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Small Group Underwriting & Enrollment Guidelines

The Small Group Underwriting & Enrollment Guidelines (in accordance with the ACA laws and applicable state laws) documents the requirements for new and existing small group employers that are located in Delaware, Pennsylvania and West Virginia with **July 1, 2020 and later effective dates (unless otherwise stated)**.

Revised 03/25/2020

SMALL GROUP UNDERWRITING & ENROLLMENT GUIDELINES

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Highmark Small Group
Underwriting & Enrollment Guidelines

PREFACE

As an insurer, Highmark (herein after referred to as HM) assumes health insurance risk when providing health care coverage (much like a bank or financial institution whom assumes financial risks). Therefore, to assess and confirm a group's eligibility and that of its members for small group coverage, employers are properly 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**. HM's confidentiality statement can be found in the New Business Submission Guide and on the Sold Group Checklist.

Please note, HM 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 group and its members.

In conjunction with the Affordable Care Act (ACA) laws, the goal of these underwriting guidelines is to provide clear, consistent policies and procedures for all **small employers** that apply for or renew HM group health plans, whether that involves purchasing/renewing a post-2014 ACA plan or continuing to renew a pre-2014 (Grand-mothered) plan.

HM 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.

CONFIDENTIALITY NOTICE: The information contained herein is for the sole use of Underwriting, Sales and Producers and may contain confidential and privileged information. Unauthorized review, use, disclosure or distribution is strictly prohibited.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Defining an Eligible Group

Control Number: UC-101.1

Revision Date: July 1, 2020

Category: Group Eligibility Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

DE:

Based on Delaware law, a "small employer" is defined as a person, firm, corporation, partnership or association that is actively engaged in a business that, **on at least 50% of the working days in the preceding calendar quarter employed no more than 50 "eligible employees"**.

Note: Dormant businesses, "side and hobby" businesses, trust arrangements and investment entities do NOT qualify for group coverage.

When counting employees for group/market size purposes, employers must count all "eligible employees" who work on a full-time basis that have a normal work week of **30 or more** hours per week (including union employees that have coverage though a separate union organization). The term "eligible employee" also includes sole proprietors, partners and independent contractors included as employees under a small employer health benefit plan, but does **NOT** include employees who work on a part-time, temporary or substitute basis.

PA/WV:

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** 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 sponsor a small group health plan, an employer and employee relationship must exist among the individuals seeking coverage. In addition, the employer's average number of ***common-law*** employees in the preceding calendar year (leading to the effective date of coverage) must be **50 or less**; and there must be **one or more** active (full or part-time) *common-law* employees when coverage commences in accordance with *Affordable Care Act* (ACA).

Note: Dormant businesses, "side and hobby" businesses, trust arrangements, owner-only and investor/shareholder groups with no common-law employees do NOT qualify for group coverage.

To calculate the average number of employees, the employer should count ALL *common-law* employees that were employed **in each month during the PRECEDING calendar year AND then divide that total by 12**.

This would include all full-time, part-time, seasonal/intermittent, in and out-of-area ***employees***, union employees as well as owners and working family members who were issued a W-2.

Owners and working family members who were not issued a W-2 and 1099 independent contractors should be **EXCLUDED** from the calculation.

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 the 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.

Groups with no common law employees that are typically family run businesses may still qualify for small group coverage under the ACA by providing supporting documentation that explains the business acts in an employer/employee capacity. Supporting documentation would include ownership tax documents, unemployment compensation quarterly tax filings, federal tax Form 941, as well as a written letter from the employer describing how the relationship exists.

All Regions:

Note: Employers that have multiple (affiliated) businesses that are part of a controlled group which are to be treated as a **"single employer"** under the Internal Revenue Code *Section 414* rules must provide an aggregated average employee count **for the combined businesses** for group/market size purposes - regardless of whether some or all of the companies are seeking coverage through HM. (Refer to UC-101.4 and 105.1 for more information.)

In addition to the above ACA requirements, groups must provide current Unemployment Compensation tax (or payroll report if the entity is not required to pay Unemployment Compensation tax) and ownership tax documents as outlined in UC-103.2 and in the New Business Submission Guide and satisfy all applicable underwriting requirements.

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

- Employer must provide the number of employees that are **"reasonably expected"** to be employed at the time of enrollment on the Small Group Business Application;

- If the UC report is not yet available, then a payroll report (identifying all employees and hours worked per pay period) that is annotated according to employee eligibility, signed and dated **by the employer**;

- New Employee Affidavit can be submitted only for any new employees that do not yet appear on the UC report or payroll report;

- New Start up Business Affidavit can be submitted only if the UC report or payroll report is not yet available;

- SS-4 letter received from the IRS showing the EIN assignment.

Note: (applicable to DE region only) If a sole proprietor/business owner does not employ any individuals and did not apply for an EIN, they must submit a copy of their W-9 form and tax identification number (TIN) acknowledgment form.

- Upon request, Underwriting may require additional information to support group eligibility (e.g., declaration pages from the employer's workers' compensation and/or liability policies, business license, sales invoices/materials, etc.).

All regions:

Former Groups canceled for nonpayment of premiums may be quoted on the Producer Portal. However, additional financial safeguards will be included but are not limited to:

- Requiring advance month's premium, acceleration of cancellation process due to future delinquent payment, etc.

- All groups must satisfy applicable HM group contribution and participation requirements in order to be eligible to purchase or renew coverage.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Group Location/Residency Requirements

Control Number: UC-101.2

Revision Date: July 1, 2020

Category: Group Eligibility Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

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

- **DE**
  Delaware law defines "small employer" as "any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom were employed within this State. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered 1 employer." (18 Del. C. § 7202(33)). Delaware small group law will apply to a plan issued to a small employer where: (1) the majority of eligible employees of such small employer are employed in Delaware; or (2) if no state contains the majority of eligible employees of such small employer, the primary business location of the small employer is in Delaware. (Regulation 1308, §3.6.1.1). If no state contains a majority of the eligible employees of the small employer (e.g. a 50/50 split or a 30/30/20/20 split of employees between several states), then we need to require that the primary business location of the small employer be in Delaware. Delaware law permits, but does not require, a small employer carrier to offer coverage to an employee where the employee does not work or reside within the carrier's established geographic area. (18 Del. C. § 7207(d)(1)).

- **PA/WV**
  At least 25 percent of a group's eligible employees (including owners and COBRA continuants) must live, work or reside within Highmark's service area or in an out-of-state county that is adjacent to Highmark's and at least one of the 25% must be enrolled in the group health plan.

  Note: The residency rule does not apply to grand-mothered groups.

Note: Private residences do not qualify as a branch office and post office boxes cannot be used as physical locations.

Requirements for groups with multiple locations are as follows:

PA:

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

All Regions:

- If a company is headquartered outside of HM's licensed service area and it has a **branch location within the service area**, HM may write the branch location based on the following provisions. However, the size of the entire group would be taken into account for purposes of determining appropriate market segment (Large Group/ Small Group) including the headquartered location.
  1. The headquarters must provide written authority to HM to negotiate coverage with the branch location(s).
  2. The group must have an authorized decision maker (contract signor as noted on the Small Group Business Application) at the insured location.
  3. HM will issue a notification to the BCBSA licensee located in the other state or region.

- If a company's headquarter location is within HM'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 written approval by Underwriting.**

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Carve-Out Groups/Employee Classes
Control Number:	UC-101.3
Revision Date:	July 1, 2020
Category:	Group Eligibility Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

Carve-Out Groups

Union/Non-union

All Regions:

Employers that have union employees who are provided health coverage through a separate union organization may choose to only cover non-union employees. To validate the union employees have "creditable" waivers, the group **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). In addition, the employer must also provide a copy of its current unemployment compensation (UC) report which must be annotated according to eligibility and union/non-union status.

Management/Non-management

DE:

Delaware's small group law (Chapter 72, 18 Del. C. Section 7207(c) (6)a and Regulation 1308) requires that HM offer coverage to all eligible employees of a small employer and their dependents. For small group, HM is not permitted to offer coverage only to members of a certain employee class.

PA/WV:

Employers seeking to only cover management employees, while carving out non-management employees, **must submit the request in writing on group letterhead** and a year-to-date payroll register that identifies the employee class.

Employee Classes

All Regions:

Groups may offer differing levels of coverage and contributions and apply different hourly and new hire waiting period requirements to various employee classes (e.g., hourly/salary, union/non-union, 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.

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

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: "Single Employer" Groups Involving Multiple Businesses

Control Number: UC-101.4

Revision Date: July 1, 2020

Category: Group Eligibility Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions (please see DE, PA and WV differences noted below)**:**

Multiple businesses may be quoted and written as a **"single employer"** under one small group health plan provided all of the following requirements are met:

- The group's authorized representative must provide a *Certification of Eligibility to Combine and Employer Group* Size form that cites all affiliated entity names **as evidence of "single employer" status** (i.e., (a) controlled group of corporations, (b) partnership, proprietorship, etc. that are under common control or (c) affiliated service group).

Note: The *IRC Section 414* aggregation rules are not applicable to public and religious entities. Therefore, when seeking coverage for multiple entities of this nature, please contact Underwriting **PRIOR to quoting such groups**.

- The employer must provide an aggregated average employee count **for all related entities** leading to the effective date of coverage (regardless of whether all entities are seeking coverage through HM) and the below must apply for each region. (Refer to UC-101.1 for employee count information.)

    - **DE** – Client size is determined based on the total number of eligible employees in the preceding calendar quarter, collectively for all related entities and the number of eligible employees must be **50 or less**.
    - **PA/WV** - Client size is determined based on the average number of employees during the preceding calendar year, collectively for all related entities and the average must be **50 or less**.

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

- **Each business must be located within HM's licensed service area unless they meet the requirements of the Inter-Plan (IPP) programs, policies and provisions (refer to exceptions below).**

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

Note: Multiple businesses written as a "single employer" group do **not** have the option of breaking apart at a later date simply to obtain more favorable rates.

If approved by Underwriting, separate group numbers will be assigned to each business to identify the respective EIN, SIC code, physical location and enrollment information for audit/legal purposes.

Likewise, if an existing group is found to have multiple businesses enrolled/embedded under one group number, they will be separated and assigned separate group numbers provided a *Certification of Eligibility to Combine and Employer Group Size* form confirms "single employer" status and all underwriting requirements are met. If they do not qualify as a "single employer", the businesses must be quoted and underwritten as separate groups at the end of the contract period (via the new business process).

In addition, "single employer" groups that experience ownership changes (e.g., businesses are sold or acquired) must report such changes to HM (in writing) **within 30 days from date of the change**. Enrollment of newly acquired businesses is contingent upon the above requirements and **written approval by Underwriting**.

(Refer to UC-106.2 and 106.3 for more information regarding ownership and group size changes.)

Exceptions

Parent-Subsidiary:

- If ***both*** the parent and the subsidiary are headquartered in the same Highmark service area, then Highmark can issue a policy of insurance to the parent that covers ***both*** the parent and the subsidiary.
    - If ***only*** the parent or ***only*** the subsidiary is to be covered, then Highmark can issue a policy to either.

- If the parent is headquartered in a Highmark service area and the subsidiary is headquartered in another state, then Highmark can issue the policy to the parent that would cover both; ***if*** (i) the subsidiary is wholly-owned (100%) by the parent; and (ii) the parent makes all benefits decisions for the subsidiary. In this case, no cede is required from the Local Licensee where the subsidiary is headquartered; however, Highmark is required to issue a consolidation of companies notification to the Local Licensee.

- If the parent is headquartered in Highmark's service area and the subsidiary is headquartered in another state, and ***both*** (i) and (ii) of the immediately above paragraph cannot be satisfied, then Highmark can issue the policy tothe parent that would cover both; ***provided*** that (i) the subsidiary is a National Account; and (ii) Highmark obtains a cede from the Local Licensee where the partially owned subsidiary is headquartered.

- If the parent is headquartered in a state outside of Highmark's service area and the subsidiary is headquartered in a Highmark service area, then Highmark can only issue a policy of insurance to the subsidiary.

Brother-Sister Corporations (Common Ownership but no Parent-Subsidiary Relationship):

- Highmark can issue a policy of insurance to one or the other or under a single policy **if both** are headquartered in the same state as Highmark's service area.

- If **only** one brother-sister corporation is headquartered in the same state as Highmark's service area, then Highmark can only issue a policy to the corporation headquartered in Highmark's service area **unless the following criteria have been met**:

  (i). The out of state brother-sister corporation is a National Account;

  (ii). A cede is obtained from the Local Licensee;

  (iii). Both entities are within the same controlled group of corporations – as that term is defined in Section 414 of the Internal Revenue Code;

  (iv). The brother-sister corporation located within the Highmark service area makes benefit decisions on behalf of the brother-sister entity located outside of the state where the Highmark service area is located; and

  (v). An officer capable of binding both brother-sister corporations is located in the state where the Highmark service area is located.

Affiliated Service Group of Companies (controlled group of corporations bound by common ownership and service relationships; typically, doctor groups):

- Same rules as noted for brother-sister corporations.

Note: Under BCBSA Inter-Plan Programs Policies and Provisions (IPP), only "National Accounts" can be ceded by a Local Licensee. For purposes of the IPP, a National Account is an entity having employee(s) or retiree(s) that reside in more than one BCBSA licensee service area.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Employer (Group) Responsibilities

Control Number: UC-101.5

Revision Date: July 1, 2020

Category: Group Eligibility Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

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

- Administer coverage by uniformly offering enrollment opportunities to **ALL** individuals that meet the employee and dependent eligibility requirements as noted on the Small Group Business Application and as outlined in guidelines in Section UC-103. Please note, eligibility changes **must be reported to HM in writing and may only be made at renewal**.

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

DE/PA:

Contribute at least 10% of the total employee premium.

WV:

Contribute at least 25% of the total employee premium based on state mandate requirement (WV §33-16D-13).

All Regions:

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

- Submit all enrollment terminations to HM in a timely fashion to remove members on the dates that they cease to be eligible for coverage. The effective date of cancellation should be no earlier than the date the member ceases to be eligible and, in no event should it be earlier than the first day of the month preceding the month from which HM receives the termination notice.

- Report accurate employee counts at initial enrollment and annually for renewal purposes for ACA group/market size, Medicare Secondary Payer and applicable COBRA law purposes. 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 the change**. (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.

HM 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.

Exceptions
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**.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Medical/Vision/Dental Participation Minimums
Control Number:	UC-102.1
Revision Date:	July 1, 2020
Category:	Group Participation/Product Requirements

Definitions - ***Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.***

All Regions:

Groups must have a minimum of 75% participation in medical/drug when offered through an employer sponsored group health plan (unless stated otherwise). See chart on UC-102.2.

The total number of eligible employees is tabulated by counting all active, eligible employees and owners that qualify for coverage and those waiving for no coverage (as outlined in UC-103.1 and 103.2). Eligible employees who waive for "creditable coverage" (as described below) should be EXCLUDED from the tabulation.

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

"Creditable coverage" is defined as: other group coverage through a spouse, parent or other employer; individual coverage; Medicare (Part A or Parts A and B); Medicaid; Medicare replacement plan; coverage through the Indian Health Service or a tribal organization; or a state, federal or Peace Corps health benefits plan. To receive credit, such individuals must submit a waiver form and upon request, may be required to provide a copy of their subscriber identification card as proof of other coverage.

Note: Short Term or Limited Benefit plans are not considered "creditable coverage". Waivers for Short Term/Limited Benefits plans or "no coverage" are not considered valid waivers and will not be carved out.

Please note, 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 counted as two eligible employees and two enrollees for participation purposes (regardless of the fact that they are enrolled under one 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.

Exceptions

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**.

Vision DE/PA:

Blue Edge Vision calculates participation as follows:

- Vision DOES provide waivers based on Underwriting guidelines below:
  - This mirrors how medical participation is calculated
  - The total number of eligible employees is tabulated by counting all active, eligible employees and owners that qualify for coverage and those waiving for no coverage (as outlined in UC-103.1 and 103.2). Eligible employees who waive for "creditable coverage" should be EXCLUDED from the tabulation.
- Participation rules:
  - Non-voluntary plans requires 70 % participation
  - Voluntary plans requires 20% participation

Vision: Fashion Advantage PA

- All current participation rules will still apply
- 75 % percent participation rule except for the 1 voluntary plan
- All current rules as stated in the Underwriting guidelines will apply
- Existing clients can ONLY Renew AS IS in the existing Vision Plan
- All Plan Changes, New to Blue, or New to Vision clients are ONLY eligible to select a plan from the New Blue Edge Vision portfolio. For any exceptions, please reach out to Vision UW mailbox.

Dental All Regions:

Blue Edge Dental (BED) calculates participation as follows:

- Dental DOES provide waivers based on Underwriting guidelines below:
  - This mirrors how medical participation is calculated
  - The total number of eligible employees is tabulated by counting all active, eligible employees and owners that qualify for coverage and those waiving for no coverage (as outlined in UC-103.1 and 103.2). Eligible employees who waive for "creditable coverage" should be EXCLUDED from the tabulation.
- Participation rules:
  - All plans require 20% participation
    Note: There are separate rates for 70%+ (lower rates) and for 20% - 69.99% (higher rates).

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Medical Participation Chart

Control Number: UC-102.2

Revision Date: July 1, 2020

Category: Group Participation/Product Requirements

The following participation requirements apply to medical/drug coverage offered through employer sponsored group health plans.

Eligible Employees After Carve Out	Minimum	Eligible Employees After Carve Out	Minimum	Eligible Employees After Carve Out	Minimum	Eligible Employees After Carve Out	Minimum	Eligible Employees After Carve Out	Minimum
1	1	13	10	25	19	37	28	49	37
2	2	14	11	26	20	38	29	50	38
3	3	15	12	27	21	39	30	51	39
4	3	16	12	28	21	40	30	52	39
5	4	17	13	29	22	41	31	53	40
6	5	18	14	30	23	42	32	54	41
7	6	19	15	31	24	43	33	55	42
8	6	20	15	32	24	44	33	56	42
9	7	21	16	33	25	45	34	57	43
10	8	22	17	34	26	46	35	58	44
11	9	23	18	35	27	47	36	59	45
12	9	24	18	36	27	48	36	60	45

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Medical/Vision/Dental Product Offerings
Control Number:	UC-102.3
Revision Date:	July 1, 2020
Category:	Groups Participation/Product Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

Medical All Regions:

ACA:

- Groups with 1 enrolled may choose one medical/drug plan
- Groups with 2 to 10 enrolled may choose up to two medical/drug plans
- Groups with 11 or more enrolled may choose up to three medical/drug plans

If an employer offers a dual medical option, employees are prohibited from changing products until the group's next open enrollment/contract period (unless there are circumstances that allow for special enrollment rights under state or federal laws).

Exceptions

Vision PA:

- Only 1 vision product offering for group size 1-50 enrolled

Dental PA/WV Regions:

- Groups with 2-9 enrolled may choose one Blue Edge Dental (BED) plan
- Groups with 10-50 enrolled may choose up to two BED plans

Dental DE Regions:

- Groups with 1-50 enrolled may choose one Blue Edge Dental (BED) plan

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Eligible Employees
Control Number:	UC-103.1
Revision Date:	July 1, 2020
Category:	Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

DE:

Under Delaware's small employer law an "eligible employee" is defined as: "an employee who works on a full-time basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis." 18 Del. C. Section 7202(16). An employee that is not a part-time, temporary or substitute employee, but, for various reasons, might work 30+hours/week for fewer than 9 months could still be considered an eligible employee if the employee is employed full-time and the employee's "normal work week" is 30+ hours.

A seasonal employee, or one that works on a temporary basis, is not legally required to be an eligible small group employee under Delaware law. Delaware law does not specifically define seasonal employee, but under PPACA a seasonal employee is one who works 120 days a year or less for the employer (these days do not have to be consecutive).

In accordance with Delaware law, an employer's weekly hourly requirement for eligibility cannot be more than 30 hours per week and the new hire waiting period requirements **cannot exceed 60 calendar days** from the hire date. DE employers must offer coverage to all full-time employees who regularly work 30 or more hours per week. That said, coverage may also be offered to employees who routinely work 20 or more hours per week. As such, employers must clearly identify their weekly hour requirements on the Small Group Business Application.

PA:

Per Highmark's business decision, regardless of age or employee class, individuals need to regularly work a minimum of 20 hours per week and at least 9 months a year. According to PA laws an employer's weekly hourly requirement for eligibility cannot be more than 40 hours per week and in accordance with the ACA laws, new hire waiting period requirements **cannot exceed 90 calendar days** from the hire date.

WV:

Per the Group Contract, regardless of age or employee class, individuals need to regularly work a minimum of 20 hours per week and at least 9 months a year. According to WV law an employer's weekly hourly requirement for eligibility cannot be more than 40 hours per week and in accordance with the ACA laws, new hire waiting period requirements **cannot exceed 90 calendar days** from the hire date.

All Regions (please see DE, PA, and WV differences noted below):

Note: Retired employees, stockholders, board members, professional associates, trustees, legal counsel, and elected officials who do not meet the employee eligibility requirements are **not** eligible for group coverage. Also, 1099 consultants/independent contractors are not eligible for coverage in **PA/WV**, however, they are eligible in **DE** as long as they meet the employee requirements.

In addition to the weekly hourly requirement, employees must also meet all of the following requirements:

- Receives a regular hourly wage (or salary) as shown on the employer's most recent unemployment compensation (UC) tax report (and/or year-to-date payroll report). These documents should **not** be altered, the wages/credit weeks omitted and must be annotated according to employee eligibility, **signed and dated by the employer.**

- Satisfies the new hire waiting period requirement (as noted on the employer's group application).

  Note: The group has the option to waive the new hire waiting period requirement for all employees at the time of initial enrollment, the group should indicate this on the SGBA, or via a client letter or email.

Additional waiting period requirements include the following:

Part-Time Employees Moving to Full-Time Employment – The employee must satisfy the same as the newly hired waiting period from the date that full-time employment begins.

Recalled Employees – Per Highmark's business decision, employees returning to work from a laid-off status of one year or LESS are eligible for coverage on the date they return to work. If laid off for MORE than one year, the employees must re-satisfy the new hire waiting period requirement.

Rehired Employees – Per Highmark's business decision, returning employees who were enrolled in coverage prior to a "loss of employee relationship" of who are rehired **within 13 weeks from their termination date** are eligible to enroll on their rehire date or no later than first of the month following the rehire date.

Please note, employers may apply different hourly and/or new hire waiting period requirements for multiple employee classes (e.g., hourly/salary, union/non-union, etc.) provided the classes are directly related to employment divisions and the segmentations exist for purposes other than insurance coverage. In addition, employee 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.

Changes to hourly and new hire waiting period requirements may only be made **at renewal and must be reported to HM in writing**.

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 covered 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.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Eligible Owners
Control Number:	UC-103.2
Revision Date:	July 1, 2020
Category:	Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

DE:

Based on Delaware law, the definition of an "eligible employee" includes sole proprietors and partners. Independent (1099) contractors may also be considered eligible for coverage provided they meet the group's weekly hour requirements and their income on their 1099 Forms and the group's payroll records supports the group's weekly hour requirements (as stated on the group application).

PA/WV:

Business owners may only enroll in group coverage provided they are eligible to sponsor a "small employer" group health plan under the ACA. Specifically, the employer must have an average of **50 or less** *common-law* employees in the prior calendar year (leading to the effective date) **AND** have **at least one** (full or part-time) active *common-law* employee when coverage commences. (Refer to UC-101.1 and 105.1 for common law employee definition and 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 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.

All Regions:

To validate that a business exists and to objectively identify the total number of eligible owners/partners, the following tax documents are required:

- **Sole Proprietors** (for non-incorporated businesses) - Schedule C (Sole Proprietorship – Profit or Loss from Business), Schedule F (Profit or Loss from Farming), Schedule E (Form 1040 for rental businesses), or Schedule H (Form 1040 for Household Employers).

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

Note: Limited liability companies/partnerships (those that file the Form 1065 and Schedule K-1's) have the option to not offer coverage to Limited, Domestic, or Foreign partners (who are not involved in the day-to-day business operations). In this case, **only general partners are considered eligible for coverage**. Should any Limited, Domestic, or Foreign partners elect coverage, then they are all considered eligible. Limited, Domestic, or Foreign partner exclusions must be submitted **in writing** (via the comments section on the group application or a signed letter from the group on company letterhead). However, partners of an S-Corporation (1120S and Schedule K-1s) do not have the option of carving out their partners.

- **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 tax report (or year-to-date payroll register) and wage/salary information must support the weekly hour requirement as stated on the Small Group Business Application.

  Note that the following document can be reviewed for eligibility for those Officers that are not showing up on the UC report:
  - Form 1125-E, Compensation of Officers, can verify for those entities with total receipts of $500,000 or more (gross sales of the company) the full time wage compensation paid to officers.

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

  All owners not enrolling in coverage must complete waiver forms and subsequently, do not have the option to enroll in coverage prior to the next open enrollment/contract period unless an event occurs that allows for special enrollment rights as defined under HIPAA and the ACA.

  In accordance with the ACA, owners/partners having multiple businesses may only combine them under one group health plan provided they are part of a controlled group of entities that are to be treated as a **"single employer"** under the Internal Revenue Code *Section 414* (aggregation) rules. (Refer to UC-101.4 for more information.)

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Employees with Disabilities

Control Number: UC-103.3

Revision Date: July 1, 2020

Category: Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

Employees with disabilities do not have to qualify for Social Security benefits and may continue under the active benefit program. Group coverage may be offered to employees with disabilities provided that **ALL** of the following requirements are met:

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

- The employer must provide a copy of the unemployment compensation (UC) tax report (or payroll register) which identifies the employee with disabilities **as being actively employed at the time the disability occurred** (e.g., if the employee became disabled in October 2019, a fourth quarter 2019 unemployment compensation report is required).

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

- The employer must submit a Disability Verification Form for **each** employee with disabilities enrolling. Disability Verification form is available on the Producer Portal.

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

Exceptions

The above definition does **not** include an individual with qualified disabilities 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.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Dependent Spouse
Control Number:	UC-103.4
Revision Date:	July 1, 2020
Category:	Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

DE:

Based on Delaware law, employers are required to offer dependent coverage.

All Regions (please see DE, PA, and WV differences noted below)**:**

Eligible dependents include an employee's spouse under a legally valid existing marriage between persons of the opposite or same sex. Upon request, HM may request copies of marriage certificates or a letter from the employer certifying the marriage exists, validating the eligibility of spouses.

Note: 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.

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 must be completed **and** at least three supporting financial documents must be attached (e.g., joint titles to property or automobiles, joint bank/credit account information, etc.). Affidavit of Common-Law Marriage form is available on the Producer Portal.

Notes:

DE/WV: Common law marriage never existed and only the common law marriages validated in a state that recognizes common law will be accepted.

PA: Common law marriage was abolished on January 2, 2005, however, couples who entered into this before that date are still considered married as common law spouses.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Dependent Children
Control Number:	UC-103.5
Revision Date:	July 1, 2020
Category:	Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions (please see DE, PA, and WV differences noted below)**:**

Based on **DE** law, employers are required to offer dependent coverage **-OR-** under the ACA for **PA or WV** employers who elect to offer dependent coverage are required to insure that dependent child for group coverage until they reach age 26, regardless of marital or student status or financial dependency. Upon request, HM may request copies of birth certificates, adoption/ court ordered legal custodial documents or other information to validate dependent eligibility.

Eligible children include the following:

- Natural children (including newborns)
- Stepchildren
- Children legally placed for adoption
- Adopted children of the employee or the employee's spouse
- Children awarded coverage pursuant to an order of a court
- Children of a valid domestic partnership (if such coverage was elected by the employer)
- Children of a legal guardian who has assumed financial responsibility for the children

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

Please note, health coverage for foster children is the responsibility of the appropriate social services agency.

PA:

Under Pennsylvania Act 4 of 2009, employers may extend medical coverage only for adult children to age 30 provided the election is made when they **initially enroll or upon renewal** (on the group application). To be eligible for Act 4 coverage, 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.

- The Act 4 Dependent will be:
    - Moved over to their own individual contract and Act 4 group number under the parent's employer medical group as they no longer can be on the employee/child(ren) or family contract.
    - Be charged the individual rate and the employer may collect this from the employee
    - Recertified on a yearly basis

To enroll an adult child, the 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. The Act 4 of 2009 Health Insurance Coverage for Adult Children Dependent Verification form is available on the Producer Portal.

Exceptions

DE:

Eligibility may continue beyond age of 25 for unmarried children who reach age 26 who are medically certified by a physician to be incapable of self-support due to mental retardation, physical disability, mental illness or developmental disability. A disability form **must** be completed and submitted with the new submission paperwork to HM for review and approval.

PA/WV:

Eligibility may continue beyond age of 25 for unmarried children who reach age 26 who are 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**. A disability form **must** be completed and submitted with the new submission paperwork to HM for review and approval.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: COBRA Continuants

Control Number: UC-103.6

Revision Date: July 1, 2020

Category: Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions (please see DE, PA, and WV differences noted below)**:**

Federal COBRA:

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health and/or supplemental coverage is available to eligible employees and dependents (that were covered at the time of the qualifying event) for employers 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.

Mini-COBRA:

Qualified employees and dependents enrolled in employer groups with:

DE:

1 to 19 total employees. However, unlike federal COBRA, covered individuals may only continue medical and prescription drug coverage **up to nine months**.

For 1 person groups, the provisions of law HB 170 apply only to dependents that lose coverage due to a qualifying event.

DE law would not be applicable to self-insured small groups unless they choose to adopt the ERISA preemption rules.

PA:

2 to 19 total employees. However, unlike federal COBRA, covered individuals may only continue medical and prescription drug coverage **up to nine months.**

PA mini-COBRA would not apply to a self-insured small group.

WV:

2 to 19 total employees. However, unlike federal COBRA, covered individuals may only continue medical and prescription drug coverage **up to 18 months**.

WV mini-COBRA would not apply to a self-insured small group.

All Regions:

For the purposes of determining which COBRA law applies, employers must calculate their full-time and full-time equivalent employees **for the preceding calendar year** (referring to the COBRA definition for counting employees and if applicable, the Internal Revenue Code *Section 414* (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.

Notes:

Although the law does not extend to ancillary coverage, qualified continuants that were enrolled in ancillary coverage at the time of the qualifying event may also continue that coverage.

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

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**. Upon request, additional information may also be required to support eligibility.

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

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Domestic Partners
Control Number:	UC-103.7
Revision Date:	July 1, 2020
Category:	Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

Domestic Partner coverage is only available at the employer's discretion and the election must be made known at the 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). In order to qualify for group health coverage, the following requirements must be met:

- 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;
- Is not related to the other party by adoption or blood;
- Is the sole Domestic Partner of the other partner and has been a member of the Domestic Partnership for at least six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- 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.

In addition to the above requirements, evidence of a Domestic Partnership must exist. Employees enrolling a domestic partner must complete a Domestic Partner Affidavit and submit verification of one of the following three items along with their enrollment application. Domestic Partner Affidavit is available on the Producer Portal.

- Employee and Domestic Partner registered with a Domestic Partner Registry in effect in the municipality or government entity within which the Domestic Partner currently resides.

- Employee and Domestic Partner currently meet the definition of a Domestic Partner as defined by the state or local government in which you and your Domestic Partner reside.

- Attach two (2) or more of the following documents to the Affidavit:
    - A joint mortgage or lease on the primary residence
    - A designation of one of the partners as beneficiary in the other partner's will
    - A durable property and/or health care power of attorney
    - A joint title to an automobile
    - A joint banking account
    - A joint credit account

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: New Entrants

Control Number: UC-103.8

Revision Date: July 1, 2020

Category: Subscriber/Member Eligibility

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

HM reserves the right to verify the eligibility of new entrants (as described below) **at any time during the contract period**. Upon request, groups are required to supply information that establishes employee and dependent eligibility in accordance with the special enrollment rights and the employer's eligibility requirements. Supporting documents may include employee tax/payroll information, marriage/birth certificates, adoption/legal custody papers, etc.

New Entrants include the following:

- Newly hired/rehired employees (and eligible dependents) who meet the eligibility requirements as outlined in UC-103.1.

  Note: New enrollment received within 90 days of the eligibility effective date will receive the eligibility effective date as their enrollment effective date. Any enrollments received after 90 days from the eligibility effective date will receive an effective date retro to the 90th day prior to notification (i.e., count back 90 days from the date notification is received).

- Employees and dependents who waived HM coverage at initial or open enrollment that have special enrollment rights based on the occurrence of certain qualifying events or changes (loss of other coverage, marriage, birth, adoption, placement for adoption or employer contribution has stopped).

  Note: Enrollment received within 90 days of the qualifying event will receive the qualifying event effective date. If the date of the notification is greater than 90 days from the qualifying event they will receive an effective date on the 1st of the following month from the date of the notification.

- Employees and eligible dependents that meet eligibility requirements per UC-103.1 at the group's open enrollment.

  Note: Enrollment received within 30 days of open enrollment (renewal) will receive the renewal effective date. Any enrollment applications received after 30 days of the renewal date will be required to wait until the next renewal.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Enrollment Documentation and Other Requirements
Control Number:	UC-104.1
Revision Date:	July 1, 2020
Category:	Enrollment Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

Proper field underwriting is crucial during the new business quoting and submission process to determine whether a business qualifies as a small employer and whether it is affiliated with other entities (as part of a controlled group) that are to be treated as a **"single employer"** under the IRC *Section 414* aggregation rules for group/market size purposes.

Specifics regarding necessary enrollment materials, required tax documents and other helpful information can be found in the New Business Submission Guide and Sold Group Checklist. Situations not addressed in the guidelines, New Business Submission Guide or checklist should be directed to the appropriate Sales contact or Underwriting **prior to submission**.

Note: 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).

Please note, Underwriting reserves the right to:

- Contact the Sales Representative directly to clarify discrepancies/ambiguous information and/or to obtain additional information as deemed necessary.
- Deny coverage to groups that refuse to provide all necessary tax documents, legal documents and/or other information to support group/member eligibility; 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 a written notice to the Sales Representative to be presented to the group.

Retroactive Terminations & Enrollment Adds/Changes

In accordance with the ACA, retroactive terminations should be no earlier than the date for which a member ceases to be eligible for coverage and, in no event, shall be earlier than the first day of the preceding month from the month in which HM receives the termination notice. All requests for retroactive terminations beyond the above timeframe must be submitted and **approved by HM senior management**. Supporting documentation may be needed when submitting such a request.

Newly approved and renewing employers are required to adhere to the weekly hour and waiting period requirements for employee eligibility and chosen dependent coverage elections as stated on their Small Group Business Application for the duration of the contract period. As such, employers do not have the prerogative to waive waiting period requirements for newly hired employees or make off-cycle changes to the eligibility requirements without prior written consent by HM Underwriting.

Note: The weekly hour and new hire waiting period requirements for employee eligibility and chosen dependent coverage elections should not violate any applicable state or federal law (refer to 103.1 for more information).

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Group/Market Size and Rating Methodologies
Control Number:	UC-105.1
Revision Date:	July 1, 2020
Category:	Rating Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

Group/Market Size:

DE:

In accordance with Delaware law, employers must report accurate employee counts for the purpose of determining applicable group/market size. To qualify for small group coverage, an employer can have **no more than 50 eligible employees** on at least 50% of the business days during the PRECEDING calendar quarter (leading to the effective date of coverage).

Employers having **51 or more** eligible employees for at least 50% of the business days in the preceding calendar quarter will be rated in the large group market.

When counting employees, employers are to count all eligible employees who work on a full-time basis that have a normal work week of **30 or more** hours (including union employees that have coverage through a union organization). The term "eligible employees" also includes sole proprietors, partners and independent contractors included as employees under a small employer health benefit plan but does **NOT** include employees who work on a part-time, temporary or substitute basis.

PA:

In accordance with the ACA, employers must report accurate employee counts for applicable group/market size determinations. To qualify for small group coverage, at initial submission, employers must have had an average of **50 or less** *common-law* employees in the preceding calendar year (leading to the effective date of coverage) **AND** have at least **one or more** *common-law* employees (may be full-time or part-time) when coverage commences.

For more information regarding how employers are to calculate their average number of employees, refer to UC-101.1.

WV:

In accordance with the ACA, employers must report accurate employee counts for applicable group/market size determinations. To qualify for small group coverage, employers must have had an average of **50 or less** *common-law* employees in the preceding calendar year (leading to the effective date of coverage) **AND** have at least **one or more** *common-law* employees (may be full-time or part-time) when coverage commences.

For more information regarding how employers are to calculate their average number of employees, refer to UC-101.1.

All Regions:

Notes:

If an employer has one or more affiliated businesses that are to be treated as a "single employer" under the IRC *Section 414* aggregation rules, the employer must count all eligible employees (as defined above) for the combined businesses for group/market purposes (refer to UC-101.4 for more information).

Multiple businesses written as part of a "single employer" group under the IRC Section 414 aggregation rules do not have the option of breaking apart at a later date simply to obtain more favorable rates.

Rating Methodologies:

DE:

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

- If a group's eligible employee count was **50 or less** (in the preceding calendar quarter), it will be rated as a **small group**.
- If the eligible employee count was **50.01 or greater**, it will be rated as a **large group**.

Employers of new "start-up" businesses (that were not in existence in the prior calendar quarter) should report the number of individuals **"reasonably expected"** to be employed at the time of enrollment.

Note: Under Delaware law, 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 eligible employees reported in the PRECEDING calendar quarter** (leading to the effective date of coverage).

PA/WV:

Based on the above group/market size 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 preceding calendar year), it will be rated as a **small group**.

- If the average employee count was **50.01 or greater**, it will be rated as a **large group**.

Employers of new "start-up" businesses (that were not in existence in the prior calendar year) should report the number of individuals **"reasonably expected"** to be employed at the time of enrollment.

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 determined small group one year and large group the next year **depending on the average number of *common-law* employees reported in the PRECEDING calendar year**. Therefore, it is important that employers report accurate average employee counts as outlined in UC-105.1.

Exceptions
Multiple businesses written as a "single employer" that experience ownership changes (that no longer qualify as such) must provide a *Certification of Eligibility to Combine and Employer Group Size* form from an authorized group representative confirming that "single employer" status no longer exists. Subsequently, each business must re-apply for separate group health plans via the new business process. The same premise applies for non-aggregated businesses that are discovered during the course of an underwriting audit. (Refer to UC-106.2 and 106.3 for more information.)

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Rating Factors
Control Number:	UC-105.2
Revision Date:	July 1, 2020
Category:	Rating Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

The following rating factors are applicable to all small group employers:

- **Age Bands** – Employees and dependents will be rated as separate members based on their respective ages.

- **Area Factor** – An area factor will be applied based on the county where the group is physically located based on the group's principal place of business/headquarter location or a satellite location that is physically domiciled within the service area verifiable through tax documents or a declaration page from the group's liability insurance policy.

Rates may be adjusted due to area factor and/or effective date of coverage changes. In addition, premium adjustments for new business are also subject to change based on differences between the ***quoted*** and ***actual*** enrollment. As such, initial premium amounts are not considered final until written approval is issued by Underwriting.

Please note, although not applicable for rating purposes, groups are required to report their Standard Industry Classification (SIC) Code (on their group application) and immediately report any changes to HM.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Communication of Approved Rates/Premiums
Control Number:	UC-105.3
Revision Date:	July 1, 2020
Category:	Rating Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

For newly approved groups, Underwriting will issue a written approval notice (which includes the product/rate information and effective date of coverage) to the applicable sales representative. The notice must be presented to the group.

Should a group (or any of its members) not meet the Underwriting & Enrollment Guidelines, Underwriting will reach out to Sales to work with the group to get into compliance.

Note: HM reserves the right to approve multiple product offering options involving enrollment changes when applicable. In such cases, the producer must submit an amended group application to reflect the new product(s) chosen.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Adding/Changing Products
Control Number:	UC-106.1
Revision Date:	July 1, 2020
Category:	Existing Business Re-Underwriting Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

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**.

DE/PA:

Existing medical groups may add vision coverage **at any time**. Such additions do not need to be reviewed by Underwriting.

Note: Renewal dates for supplemental coverage will be aligned with the medical renewal dates. **For example:** If a group renews its medical plan on 10/1/2019 and adds vision coverage effective 5/1/2020, 2020 vision rates will apply and the group's vision renewal date will be 10/1/2020 (to coincide with the group's medical renewal).

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

WV:

Groups with medical can only **buy-up** to richer benefit products **at renewal time**.

All Regions (please see DE, PA, and WV differences noted below)**:**

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), provided all participation and contribution requirements must be met.

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

Off-cycle buy-down changes are subject to the following requirements and conditions (all regions) and only (PA/WV) for groups moving from a Grand-mothered (GM) to ACA; GM to GM and ACA to ACA:

Note: ACA to GM (PA/WV), and all regions for renewal or off cycle are not permitted. Benefit upgrades off cycle are not permitted.

- The group must stay with the same product/contract form number (e.g. PPO, EPO, Flex, etc.) and select a product plan design with lesser benefits or increased member cost sharing as all member cost sharing accumulations will be applied to the new design as applicable to the new program (**except** when moving from a qualified [H.S.A. plan] to a non-qualified [non H.S.A.] 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 HM 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.

PA/WV:

The following applies to each scenario:

1) GM to GM - The group's renewal date will stay the same. Use the rates that were in effect at their renewal.
2) ACA to ACA - The group's renewal will stay the same. Use the rates that were in effect at their renewal.
3) GM to Government (ACA) product - A new contract would be issued with a new renewal effective date.

HM 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 the additional information.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Ownership Changes/Business Restructures
Control Number:	UC-106.2
Revision Date:	July 1, 2020
Category:	Existing Business Re-Underwriting Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

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 HM Sales contact as such changes must be reviewed and approved by Underwriting for compliance purposes. Such changes include but are **not** limited to the following scenarios:

- **Ownership Change** - Group is sold and new owner wishes to assume the role of policyholder for the current group health plan.
- **Business Restructure** - e.g., a non-incorporated business incorporates whereby, a new Employer Identification Number (EIN) is assigned.
- **Acquisition or Merger** - Group acquires a new business or merges with another business.
- **Adding Other Affiliated Entities** – Group wishes to add other related entities (not currently insured by HM) that are to be treated as a "single employer" under the IRC *Section 414* aggregation rules. Note that newly purchased or newly started "single employer" entities can be added during the current policy period. Existing entities that the group wishes to add can only be added at renewal.
- **Asset Purchases** - Group acquires the assets/employees of another business and wishes to cover the new employees.
- **Spin-off Groups** - Group experiences ownership or business structure changes whereby, new companies are formed (or businesses are sold off) that do not qualify as a "single employer" and must be written separately.

Note: Existing groups involving ownership changes should not be quoted as new business or added to a current group health plan without approval from Underwriting.

Depending on the type of change, groups may be required to submit some (or all) of the following documents as deemed necessary by Underwriting for review and approval:

1. **Group Application** – Fully completed and signed by an authorized group representative.

2. **Letter of Explanation** – Written by group's policymaker citing all details of change (e.g., ownership/business structure and name changes, date sale/acquisition was finalized, enrollment increases/decreases, etc.).

3. **Certification of Eligibility to Combine and Employer Group Size form** – Required for additional entities being added to a current group health plan

(or to separate multiple entities written under one group health plan that no longer qualify as such). The *Certification of Eligibility to Combine and Employer Group Size* form must be submitted by an authorized representative of the group citing all affiliated entity names (or an explanation as to why multiple entities written as a "single employer" no longer qualify as such). (Refer to UC-101.4 for more information).

4. **Tax/Legal Documentation** – e.g., copy of the group's SS-4 application and the Employer Identification Number assignment form, operating/purchase agreement **and/or** other current tax and/or payroll documents as applicable.

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

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Changes in Group Size
Control Number:	UC-106.3
Revision Date:	January 1, 2019
Category:	Existing Business Re-Underwriting Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

DE Region:

In accordance with Delaware law, it is important that employers accurately report the total number of eligible employees employed on 50% of their business days in the preceding calendar quarter leading the effective date (months leading to up to the renewal preparation) for group/market size purposes.

- To renew in the small group market, an employer must have had **50 or less** eligible employees for the majority of its business days in the preceding calendar quarter.

- If an employer reports an average of **51 or more**, it will be renewed in the large group market.

PA/WV Regions:

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 an **50 or less** *common-law* employees in the preceding calendar year (leading to the renewal effective date) **AND** have at least **one or more** *common-law* employees (may be full or part-time) when coverage commences.

- If an employer reports an average of **51 or more**, it will be renewed in the large group market.

All Regions:

If Highmark determines that a group does not meet the underwriting guidelines or that it does not qualify as a small group employer, coverage will be cancelled at the end of the current contract period.

In the event of cancellation, Highmark will issue a minimum 60 day written notice to the group via certified mail. Subsequently, **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.

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

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Renewal Information and Changes
Control Number:	UC-106.4
Revision Date:	July 1, 2020
Category:	Existing Business Re-Underwriting Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

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 (via a signed letter on company letterhead or email) from the group and cite the business reason(s) for the change. Supporting documentation must also be included (e.g., change is being requested as a result of a new union bargaining agreement).

Note: 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.

All requests are subject to **review and approval by Underwriting**. If approved, the current contract period can be no greater than 12 months (e.g., if group renewed on 7/1/2019 and wants to move to a 1/1/2020 renewal date, then the current coverage will end on 12/31/2019).

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Existing Business Audits
Control Number:	UC-106.5
Revision Date:	July 1, 2020
Category:	Existing Business Re-Underwriting Requirements

Regional differences may apply, see your section below if applicable. Requirements for 'All Regions' are noted throughout the guidelines.

All Regions:

HM reserves the right to audit existing groups **at any time** to confirm compliance with the underwriting guidelines and eligibility of members. Selection criteria may be random, routine, by referral or based on enrollment variances, etc.

DE/WV:

Ineligible members will be canceled first of the month after **60-days.** A written notice will be sent to the employer and all cancelled members who are entitled for a conversion will receive conversion information for individual (direct pay) coverage. Subsequently, the **members will have the opportunity to enroll in group coverage via the employer's next open enrollment/contract period** provided they qualify as
eligible employees or dependents at that time. It is the employer's responsibility to notify all members of the cancellation of coverage.

Note for WV clients:
Those contracts that were never eligible to be added (erroneous or fraudulent adds) will **not** be eligible to be offered conversion information.

PA:

Ineligible members will be canceled first of the month after **30-days.** A written notice to the employer and all cancelled members who are entitled for a conversion will receive conversion information for individual (direct pay) coverage. Subsequently, the **members will have the opportunity to enroll in group coverage via the employer's next open enrollment/contract period** provided they qualify as eligible employees or dependents at that time. It is the employer's responsibility to notify all members of the cancellation of coverage.

Note for PA clients:
Those contracts that were never eligible to be added (erroneous or fraudulent adds) will **not** be eligible to be offered conversion information.

All Regions:
Employers should be reminded that they are to adhere to the employer/member eligibility requirements (participation, hours and contribution requirements) as stated on their group applications (or other written communications to HM) for the duration of their contract periods as eligibility changes may only be made upon renewal.

Misrepresentations/omissions on applications may result in cancellation (as described on the previous page) and/or retroactive premium adjustments. In addition, certain cases may be referred to HM's Special Investigations Unit.

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. HM 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 receive a written cancel notice (via certified mail) **and coverage will be canceled upon renewal** (or earlier for nonpayment of premiums or fraud). HM Sales contacts will be notified by Underwriting of all group cancellations and will have the opportunity to assist groups in achieving underwriting compliance **prior** to cancellation (when applicable).

In the event that a group is audited and it does not meet the minimum participation requirement, additional employees (who previously waived coverage) can be added prior to the group's open enrollment/contract period in order to satisfy the minimum participation requirements. Renewability of coverage is contingent upon employers meeting the participation requirements for the next contract period.

Subsequently, if they are able to meet the participation requirement once all employees have made their enrollment elections for the next contract period, employers must submit that enrollment information along with their most recent tax/payroll documents to HM Underwriting at least 30 days prior to the cancel date for the current contract period. If found to be compliant, Underwriting will rescind the cancellation and group coverage will be renewed.

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 HM's Special Investigation Unit and may result in immediate cancellation.