse) of tobacco. Refusal to answer the tobacco attestation question will result in denial of coverage.

- **Area Factor** – An area factor will be applied based on the county where the group is physically located. If a group has in-area headquarter and branch offices (or multiple businesses that are to be treated as a "**single employer**" under the IRC section 414 aggregation rules), the headquarter location will be used for rating purposes.

  If a group's headquarters are outside the service area, but it has in-area branch offices or aggregated businesses (as noted above), the county for the branch office or business that has the **most employees** (full-time, part-time, seasonal/intermittent and in and out of area employees as shown on current tax reports/payroll registers) will be used for rating purposes.

  Note: The address and county information for in-area headquarters must be entered as the lead group on the first page of the Small Group Business Application. For out of area headquartered businesses that have multiple in-area branch offices or aggregated businesses, the branch office or business that has **the most employees** must be entered as the lead group on the application.

Although not required for rating purposes, groups must also provide their Standard Industry Classification (SIC) Code on the group application. Any change to the SIC Code should be immediately reported so Highmark can update the group's record accordingly.

Highmark reserves the right to adjust quoted premiums when a group's **quoted** enrollment does not match the ***actual*** enrollment and to adjust (county) area factors if needed. Therefore, producers should ensure that the quoted enrollment **matches** the actual enrollment (as shown on the enrollment/waiver forms). For the above reasons, quoted rates (for area factor corrections) and initial premium amounts are subject to change and are not considered final until written approval is issued by the Underwriting department.

Violations

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Communication of Approved Rates/Premiums
Control Number: UC-105.3
Revision Date: July 8, 2014
Category: Rating Requirements

Definitions
The producer or sales representative is responsible for informing the group of the approved rates and initial premium amount.

Group setup is contingent upon receipt of the group's signed Underwriting Approval and Premium (UAP) notice and a check for the first month's initial premium. If a group chose a dual medical/drug offering, the initial premium amount will be calculated based on all members being enrolled in the lesser medical/drug offering (plus premiums for any ancillary products, if applicable). Subsequent premium adjustments for members enrolled in the higher medical/drug offering will be reflected on the group's first invoice.

Note: Highmark reserves the right to make adjustments for alternative product choices involving enrollment changes when applicable. In such cases, the producer must submit an amended group application to reflect the new product(s) chosen.

Violations

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Adding/Changing Products
Control Number: UC-106.1
Revision Date: July 8, 2014
Category: Existing Business Re-Underwriting Requirements

Definitions
The following rules apply to existing groups that wish to add or change products:

- Existing groups with supplemental coverage may add medical **at any time** by submitting all necessary paperwork (same as new business) **for review and approval by Underwriting**.

- Likewise, existing medical groups may add supplemental coverage **at any time**.

  Note: Renewal dates for supplemental coverage will be aligned with the medical renewal dates. **For example:** If a group renewed its medical plan on 10/1/2013 and it then adds vision coverage effective 5/1/2014, 2014 vision rates will apply and its vision renewal date will be 10/1/2014 (in conjunction with the group's medical renewal).

- Groups with medical and/or vision coverage can only **buy-up** to richer benefit products **at renewal time**.

- Groups that have a single medical product can only add a dual medical offering **at renewal** (unless the group is buying-down to a lesser product in which case, a second medical offering may also be offered **off-cycle** provided **the new products are of lesser value** than the original single product offering).

Off-cycle buy-down changes are subject to the following requirements and conditions:

- The group must select a product with lesser benefits or increased member cost sharing as all member cost sharing accumulations will be transferred to the new program (**except** when moving from a qualified to non-qualified product or vice-versa).

- The request must be made within the **first eight months** of the group's contract period with no change to the group's next anniversary date.

- The group must submit a signed Small Group Business Application (SGBA) reflecting chosen product(s) and the group's renewal date and business reason(s) for the change should be noted in the comments section.

- The SGBA must be received by Highmark in a timely fashion to ensure that the group receives its "Summary of Benefits and Coverage" (SBC) 60 days prior to the effective date so that it can provide proper notice to its employees as required by the ACA.

Highmark reserves the right to request tax documentation to verify that the group is in compliance with the underwriting and enrollment guidelines at any time. If requested, the

tax documentation requirements are identical to those for new group submissions. Refer to the New Business Submission Guide for additional information.

Violations
Groups in arrears with unpaid premiums will **not** be allowed to add/change products.

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Ownership Changes
Control Number: UC-106.2
Revision Date: July 8, 2014
Category: Existing Business Re-Underwriting Requirements

Definitions
Existing groups are required to report ownership and/or other changes that affect their group health plan **within 30 days from the change** to their producer or Highmark Sales contact as such changes must be evaluated by Underwriting for compliance purposes. Such changes include but are **not** limited to the following scenarios:

- Insured business is sold.
- Employer Identification Number (EIN) changes - due to ownership changes or restructuring of business (e.g., company is incorporated, etc.).
- Insured business acquires or merges with another business. In such event, the group's tax accountant or legal counselor must provide a written letter attesting to whether (or not) the combined businesses are to be treated as a "**single employer**" based on applicable Internal Revenue Code section 414 aggregation rules.
- Insured business acquires assets (including employees) of another business and wishes to cover the new employees under its current health plan.
- Spin-off groups (e.g., multiple businesses written as an aggregated "single employer" no longer qualify as such due to ownership or tax filing status changes).

Groups making changes as noted above are required to submit the following documents to Underwriting for review and approval:

1. **Group Application** – completed and signed by the **new** or current owner/common owner or an authorized policymaker as applicable.

2. **Letter of Explanation** – written on company letterhead by the group's policymaker citing all changes (e.g., ownership/business structure and name changes, date sale/acquisition was finalized, enrollment variances, etc.).

3. **Tax/Legal Documentation** - copy of the group's SS-4, PA Form 100, or operating/purchase agreement **and/or** other current tax and/or payroll documents (as outlined in the New Business Submission Guide).

4. **Enrollment/Waiver Forms** – for all new employees being added as a result of ownership changes.

Violations
Existing groups involving ownership changes should **not** be submitted as new clients or be quoted on the Highmark Producer Portal and newly acquired businesses (and members) should not be added to existing groups **without approval from Underwriting**.

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name: Changes in Group Size
Control Number: UC-106.3
Revision Date: July 8, 2014
Category: Existing Business Re-Underwriting Requirements

Definitions
Under the ACA, the number of enrolled contracts has no bearing on group/market size determinations nor does it allow for flexibility to groups that experience enrollment changes from one year to the next. As such, groups may be rated in the small group market one year and the large group market the next year **depending on the average number of common-law employees reported in the PRECEDING calendar year**. Therefore, for renewal purposes, it is important that employers report accurate average employee counts (as outlined in UC-105.1).

To renew in the small group market, an employer must have had **50 or less** common-law employees in the preceding calendar year **AND** at least **one or more** common-law employees (may be full or part-time) when coverage commences. If Highmark determines that a group does not meet the underwriting guidelines or that it does not qualify as a small group employer under the ACA, coverage will be cancelled at the end of the current contract period.

Note: Highmark reserves the right to terminate group coverage at any time should a group perform an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact. Groups may also be canceled at any time for nonpayment of premiums.

In the event of cancellation, **it is the employer's responsibility to notify its subscribers of the termination of group coverage**. Conversion notices for individual coverage will be offered as options for replacing group **medical** coverage.

Violations

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Renewal Information and Changes
Control Number:	UC-106.4
Revision Date:	July 8, 2014
Category:	Existing Business Re-Underwriting Requirements

Definitions
Based on the HIPAA laws and the ACA, groups are guaranteed renewable unless they are in violation of the following conditions:

- The group fails to pay its monthly premiums in a timely fashion and falls into a delinquent or nonpayment status.
- Fraud or misrepresentation of the policyholder, contract holder or employer with respect to coverage of individual insured or their representatives.
- Group fails to meet the applicable underwriting requirements.
- Market exits (products withdrawn from marketplace).
- Service area limitations (e.g., group moved and is no longer located in the designated service area or provider network is not available in the area that the group is located).

Groups may request a renewal date change **contingent upon legitimate business reasons**. All requests must be submitted in writing (on company letterhead) citing the business reason(s) for the change and be signed by the group's policymaker. Supporting documentation must also be included (e.g., change is being requested as a result of a new union bargaining agreement).

Requests should be directed to the group's producer or Highmark Sales contact and are subject to **review and approval by Underwriting**.

Violations
Requests for renewal date changes for the purpose of aligning medical products with other carriers' supplemental products, health savings accounts, etc. will **not** be honored.

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Existing Business Audits
Control Number:	UC-106.5
Revision Date:	July 8, 2014
Category:	Existing Business Re-Underwriting Requirements

Definitions

Highmark reserves the right to audit existing groups **at any time** to confirm compliance with the underwriting guidelines.

Group selection criteria may be random, routine, by referral or based on enrollment variances, etc.

Audit letters and underwriting questionnaires will be mailed to each group's policymaker. The policymaker is asked to complete the questionnaire and return it along with current tax documentation to Underwriting. Highmark Sales and producers will be notified of any groups that fail to respond and will have the opportunity to contact the groups to encourage a response.

Upon receipt of the response, Underwriting will review the groups for compliance and will contact groups **directly** to obtain and/or to clarify any additional information **as the audit is between the insurer and the group**.

Groups that do not respond or fail to meet the underwriting requirements **will be canceled upon renewal** (or earlier if they stop payment of premiums). The group's Highmark Sales contact and/or producer will be notified of any group cancellations and will have the opportunity to assist the group in achieving underwriting compliance **prior** to cancellation.

Should a group's contract be terminated, members will be offered individual products as options for replacing group **medical** coverage. It is the group's responsibility to notify the subscribers of the termination of their group coverage as noted in the small group contract.

Note: Certain violations that have the appearance of fraud or misrepresentation will be referred to Highmark's Special Investigation Unit and may result in immediate cancellation.

Violations

Exceptions

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HIGHMARK Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Association Guidelines
Control Number:	UC-107.1
Revision Date:	July 8, 2014
Category:	Association Information

Definitions

For purpose of this guideline, "association" refers to any multiple employer arrangement that represents a collection of individuals and/or employers, such as Associations, Trusts, multiple employer welfare arrangements (MEWAs), Consortiums, Purchasing Alliances, or Purchasing Cooperatives. Multi-employer arrangements such as Taft-Hartley Trusts and Union-sponsored Trusts, which are collectively bargained plans maintained by more than one employer, are **not** included in this definition.

As defined by the ACA, association coverage does not exist as a distinct category of health insurance coverage. Instead, it must be categorized as individual or group coverage for purposes of determining applicable market rules. Determination is made by identifying whether the group health plan exists at the individual employer level or at the association level.

- **If the plan exists at the individual employer level**, the size (average employee count as defined by the ACA) of each individual employer participating in the association determines whether that individual employer's coverage is subject to individual, small group or large group market rules.

- **If the association is the sponsor of the group health plan**, the association coverage is considered a single group health plan and the number of employees employed by all of the employers collectively determines whether the association coverage is subject to small group or large group market rules.

If an association believes it meets the single group health plan definition, a representative of the association must complete an Association Group Health Plan Status Disclosure Form (Form No. DS-1 shown on next page) and return it along with a copy of a U.S. Department of Labor Advisory Opinion Letter or a Legal Counsel Opinion letter affirming that status.

Violations

Exceptions

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UC-107.1A

ASSOCIATION GROUP HEALTH PLAN STATUS DISCLOSURE FORM*

ASSOCIATION CLIENT NAME: _____

ADDRESS: _____

_____

I. DECLARATION OF GROUP HEALTH PLAN STATUS

The undersigned, on behalf of the Association Client identified below, hereby represents that the group health plan for which Highmark Health Services provides group health insurance coverage to this Association Client is maintained at the association level.

II. DOCUMENTATION OF GROUP HEALTH PLAN STATUS *(REQUIRED)*

Indicate the type of documentation of association group health plan status being submitted and attach a copy of that writing or document to this Disclosure Form. (*No other forms of documentation can be accepted.)*

_____ U.S. Department of Labor Advisory Opinion letter

_____ Legal Counsel Opinion letter

III. AUTHORIZED SIGNATURE *(REQUIRED)*

The undersigned hereby represents that he/she is authorized to make this declaration and disclosure, that the information contained in this Disclosure Form is true and correct and that the above-identified Association Client agrees to indemnify, reimburse and hold harmless Highmark Health Services, and its designated agents, from any and all fines, penalties, interest, claims and/or other amounts that may become due arising out of any claim, action, litigation or regulatory proceeding involving or based upon a determination that the group health plan is not maintained at the association level.

Name _____

Title/Position _____ Date _____

Note: This Disclosure Form must be completed and is intended for use only by those association clients that maintain a single group health plan at the association level which covers association member enrollees.

Form No. DS-1