

UNDERWRITING GUIDELINES - DENTAL AND VISION ADVANTAGE PLANS

A. Employer Eligibility

Eligible employer groups must employ 2 to 50 eligible employees. An employer-employee relationship between each individual seeking coverage and the small business entity, regardless of the marital or ownership status of any individual seeking coverage, 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 (3) months to be eligible for coverage.

Employer group contributions toward the cost of dental and vision coverage must be equal to or greater than contributions for the employer's group medical coverage as a percentage of the premium.

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.

Out-of-area coverage is limited to 10% of the enrolled population. If for any reason an existing group's out-of-area enrollment becomes greater than 10%, the entire group may be non-renewed for failure to meet UPMC Health Plan participation guidelines.

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 considers full-time employees as employees who work a minimum of 25 hours per week. Part-time employees (employees working less than 25 hours per week), absentee owners, seasonal workers, 1099 employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage. An owner must receive full-time compensation from the company to be considered for coverage.

Waiting periods are determined by the employer group and 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. Employees enrolling with UPMC medical for themselves and their dependents may elect UPMC Dental *Advantage* for themselves, but they are not required to enroll all of their dependents. Dependent only coverage is not available; the employee must elect UPMC Dental *Advantage* for themselves before their dependents could be eligible for coverage. Additional dependents not enrolled on the effective date (other than those resulting from a documented qualifying event) will be permitted to enroll at the employer group's benefit plan anniversary date or during open enrollment.

Employees initially waiving group coverage for any reason other than the employer's waiting period must wait until the next open enrollment period to enroll, unless there is a documented qualifying event.

C. Group Size and Enrollment Requirements

After the initial effective date, UPMC Dental *Advantage* and/or UPMC Vision *Advantage* quoted in combination with UPMC medical must renew on the same renewal date. Plan deductibles and annual maximums will need to be re-satisfied based on the new effective date of the UPMC dental and/or UPMC vision coverage.

For groups with 2 to 9 eligible employees, At least 100% of all employees enrolled in UPMC medical must enroll for UPMC dental and/or UPMC vision. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. Coverage will not be

accepted if the overall average number of members per contract is 5 or more. UPMC Dental *Advantage* and/or UPMC Vision *Advantage* purchased as stand-alone coverage(s) will require 100% participation and will only be eligible for basic dental and/or basic vision coverage.

For groups with 10+ eligible employees, rates quoted in combination with UPMC medical require that a minimum of 50% of the employees enrolled for UPMC medical coverage elect UPMC dental and/or UPMC vision. UPMC will allow eligible employees who waive UPMC medical coverage to elect UPMC dental and/or UPMC vision coverage for themselves and their dependents. These employees will not be counted toward the participation requirement. If required participation levels are not met by the effective date of coverage, dental rates will be adjusted to the quoted stand-alone dental rates. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

For groups with 10+ eligible employees, rates quoted for stand-alone dental and/or stand-alone vision require that a minimum of 70% of all eligible employees must enroll in UPMC dental and/or UPMC vision coverage, including employees waiving for spousal coverage. Coverage may be terminated if required participation levels and minimum enrolled contracts are not met and maintained throughout the policy period. If the overall average number of members per contract is 5 or more, UPMC Health Plan reserves the right to re-evaluate our quoted rates.

UPMC Health Plan must be offered as total replacement coverage for groups of 2 to 50 eligible employees. Dual option plans are not permitted for groups with less than 51 eligible employees.

Groups with no prior dental coverage will only be permitted to enroll in basic dental for the first 12 months of coverage.

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 whom UPMC Health Plan is required to offer coverage under state or federal law. The percentage of COBRA subscribers cannot exceed 10% 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.

Should final enrollment change by +/- 10% during new group implementation or at annual open enrollment either in total or by tier, UPMC Health Plan reserves the right to re-evaluate rates.

Dental and vision benefit plan changes/ additions/deletions are permitted at time of renewal only.

Non-standard dental and vision benefit plans will not be permitted.

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

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.