UPMC HEALTH PLAN

2014 Underwriting Guidelines
UPMC Business *Advantage*
100+ Employees

A. Employer Eligibility

Eligible employer groups must employ 100 or more employees. An employer/employee relationship must be present in order for an individual to be eligible for coverage. Employee eligibility is further defined in the next section.

Employer groups must be in business for a minimum of three months to be eligible for coverage.

Employer group contributions toward the cost of medical coverage will be no less than 50% of the total cost of each rating tier or 50% of the individual premium in each of the tiers. Underwriting may consider exceptions when reviewing cases as long as participation guidelines are met.

Union employees may be carved out. Non-union carve-outs will be considered on a case-by-case basis. Executive management level carve-outs will not be permitted.

Employer groups that have been terminated by UPMC Health Plan for non-payment of premium will not be eligible to reapply for coverage until 12 months have lapsed after the termination date. In the event that UPMC Health Plan grants the reapplication, UPMC Health Plan will require payment of two months of premium in advance of issuance of the policy.

Employer groups with employees residing outside of the UPMC Health Plan service area are limited to 25% of a group's total workforce. If, for any reason, an existing group's out-of-area enrollment becomes greater than the 25% guideline listed, the entire group may be non-renewed for failure to meet UPMC Health Plan Underwriting Guidelines.

Out-of-Area Coverage	
# of Eligible Employees	**Maximum Out-of-Area % of Total Eligible Employees**
100+	25%

Out-of-area plans are applicable only if UPMC Health Plan is offered as the total replacement carrier. Preferred Provider Organization (PPO), Health Incentive Account (HIA), Health Reimbursement Arrangement (HRA), and Health Savings Accounts (HSA) products are the only out-of-area plans offered. If the in-area plan selected is a PPO, an HIA, HRA, or HSA, the out-of-area plan must be equal to or a lesser benefit than the in-area plan. UPMC Health Plan will allow blended rates for in-area and out-of-area plan offerings. In no event will a blended out-of-area rate be approved if sold with a non-blended in-area rate or vice versa.

B. Employee Eligibility

Eligible employees are active, full-time employees, as defined by the employer, who have met the employer's probationary period. UPMC Health Plan allows employers to offer coverage to part-time employees working a minimum of 20 hours per week. Part-time employees (employees working less than 20 hours per week), absentee owners, seasonal workers, IRS 1099 contractors

who are not employees, directors and trustees of the company, and Medicare-eligible retirees* are **not** eligible for coverage.

The employer group determines waiting periods, which must be applied consistently to all employees.

Only new employees and employees experiencing a documented qualifying event will be permitted to enroll outside the open enrollment period during the benefit year. For the purposes of this section, a qualifying event is defined as a (1) marriage, (2) birth/adoption of a child, or (3) a loss of other existing coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or other verifiable reason for loss of coverage eligibility.

Dependent coverage will be permitted to begin on the effective date of the covered employee's coverage. Coverage for additional dependents (other than those resulting from a qualifying event) will be permitted at the employer group's benefit plan anniversary date or during open enrollment.

**Medicare-eligible retirees may not enroll within the active group. UPMC Health Plan offers group and individual Medicare Advantage plans for such individuals. Please call 1-877-381-3765 for more information.*

C. Group Size and Enrollment Requirements

A minimum of 75% of eligible employees must have coverage in a health benefit plan either through a plan offered by the employer group, a spouse's employer, government programs (Medicare, Medical Assistance, military), a union, the Marketplace, or other comparable coverage.

At least 50% of all eligible employees must be enrolled in a plan offered by UPMC Health Plan.

Medicare-eligible retirees do not qualify as eligible employees.

Plan options are limited to three plans. *HealthyU* HIA/HRA/HSA can only be offered alongside a PPO/EPO with a minimum deductible of $500. Multiple HIA/HRA/HSA options are permitted. Exceptions can be considered for groups with 200+ eligible employees, but must be approved by the Underwriting Department.

Optional basis plan offerings will be at the discretion of UPMC Health Plan. Optional basis is defined as a situation where another carrier(s) group health insurance (medical/pharmacy) is offered alongside a UPMC Health Plan group plan. If an optional basis quote is desired, optional coverage must be indicated on the rate request form to enable proper pricing of the risk. Otherwise all quote requests will be assumed to be on a total replacement basis. If UPMC Health Plan is offered on an optional basis, the employer's contribution strategy, funding, and plan design must not discriminate against UPMC Health Plan option in any manner. In the event that a UPMC Health Plan group plan is offered on an optional basis, the following guidelines will apply:

Fully Insured:

Eligible Employees Within UPMC Health Plan Service Area	Minimum Participation Requirement
500+	20%
250–499	25%
150–249	30%
100–149	35%

ASO:

Eligible Employees Within UPMC Health Plan Service Area	Minimum Participation Requirement
200+	0%

For employer groups with 100-199 eligible employees, self-funded plans (ASO) will be offered on a total replacement basis only.

Additional participation requirements may be set at the discretion of the UPMC Health Plan Underwriting Department. Out-of-area enrollment maximums still apply.

UPMC Health Plan reserves the right to non-renew groups that do not meet the minimum participation requirements.

Consolidated Omnibus Budget Reconciliation Act (COBRA) will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those who UPMC Health Plan is required to offer coverage under state or federal law. Total COBRA-enrolled subscribers cannot exceed 15% of the total number of enrolled subscribers.

All employer groups must submit their first month's premium no later than the 10th of the month prior to the effective date of the benefit plan.

D. Rate Determination

UPMC Health Plan uses a demographic rating methodology adjusted for experience for groups with more than 100 eligible employees. Employer SIC code or description of industry and census data must be provided for all eligible employees. Industry classification for a particular group is based on the overall description of the employer group's business and not on the individual duties of its employees or locations.

Submitted census data must include those employees waiving coverage as well as COBRA participants, and must reflect date of birth, gender, residence ZIP code, and tier status on each employee. Groups currently without any coverage must submit a census of all eligible employees.

Current carrier(s) claim utilization, if available, must be provided to obtain a quote.

Quoted rates are subject to change pending validation of group demographics, tier status, group SIC and for legislative/mandate requirements.

If the number of enrolled contracts of an existing group changes by +/- 50% within the contract period, Underwriting reserves the right to re-underwrite the group and adjust rates accordingly.

Should final enrollment change by +/- 15% either in total or by tier during new group implementation or at annual open enrollment, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

All PPO and EPO plans with deductibles quoted by UPMC Health Plan assume that the employee is paying 100% of the total plan deductible. Any deviation from these assumptions will result in a change in the quoted rates.

All UPMC *HealthyU* products (HIA/HRA/HSA) assume that the Health Incentive Accounts (HIA) are funded by UPMC Health Plan and have maximum limits of $500 single/$1,000 family. HRA rates assume that employer HRA allocation is 50% of the total plan deductible minus the HIA limit (HRA allocation + HIA limit = 50% of total plan deductible). Employer HRA allocation for $750/$1,500 deductible plans will be $125 single/$250 family. HRA administration is assumed to be the responsibility of UPMC Health Plan. Employer level of HSA funding will not affect quoted rates. Deviations from these assumptions will not be permitted for employer groups with less than 200 eligible employees.

Prescription drug carve-out will not be permitted for groups with less than 200 eligible employees.

Stop Loss coverage is required for all self-funded groups with 100–199 eligible employees and is recommended for self-funded groups with 200+ eligible employees. Please refer to the Stop Loss Guidelines for more details on quoting.

Benefit plan changes/additions/deletions are permitted at benefit plan renewal only.

Certain benefits will be available for "flexing" for new business and renewals. Non-standard benefits will be permitted for employer groups with greater than 200 eligible employees. Flexed and non-standard benefits must be approved by the Underwriting Department.

For groups of **100–199 eligible employees**, firm renewals may be provided no earlier than **90 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

For group with **200–499 employees**, firm renewals may be provided **120 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

For groups with **500+ employees**, firm renewals may be provided **180 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

All rates must be approved by the UPMC Health Plan Underwriting Department.

E. Common Ownership

If the controlling owner/decision maker owns more than one company, common ownership must be documented and the owner/decision maker must have majority ownership in each company. Shareholders are not considered to be controlling owners/decision makers.

If groups have only one SIC code, the companies can be rated as one employer group, or, at the request of the employer group, UPMC Health Plan will permit separate rate development.

If groups have different SIC codes, the groups will be rated as two separate groups. Requests for blended rates will be permitted following the initial rating.

Any deviation from the underwriting guidelines must have UPMC Health Plan Underwriting Department approval.

This document is meant to be informative and is not intended to be an all-inclusive statement of UPMC Health Plan underwriting guidelines. Other policies and guidelines may apply.