Excellus

Medical Commercial Community Rated

Underwriting Guidelines Applied on a Group Level

Policies Effective: January 1, 2014

Last Revised: April 3, 2014

Introduction

Commercial health insurance coverage is available to employers, trust and association groups, subscribers and dependents that meet the qualifications specified in applicable state and federal requirements and the underwriting guidelines of Excellus BlueCross BlueShield. Throughout this document, Excellus BlueCross BlueShield will be referred to as the health plan. Outlined below are the basic criteria that the health plan will follow to qualify employers, trust and association groups, employees and dependents for commercial coverage.

Disclaimer

The health plan reserves the right to make exceptions to these guidelines for circumstances where the group/subscriber/dependent does not meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective January 1, 2014, and replace all previous group commercial guidelines in use.

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I. Group Eligibility

A. Eligible Groups:

A group, or if the group is a trust or association, a member firm participating in the group, is eligible for commercial group coverage if it meets the following criteria and complies with applicable state and federal requirements:

Employer group/trust:

The group/trust:

1. Is headquartered in the health plan's service area. In the event that the health plan is insuring only the local employees of a multi-location group, the group must have an office in the health plan's service area.
2. Is engaged in a legal business or is a government entity with the legal authority to contract.
3. Regularly employs persons on an active basis for salaries or wages throughout the year.
4. Maintains a non-seasonal business which employs at least one employee for 50 percent of the working days in the previous year.
5. Maintains an employer-employee relationship with its subscribers.
6. Files state and federal income taxes as an ongoing commercial enterprise, nonprofit entity, or is validly exempted from filing taxes, or is a government entity.
7. Meets and maintains applicable participation requirements as required by the health plan's underwriting guidelines and as permitted by state and federal requirements. See participation requirements below for additional details.

Association groups:

The association:

1. Must meet criteria listed as "1" above for employer groups/trusts, as well as other criteria specified in applicable state and federal requirements related specifically to associations.
2. Member firms must comply with the same underwriting guidelines as groups/trusts enrolled by the health plans on a direct basis and must comply with applicable state and federal requirements.

B. Ineligible Groups:

The following groups are ineligible for commercial group coverage:

1. Groups previously terminated for fraud.
2. Groups that do not have common law employees eligible for coverage.

C. Group Size:

Small groups, including small group coverage offered through an association, will be defined in accordance with applicable state and federal requirements.

To determine a group's classification as "small" or "large," the health plan calculates eligible employees based on the following general guidelines:

1. Groups with common ownership/control count as being part of one group.
2. Groups with membership inside and outside of the health plan service area will be counted together, even if membership within the service area is minimal.

D. Group Effective Date:

New groups must provide all required enrollment information to the health plan 30 days in advance of the effective date. Groups making changes to existing coverage must provide all required enrollment information 15 days in advance of the effective date in order to be effective the first day of the following month. New small groups must include payment of the first month's premium, along with all other enrollment materials.

Note: New York State of Health Marketplace business must comply with applicable state and federal requirements.

E. Group Renewal Date:

Groups renew annually as follows:

1. Community-rated groups outside of the New York State of Health Marketplace renew on January 1, unless the product has rolling rates or a level premium.
2. A group with rolling rates renews on the first day of the month of the anniversary of its effective date and the benefit plan year coincides with the anniversary date.
3. Level premium groups renew throughout the year, based upon a date the group specifies at the time the rate is quoted.
4. New York State of Health groups renew based upon the group's enrollment date.

F. Guaranteed Renewal:

A covered small group or, if the group is a trust or association, a member firm, will be renewed unless terminated due to any of the following occurrences:

1. Nonpayment of premium.

2. Fraud or misrepresentation of material facts.
3. Violation of the health plan's participation requirements.
4. Violation of the health plan's service area requirements.
5. Lapsed membership or membership that is downgraded from "full" to "associate" in the trust or association (including a chamber of commerce) through which the coverage is offered.
6. Inability to meet the definition of a permissible group under applicable state and federal requirements.
7. The health plan discontinues participation in the market or discontinues the class of coverage.

G. Open Enrollment Period:

The health plan's standard policy is one open enrollment (reopening) period per year, at the time of the group's renewal. The open enrollment period is the time when eligible group members who have previously declined coverage through the group may enroll. Subscribers may select from among the various offerings available through the group during the open enrollment period.

H. Special Open Enrollment Periods:

A group may request a special open enrollment period when a significant change in business conditions occurs, such as a purchase of a new division or the group expands coverage to a new class of employees.

II. Subscriber/Dependent Eligibility

A. Eligible Subscriber:

An eligible subscriber must be a citizen of the United States or must be in the United States validly working on at least a semi-permanent basis (e.g., "H" visa). The subscriber must live, work or reside in the appropriate health plan service area.

Note: For products offered on the New York State of Health Marketplace, subscriber eligibility will be determined in accordance with applicable state and federal requirements.

For coverage through an employer group (including member firms within a trust or association), an eligible subscriber must be:

1. A permanent, full or part-time employee working at least 20 hours per week.
2. An officer or director if engaged in the operation of the business at least 20 hours per week and receiving compensation.

3. An elected or appointed official if the employer group is a public entity (e.g., city, school district).
4. If a retiree, covered by the health plan immediately prior to retirement and with continuous coverage through the health plan.
5. An employee disabled or on Family Medical Leave Act.
6. A former employee on COBRA/New York state extension of benefits, until the maximum period ends.
7. A reservist.
8. A "1099 employee" who is considered an employee per Department of Labor regulations (e.g., realtors, contractors).

B. Employer Probationary Periods:

Employers may select probationary periods from zero to ninety days.

C. Eligible Dependent:

The eligible dependents are dictated by the subscriber contract/certificate. In general, the eligible dependents are as follows:

1. Spouses

   Spouse, unless the marriage is dissolved through divorce or annulment. A same-sex marriage will be recognized when the marriage is performed in a state where full legal status is conferred on the marriage.

2. Dependent Children
   a. Children of a subscriber are covered until age 26, regardless of financial dependence, residency, student status, employment, marital status, or eligibility for other coverage.
   b. In addition to the coverage listed in subparagraph (a) above, coverage for the children of a subscriber is available, if elected by the subscriber or eligible young adult, for unmarried adults younger than 30 years of age who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or within the health plan's service area and who are not covered under Medicare.
   c. In addition to the coverage listed in subparagraph (a) above, coverage may be available through a "make available" rider, if elected by a group, for the children of a subscriber who are unmarried, younger than 30 years of age, who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the health plan's service area, and who are not covered by Medicare.

3. For purposes of subparagraphs b. and c. above, the term "children" includes natural children, stepchildren, legally adopted children and children for whom a court of law has appointed the subscriber or spouse their legal guardian and who are chiefly dependent upon the subscriber for support.

   Note: For products offered on the New York State of Health Marketplace, dependent eligibility will be determined in accordance with applicable state and federal requirements.

D. Subscriber/Dependent Initial Enrollment and Retroactivity

   The health plan will enroll a subscriber and/or dependent for the requested date, provided that:

   1. The application is received within the retroactive period specified in the subscriber contract/certificate from the date of the qualifying event.
   2. If the retroactive period is unspecified, within 30 days.

   If not enrolled when initially eligible, the subscriber/dependent must wait until the next open enrollment period, unless the subscriber/dependent qualifies for a special enrollment period (see following Section E).

   Note: For products offered on the New York State of Health Marketplace, dependent eligibility will be determined in accordance with applicable state and federal requirements.

E. Special Enrollment Periods:

   Special enrollment periods are available in accordance with the terms of the member's contract.

III. Product Offering Requirements

A. Participation Percentages:

   HMO products are not subject to participation requirements, but enrollment in the health plan's HMO products may contribute to the total participation percentages for small groups.

   The group size and participation requirements are based on net-eligible employees (after valid waivers) and will be applied as follows:

   To obtain small group coverage from the New York State of Health Marketplace, outside of the January annual open enrollment period, 75 percent of the net-eligible employees must be enrolled in our health plan and meet applicable state law participation requirements.

Note: Minimum participation requirements do not apply to small groups during the annual open enrollment period or products offered on the New York State of Health.

B. Maximum Number of Products or Options:

Small groups meeting standard participation requirements may select the following number of products/options:

Enrolled Employees	Number of Products/Options
1 - 5	1
6 - 15	2
16 - 35	3
36 - 50	4

Groups with multiple product/option selections may choose the same or different types of products, but may not cause adverse selection by violating the health plan's multiple product offering guidelines. See Section C below.

Note: The number of product offerings for New York State of Health Marketplace business will comply with applicable state and federal requirements.

C. Multiple Offerings:

To reduce the potential for adverse selection, the following rules govern which products are available in multiple product offering situations:

1. When offered next to a competitor, the benefit level of the health plan's products must be less than the competitor's benefit offering.
2. When multi-option offerings are offered next to a competitor's plan, our lowest option has to be the lowest option offered, and we must have enrollment in this option.
3. The eligibility criteria for subscribers and dependents must be the same for all products (e.g., domestic partner, student age).
4. The underlying benefits must be essentially the same, except for benefits such as vision, which have a low risk of adverse selection.
5. Rating tiers must be identical.
6. Renewal/open enrollment periods must be the same.
7. The rate differential among health plan product offerings must be at least 5 percent and no more than 30 percent. If a health savings account product is offered, special consideration may be given.

Note: Multiple offerings on the New York State of Health Marketplace must comply with applicable state and federal requirements.

D. Group-Initiated Changes in Coverage:

If a group wishes to change its coverage, the following rules are generally in effect:

1. Riders may be added or eliminated only at the renewal.
2. Benefit changes may occur once per year at the time of renewal.

E. Rating:

Groups with one to 50 eligible employees will be community-rated. Rates are based upon the group's location and product selection, in accordance with rates filed with the New York State Department of Financial Services.

F. Rate Changes:

For community-rated plans, the health plan must provide notice to the group policyholder or contract holder, as well as certificate holders, on or before the date the health plan files its initial rate change filing with the New York State Department of Financial Services. The health plan may provide the group policyholder or contract holder with a sufficient supply of rate change notices for distribution to certificate holders. The rate contained in the notice to group policyholders or contract holders and certificate holders must be no more than 5 percent from the actual rate. Upon receipt of approval of its rate change application, the health plan must provide the group policyholder or contract holder, as well as certificate holders, with 60 days prior written notice of the approved rate change before it may be implemented.

G. Other Requirements Eligibility Verification:

New group and subscriber/dependent eligibility and guideline compliance will be verified using information from tax forms, other filings with government agencies and appropriate company records as determined by the Underwriting Department. Recertification of a group will occur annually through a direct request for information from the health plan. The annual cycle will repeat as long as the group purchases health insurance coverage from the health plan.

Note: For products offered on the New York State of Health Marketplace, eligibility will be determined in accordance with applicable state and federal requirements.