LARGE EMPLOYER GROUP

Underwriting Guidelines 2025

Medical, Dental, Vision

of Tennessee

Contents

Eligibility Guidelines for Large Employer Groups

Group Size Definition

For quoting and renewing purposes, a large employer group is defined as an employer who employed an average of 51 or more employees on business days during the preceding calendar year. Rates and benefits offered by BlueCross BlueShield of Tennessee (BlueCross) are based on employer attestation of group size (i.e. small or large employer per Affordable Care Act (ACA) guidelines). For existing groups, the most recent ACA/Medical Loss Ratio (MLR) employer size certification will be used to determine group size. For existing groups that do not respond to the certification, the average number of total subscribers over the prior calendar year will be used to determine the group size. For prospect groups, employer size should be disclosed during the quoting process. For sales, employer size is confirmed via the Employer Group Application (EGA).

Counting Employees to Determine Group Size

All employees issued a W-2 are considered employees, regardless of hours worked or enrollment in the health plan. This would include full-time, part-time and seasonal employees. Independent contractors (i.e. 1099 workers) should only be counted as an employee if they meet the common law employee standard. A sole proprietor and his/her spouse are not considered employees. Partners in a partnership and their spouses are not considered an employee unless the partners are bona fide partners pursuant to 45 CFR 146.145(c) (2) and both work for the partnership. Corporation shareholders are not considered employees unless they meet the common law employee standard and are issued a W-2.

Some employers own multiple businesses. If the businesses are treated as a single employer under Internal Revenue Code section 414 (b), (c), (m) or (o), they should be combined for purposes of counting employees.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

Employer Eligibility

A large employer group* must meet the following requirements to be eligible for BlueCross group coverage:

- The group must be a valid employer group and actively conducting business as a going concern.

- Fully insured groups must have a Tennessee business location and employees in Tennessee.

- Self-funded groups must either have a Tennessee business location and Tennessee employees or a business location and employees in Walker, Dade or Catoosa counties in north Georgia.

- If covering out of state employees, branches, locations and/or subsidiaries, the group must have a Tennessee headquarters (or north Georgia headquarters in Walker, Dade or Catoosa county for self-funded only) and wholly own the out of state branches, locations and/or subsidiaries.

- Fully insured groups must have a minimum of two employees eligible for coverage and one Tennessee common law employee enrolled in the coverage at all times**. *Sole proprietorships must have at least one non-spouse common law employee enrolling for coverage. Partnerships must also have at least one non-spouse common law employee enrolling for coverage unless the partners are bona fide partners pursuant to 45 CFR 146.145(c)(2). Corporation shareholders are not considered common law employees unless they are issued a W-2. 1099 workers are generally not considered a common law employee.*

- For level funded groups, a minimum of 5 subscribers is required for Georgia employers and a minimum of 10 subscribers for Tennessee employers.

- If including more than one business under a single policy, the group must attest that they are a single employer/control group as defined under Section 414 (b), (c), (m) or (o) of the Internal Revenue Code. *To verify compliance, groups should submit the Single Employer Verification Form.*

  **Associations, leasing companies, Multiple Employer Welfare Arrangements (MEWAs) including Affiliated Service Groups, Professional Employer Organizations (PEOs) and unions require approval prior to quoting. See your BlueCross representative for quoting requirements.*

  ***For stand-alone dental and vision groups, a minimum of five subscribers (including one common law employee) is required.*

Eligible Employees

Employees/owners considered eligible for coverage are listed below. Employees/owners must be actively at work and have satisfied all eligibility requirements of the employer including any eligibility waiting period to be eligible for coverage. All employees/owners listed below must also be paid by the policyholder or one of its subsidiaries approved for coverage under the group plan.

Employees Eligible for Coverage:

- Full-time employees who work at least 30 hours per week

- Part-time employees who work at least 20 hours per week

- Corporate Officers and Owners who work at least 20 hours per week

- Leased employees that meet the requirements of either a full or part-time employee and are considered the common law employee of the policyholder

- Seasonal/Temporary employees who meet the requirements of either a full-time or part-time employee

- Minors (i.e. employees less than 18 years of age) may be eligible for coverage only if they meet the requirements of a full-time or part-time employee and still comply with all Tennessee and U.S. Department of Labor child labor laws

- Expatriates (i.e. U.S. citizens working at a U.S. company's foreign location) may be covered under the U.S. company's group health plan if they meet the requirements of a full-time or part-time employee

- Foreign Nationals (i.e. non-U.S. citizens who come to live and work in the U.S. for a U.S. company for a specified period of time) may be eligible for coverage if they meet the requirements of a full-time or part-time employee

Employees Not Eligible for Coverage:

- Commission employees, of counsel employees, stockholders, consultants and prior owners are not eligible unless they meet the requirements of a full-time or part-time employee

- Elected or appointed officials including board members are not eligible unless they meet the requirements of a full-time or part-time employee or serve a rural co-op or public utility. For a rural co-op or public utility, coverage should be offered to all board members as well as employees, board members must make up less than 10% of total enrollment and the group should submit a copy of their charter confirming compliance with underwriting guidelines.

- Employees who are not U.S. citizens, do not reside in the United States and who work at an employer's location not located in the United States

- Illegal immigrants

- Employees on severance that is not state continuation or COBRA unless approved by Underwriting

Eligible Dependents

Dependents eligible for coverage are listed below. If a group desires to exclude dependents from coverage, BlueCross approval is required.

- Spouse - An employee's current spouse (same sex, opposite sex or common law) as defined by the employer which may include a domestic partner. Spousal eligibility is based strictly on an employer's internal personnel policies. *Please note that domestic partners are only eligible to enroll at the initial effective date of a sale or at open enrollment of an existing group.*

- Children - The employee's or employee's spouse's natural child, legally adopted child (including children placed for the purpose of adoption), stepchild(ren) or children for whom the employee or employee's spouse are legal guardians; who are less than 26 years of age

- A child of the employee or employee's spouse for whom a Qualified Medical Child Support Order has been issued

- Incapacitated Over Age Dependent

  For NonEHB fully insured groups: An employee's or employee's spouse's incapacitated child that is age 26 or older that is unmarried, incapable of self-sustaining employment by reason of physical disabilities or intellectual disabilities and is chiefly dependent upon the employee or employee's spouse for economic support and maintenance. Proof of incapacitation is required.

  For level funded and self-funded groups: An incapacitated dependent is an unmarried child of the subscriber who is covered under the plan upon reaching the plan's limiting age, and continues to be, both (1) incapable of self-sustaining employment by reason of a physical or mental disabling injury, illness or condition and (2) chiefly dependent upon the subscriber or subscriber's covered spouse for economic support and maintenance. Proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.

  For incapacitated dependents of existing subscribers of existing groups – the child must already be covered by BlueCross when he/she reaches the plan's limiting age. Once the child reaches the limiting age, he/she may enroll within 31 days of reaching the limiting age. If the child was not previously covered by the employee prior to reaching the limiting age, he/she is not eligible to enroll as an incapacitated dependent.

  For incapacitated dependents of newly eligible subscribers of existing groups: The incapacitated child is eligible for coverage only if he/she was covered under the subscriber's or subscriber's spouse's previous plan and has less than a 63 day break in coverage from the prior plan.

  For incapacitated dependents of subscribers of new groups: The incapacitated child is eligible for coverage only if he/she was covered under the subscriber's or subscriber's spouse's previous plan and has less than a 63 day break in coverage from the prior plan.

- Dependents of an Expatriate - The employee's dependents that meet the eligibility criteria outlined above may also be covered under the group health plan whether they remain in the U.S. or relocate with the employee.

- Dependents of a Foreign National who meet the eligibility requirements outlined above are only eligible for coverage if they reside in the U.S. Dependents are not eligible for coverage if they remain in residence outside of the U.S. However, BlueCross will consider a move to the U.S. a qualifying event for such dependents and allow them to enroll within 31 days of the event.

Dependents Not Eligible for Coverage:

- Dependents who permanently reside outside the United States
- Divorced spouses
- Grandchildren (unless they meet the eligibility criteria outlined above)

Other Eligible Participants

- State Continuation/COBRA beneficiaries (Only groups with 20 or more employees or who otherwise must comply with COBRA law are eligible to offer COBRA continuation coverage)
- Employees on a military leave of absence and their dependents
- Employees on an approved leave of absence and their dependents if the approved leave meets the following criteria:
    - The employer continues to consider the subscriber as an employee and all other group benefits are continued as well as the medical benefits
    - The leave of absence is for a specific period of time established before the leave of absence began.
    - The purpose of the leave of absence is known.
    - The leave of absence does not last longer than six months. If the leave lasts longer than six months, the employee should be offered COBRA or State Continuation coverage.
- Retirees
  Retirees and their dependents may be eligible with BlueCross approval **if** the following conditions are met:
  (1) Had group coverage through their employer before and upon retirement
  (2) Have had continuous group coverage since retirement
  (3) The employer treats all retirees the same in regards to eligibility
  (4) Employer contributes the same amount towards retiree coverage as for employee coverage
  (5) The employer has a written retirement plan available to employees
  (6) Retiree enrollment does not exceed 10% of total group enrollment

  The Retiree Coverage Attestation Form and copy of group's retiree plan are required to confirm compliance.
- Independent Contractors (i.e. 1099 workers)
  If the employer group classifies their 1099 workers as common law employees per IRS guidelines, the 1099 workers are eligible for coverage just like any other w2 employee. Written attestation from the group is required to confirm the common law status of the 1099 workers. In addition, the following guidelines must be met:
    - A normal employee/employer relationship within the group is certified by being actively at work and working at least 30 hours per week.

- The group must offer coverage to all independent contractors meeting the above criteria and the employer must contribute the same amount towards their coverage as they contribute towards coverage for w-2 employees.

If the employer group does not classify their 1099 workers as common law employees per IRS guidelines, BlueCross approval is required to cover 1099 workers. The guidelines above must be met and the group should also provide the 1099 Verification form required. Additional tax documentation may also be required.

Assignment of Eligibility and Coverage Effective Dates

Assignment of Eligibility and Effective/Termination Dates

Groups are responsible for making eligibility determinations and setting effective dates for new employees, employees who have qualifying events and employees whose coverage is terminating. This applies to all BlueCross products. **Groups should continue to base all eligibility criteria as well as effective/ termination dates in accordance with state and federal regulations and BlueCross underwriting guidelines. Per our group agreement, BlueCross may conduct employee and dependent eligibility audits to ensure compliance with underwriting guidelines. Any ineligible employees or dependents will be termed from the group policy.**

Group Coverage Effective Dates

Large employer groups may purchase and renew coverage with a 1st, 5th, 10th, 15th, 20th, 25th or 30th of the month effective/renewal date.

Employee Coverage Effective Dates

Employees may enroll within 31 days of initial eligibility after successfully completing the eligibility waiting period assigned by their employer, during open enrollment or if he/she incurs a qualifying event. Employee waiting periods typically lasts 0, 30, 60 or 90 days from the new employee's initial date of employment. Waiting periods exceeding 90 days are prohibited per ACA regulations. Below are explanations of the three eligibility options and their impact on coverage:

- First billing date following eligibility period:
  New hires become eligible for health coverage on the first day of the following billing cycle after completing their eligibility waiting period. Consequently, the group is billed for the entire month for new hires. If the effective date falls on the bill cycle date, the effective date will be that date, unless otherwise requested.

- First day immediately following eligibility (i.e. give and take):
  New hires become eligible for health coverage the first day after completing their eligibility waiting period, which is not necessarily the first day of the normal billing cycle.

- Date of hire eligibility:
  New hires become eligible for health coverage the first day of hire, which is not necessarily the first day of the normal billing cycle.

Dependent Coverage Effective Dates

Dependents are eligible to enroll with the employee at the time of initial eligibility or open enrollment. In addition, the following special enrollment periods apply:

- Spouse
  If an employee marries and wants to cover the new spouse and any children acquired as a result of the marriage, he or she has 31 days from the marriage to apply for coverage. If the employee has dependents who could have been covered before the marriage but were not covered, all dependents are eligible through the 31 day special enrollment period.

- Domestic Partners
  If eligible for coverage, domestic partners may only enroll at the time of initial eligibility or during the open enrollment period. Employee status changes such as marriage and divorce would not apply to a domestic partner because there is no legal marriage. Acquiring a domestic partner is not a qualifying event that constitutes a special enrollment. These same rules apply to the children of a domestic partner that are not also the employee's children.

- Children
  Newborn children are automatically covered for 31 days after the date of birth unless waived by the group agreement. This applies to all subscribers, including those with employee only coverage. However, the subscriber must enroll the child within 31 days from the date of birth. If the subscriber does not and an additional premium is required to cover the child, the plan will only cover the child after 31 days from the date of birth on an exception basis. If the subscriber adds the child to the policy on the date of birth and additional premium is required to cover the child, the premium will be charged for the first 31 days. See information in the Spouse section above for children acquired as a result of a new marriage. For children acquired via adoption or guardianship, the children must be enrolled within 31 days of when the child is legally placed in the subscriber's home. For children whom health coverage is required via a qualified medical child support order, the children must be enrolled within 31 days of when the order is issued.

Late Applicants

Employees and dependents applying for coverage more than 31 days after the initial effective date, open enrollment or date of a qualifying event are considered late applicants. For most group agreements, late applicants must wait until the next open enrollment period to obtain coverage.

Employees Returning from Military Service/Reinstatement of Coverage

When a member returns from military service, the Uniformed Services Employment and Re-employment Rights Act (USERRA) requires the employer to reinstate his or her medical coverage without a waiting period. In addition, reinstatement must be administered without regard to Give & Take rules, Rehire Provisions, etc. USERRA also sets varying periods of time, based on length of military service, in which the employee must return to employment after military duty in order to qualify for uninterrupted benefits, including health care coverage. Here are those time frames:

- Service under 31 days
  Those who served fewer than 31 days must report to the employer on the first day of the first regularly scheduled work period following completion of service. If reporting that soon is "impossible or unreasonable through no fault of (the returning employee)," the law requires them to report "as soon as possible." For military service of fewer than 31 days, health care coverage is provided as if the service member had remained employed.

- Service of 31 to 180 days
  Returning employees who served 31 to 180 days are allowed 14 days to return to work, or "as soon as possible" if meeting that deadline is impossible through no fault of the employee. Their coverage will be reinstated back to the date of discharge, if the request for coverage reinstatement is received within 30 days of the discharge. If the request is received more than 30 days from the date of discharge, and documentation of "as soon as possible" is not submitted, the effective date will be the next open enrollment.

- Service of more than 180 days
  Employees who serve more the 180 days are allowed 90 days to apply for reinstatement with their employer, or "as soon as possible" if meeting that deadline is impossible through no fault of the employee. Their coverage will be reinstated back to the date of discharge, if the request for coverage reinstatement is received within 30 days of the discharge. If the request is received more than 30 days from the date of discharge, and documentation of "as soon as possible" is not submitted, the effective date will be the next open enrollment.

- Disabled persons
  Returning employees who are hospitalized for or recovering from injuries sustained or aggravated by military service are allowed two years to apply for employment after recovering from those injuries.

Open Enrollment Period

Employers have the responsibility to provide an annual open enrollment period. During this 31 day period, eligible employees may apply for coverage for themselves and eligible dependents. Generally, the open enrollment period should be conducted 30 – 60 days prior to the group's renewal date.

Rehire Provision

Groups may include an employee rehire provision in their eligibility policies. A rehire is any full-time or part-time employee who left the company for any reason and was allowed to return to his/her position. If this provision is included, the eligibility waiting period is waived for eligible rehires that are rehired within a certain time period (i.e. rehire period) if the application is received within 31 days of the rehire date. In addition, the rehire will be considered as having continuous coverage for the purpose of administering the deductibles and out of pocket amounts. BlueCross approval required if the rehire period is more than 180 days.

HIPAA Special Enrollment and Qualifying Events

In order to comply with HIPAA provisions, BlueCross allows qualifying employees/subscribers to enroll or change their coverage other than during open enrollment. The employee must request the change within 31 days of the change in status. Some examples of a qualifying event or change of status includes the following:

- Marriage or divorce*
- Death of the employee's spouse or dependent
- Change in dependency status
- Medicare eligibility
- Coverage by another payor
- Birth or adoption of a child of the employee*
- Termination of employment or commencement of employment
- Switching from part-time to full-time, or from full-time to part-time by the employee or the employee's spouse
- Loss of previous health coverage when:
    - Employee was enrolled in another health coverage plan at the time he or she was initially eligible for group coverage through the employer group plan; and
    - He or she stated in writing at that time why he or she chose not to enroll through the employer group plan

**When an employee gets married or has a child (birth or adoption), this constitutes a special enrollment period for not only the employee; but for everyone covered under the employee's plan. Similarly, if a dependent loses previous coverage, the employee and everyone covered under the employee's plan may enroll for coverage outside the open enrollment period.*

Additional special enrollment periods may apply. Please refer to the BlueCross BlueShield Evidence of Coverage (EOC) for complete information.

HIPAA Special Enrollment and Multi Option Plans

HIPAA requires insurance carriers to allow employees and dependents under a special enrollment to enroll in **any** benefit package the group offers, regardless of the benefit package in which the employee previously enrolled. This applies when:

- An employee or dependent loses coverage under another plan, each are eligible for special enrollment in **any** benefit package under the plan (subject to plan eligibility rules that condition dependent enrollment or enrollment of the employees);

- But only if: the employee and the dependent are otherwise eligible to enroll in the benefits package;

- And if: when the coverage of the group plan was previously offered, the employee had coverage under any group health plan or health insurance coverage.

BlueCross Administration

BlueCross's administrative policy regarding special enrollments and multi option plans is more generous than the minimum HIPAA requirement above. BlueCross will allow employees/dependents the opportunity to enroll in *any* option or product the group offers with *any* qualifying event.

Benefits, Related Provisions and Underwriting Guidelines

Medical, Dental and Vision Benefits

BlueCross offers large employer groups* a variety of medical provider networks, PPO plan designs and Consumer-Directed Health Care plan designs to meet the needs of their employees. BlueCross also offers dental coverage, vision coverage, wellness products, medical management and COBRA administration services. All benefits offered meet the pertinent ACA requirements. Groups may purchase medical, dental and vision benefits on a standalone or bundled basis. For self-funded groups, additional networks, products and services such as special pharmacy provisions and medical management services may also be available. Please refer to the Group Product Guide, Ancillary Product Guide and your Account/Sales Executive for detailed information regarding the benefit plans available to large employer groups.

Benefit Customization

Benefit customization is not available for groups with less than 151 enrolling employees. Benefit customization for large employer groups with 151+ enrolling employees may be available with BlueCross approval on a case by case basis. Certain large employer groups such as religious employers and other eligible organizations are allowed per ACA to exclude contraceptive services. Please contact your Account/Sales Executive for details.

> **Availability of fully insured benefits is based on group size (i.e. large or small employer per ACA guidelines), which is determined by employer attestation. For existing groups, the most recent ACA/Medical Loss Ratio (MLR) employer size certification will be used to determine group size. For existing groups that do not respond to the certification, the average number of subscribers enrolled during the prior calendar year will be used to determine the group size. For prospect groups, group size information should be disclosed during the quoting process. For sales, employer size is confirmed by the Employer Group Application (EGA).*

Companion Life GAP Plans

BlueCross has partnered with Companion Life to offer a group sponsored gap plan that may be offered in conjunction with BlueCross HDHP medical coverage. The purpose of allowing this combined product offering is to help employees offset the financial burden of higher out of pocket expenses associated with higher deductible/out of pocket plans.

Underwriting Guidelines

- Pre-approved options for BlueCross medical groups with 5 – 250 employees, including EHB plans. No BlueCross medical underwriting review required.
- Non-standard GAP plans require approval.
- Groups over 250 employees must obtain underwriting approval prior to quoting.
- Minimum GAP deductible of at least $2,500 required.
- Once the GAP deductible is set, the medical deductible must be twice that amount or more. For example:

- $2,500 GAP deductible must have a BlueCross medical deductible of $5,000 or higher
- $3,000 GAP deductible must have a BlueCross medical deductible of $6,000 or higher
- $4,000 GAP deductible must have a BlueCross medical deductible of $8,000 or higher
- Traditional and HSA compatible deductibles available
- Benefit amounts range from $500 to $10,000
- May be sold on an employer paid, voluntary or contributory basis
- Guaranteed issue with no pre-existing condition limitations
- Dual plan options available
- All employees and dependents are eligible if covered under the BlueCross medical plan
- Broker commissions are 10% flat on the GAP product

COBRA Administration Services

BlueCross offers a complete range of COBRA administration and billing services available to employers purchasing BlueCross products, including an initial notification option. For more information about these services, please refer to the Group Product Guide or the Group Administrator Reference Manual.

Third Party COBRA Administration

BlueCross also offers third party COBRA administration for non-BlueCross products. If purchased, all standard COBRA administration services are provided. COBRA Initial Notification services may also be purchased for an additional charge. Non-BlueCross benefits include (1) dental benefits provided by another insurance carrier and (2) medical ancillary benefits (ex. pharmacy and vision) provided by an outside vendor.

- Group Eligibility Requirements
  New or existing groups of any size that maintain medical benefits through BlueCross are eligible for this service. The group must purchase COBRA administration services as part of the BlueCross medical benefits in order to purchase COBRA administration services for the non-BlueCross benefits. The COBRA administration services purchased for the BlueCross medical and non-BlueCross benefits must be the same.

- Premium Due
  The premium due for COBRA administration of non-BlueCross benefits will be calculated on a case-by-*case basis and billed monthly in conjunction with the BlueCross medical fully insured premium.*

- Termination
  If a group terminates their medical benefits with BlueCross, COBRA administration services for any non-BlueCross benefits must terminate on the same day.

Adding Coverage/Benefit Changes to Existing Coverage

Large employer groups may add coverage and make certain benefit changes on or off renewal. Please refer to the renewal section for complete guidelines.

Carve Outs/Class Outs

A carve out or class out where only certain classes of employees are offered coverage (ex. Management-only carve out) is allowed; however **it is the group's responsibility to make sure that any carve out/class out plans comply with applicable Internal Revenue Code non-discrimination rules.** The carve out/class out group of employees should be easily identified by a clear class designation that is reasonable, non-discriminatory and uses objective business criteria for identification. Reasonable classifications include specific job categories, nature of compensation (i.e. salaried or hourly), geographic location and similar bona fide business criteria. In general, valid classes of employees should have a minimum of two employees (with the exception of an owner class).

Different Benefits by Class of Employee

Different benefits offered based on employee class is allowed; however **it is the group's responsibility to make sure that any carve out/class out plans comply with applicable Internal Revenue Code non-discrimination rules.** Employees should be easily identified by a clear class designation that is reasonable, non-discriminatory and uses objective business criteria for identification. Reasonable classifications include specific job categories, nature of compensation (i.e. salaried or hourly), geographic location and similar bona fide business criteria. In general, valid classes of employees should have a minimum of two employees (with the exception of an owner class).

Employee Only Coverage

Large employer groups may exclude dependent coverage and provide coverage only for employees or for employee/children only. **Please note that the administrative burden for this eligibility change is on the employer. They are responsible for monitoring adherence to the employee only or employee/child only eligibility for coverage. Applications that do not meet the eligibility criteria should not be submitted to BlueCross**.

Underwriting Guidelines for Employee Only and Employee/Child Only Coverage

- For large employer NonEHB groups, requests for employee only or employee/child only coverage or to add back dependent coverage requires BlueCross approval and a possible rate adjustment. It is preferred that this eligibility change is implemented only at initial effective date or renewal; however BlueCross may approve an off renewal change on a case by case basis. An off renewal change may not be made within five months of the renewal date.

- Employee only class outs are permitted (i.e. employee and dependent coverage for management but employee only coverage for non-management). Separate subgroups for each class are preferred for ease of administration.

- In a fully insured multi option arrangement where employees may choose from more than one option, employee and dependent eligibility must be the same for all options.

- Continuation of Coverage - If a group has dependent coverage and later chooses to discontinue dependent coverage, enrolled dependents are not eligible for continuation coverage such as COBRA and State Continuation because this type of loss of insurance does not meet the definition of a qualifying event. However, the enrolled dependents are entitled to a conversion policy. In addition, if dependents are not eligible for coverage, COBRA and State Continuation participants may not add their dependents to their coverage.

Multi Options

Large employer groups may offer multi options based on the number of employees. Please refer to the charts below for complete guidelines.

Medical Multi Option Guidelines for Large Employer Groups

General Information	Guideline
Group Eligibility	Multi options only allowed for groups with 5+ *eligible* employees
Number of Options	A maximum of 3 options is permitted; however 4 options are permitted if two benefit plans are offered on both networks P and S.
Medical Product Availability	• Available with all medical products • May consist of similar products (i.e. two PPO options) *or* different products (ex. one HDHP option and one PPO option)
Network Availability	Available with networks P and S
Multi Option Differential Allowed To calculate the option differential compare the individual rate of each option	• The maximum allowed differential for options with the *same* network is 35 percent. • The maximum allowed differential for *dual* options with *different* networks is 43 percent. • For groups with triple option plans with multiple networks, the maximum allowed differential depends upon whether or not the high/low options are on the same or different networks *(see examples below).* If the high/low options are on the same network, the standard 35 percent maximum differential applies. If the high/low options are on different networks, then the 43- percent maximum differential applies. *Example 1: Triple Option Offering with Multiple Networks with High/Low Options on Different Networks* High Option 1 - $500 deductible PPO with network P and $550 Indv. rate Middle Option 2 - $1,000 deductible PPO with network P and $500.00 Indv. rate Low Option 3 - $1,000 deductible PPO with network S with $450 Indv. rate *In this example since the high/low options are on different networks, the maximum allowed differential is 43 percent. Based on the calculated differentials below, all options fall within the desired range and may be offered. Option 1 is 10 percent greater than option 2. Option 2 is 11.1 percent greater than option 3. Option 1 is 22.2 percent greater than option 3.* *Example 2: Triple Option Offering with Multiple Networks with High/Low Options on the Same Network* Low Option 1 - $5,000 deductible HDHP with network P and $325.65 Indv. rate Middle Option 2 - $2,500 deductible HDHP with network S and $425.00 Indv rate High Option 3 - $2,000 deductible PPO with network P and $465.00 Indv rate *In this example since the high/low options are on the same network, the maximum allowed differential is 35 percent. Based on the calculated differentials below, this triple option offering is not allowed as the differential between option 3 and option 1 exceeds 35 percent.* *The differentials for these options are as follows:* *Option 3 is 9.4 percent greater than Option 2* *Option 3 is 42.8 percent greater than Option 1* *Option 2 is 30.5 percent greater than Option 1*
Multi Option Rates for Groups with 151+ Employees	Rates for large group quotes/renewals with 151+ employees are developed separately for single option and multi option plans. **Single option rates may not be used to quote a multi option plan design.** BlueCross evaluates each multi option plan design individually and builds in a risk adjustment factor if necessary based on the case specifics of the group.

Medical Multi Option Guidelines for Large Employer Groups (cont.)	
General Information	**Guideline**
4th Quarter Carryover	It is allowed but not recommended for 4th quarter carryover benefits to be different between options (i.e. one option with the carryover and one without). **If options are different, subscribers who move from an option with carryover to one without carryover will lose the carryover from the previous 4th quarter.**
Rate Tiers	All options must have the same rate tier structure
Minimum Enrollment	• Options must have at least one enrolled subscriber. • At initial enrollment, any options offered that do not obtain minimum enrollment will not be processed and will not be available to new hires later during the policy year. • At renewal, any benefit option with zero enrollment will automatically be cancelled and renewal rates will not be produced for this option.
Out of State Subscribers	If more than one network is offered, subscribers that reside out of state *(except for contiguous counties)* should be assigned to the option and premium associated with the broadest network offered. *For example, if a network P and network S options are offered, out-of-state subscribers should be assigned to the network P option.*
Product & Rider Information	**Guideline**
Behavioral Health	Behavioral health benefits are required and all options must have the same benefits
HDHP	Each option must have the *same* deductible option (i.e. embedded or shared but not both)
HRA	Group may offer different HRA allocations; however, the different allocations are considered separate options even though medical benefits may be the same.
Pharmacy	• All options must include pharmacy benefits • Options may have different pharmacy benefits. However, medical benefits must also be different. Plans designed so that the only difference in benefits is the pharmacy benefits are not allowed. Different medical benefits mean different copays, deductibles, coinsurance, out-of-pocket amounts, etc. Different networks do not count as different medical benefits. • All options must include the same formulary.
Special Accident	For PPO with no emergency room copay only - Each option may include or exclude extended Special Accident independently.

DentalBlue Multi Option Guidelines for Large Employer Groups	
Group Eligibility	Multi options allowed for groups with 26+ enrolling employees
Number of Options	Maximum of 2 options allowed
Allowed Combinations and Reimbursement Options	Allowed Combinations Traditional Plans may be offered in a multi option arrangement with the following exceptions: • HDDPs are not permitted. • Preventive/Deluxe combinations are not permitted. Select plans may only be offered with another Select plan. <u>Reimbursement Options (out of network)</u> Reimbursement options must be the same for all plans in a multi-option arrangement. Exceptions will only be considered on a case by case basis and must be approved by BlueCross.
Orthodontic Benefits – Select Plans	If orthodontic benefits are offered, benefits must be the same for each option. If orthodontic benefits are excluded, they must be excluded from both options.
Orthodontic Benefits – Traditional Plans	<u>For groups with less than 51 enrolled employees:</u> If orthodontic benefits offered, benefits must be the same for each option. If orthodontic benefits are excluded, they must be excluded from both options. <u>For groups with 51+ enrolled employees:</u> orthodontic benefits are not required to be the same. However, if one plan has orthodontic benefits and the other plan does not, the Class C coinsurance for the plan without orthodontia must be 10 percent or less (ex. 100/80/50/50 plan with 100/80/10 plan).
Rate Tier Structure	Must be the same for both options
Minimum Enrollment	Options must have at least one enrolled subscriber. At initial enrollment, any options offered that do not obtain minimum enrollment will not be processed and will not be available to new hires later during the policy year. At renewal, any option with zero enrollment will automatically be cancelled and renewal rates will not be produced for this option.

VisionBlue Multi Option Guidelines for Large Employer Groups	
Group Eligibility	Multi options allowed for groups with 100+ enrolling employees
Number of Options	Maximum of two options allowed
Allowed Combinations	Option 1 – Exam Only and Option 2 – Exam Plus Materials
Selection Adjustment	The plan differentials between options are within an appropriate range and do not require additional selection adjustments.
Rate Tier Structure	Must be the same for both options
Minimum Enrollment	Options must have at least one enrolled subscriber. At initial enrollment, any options offered that do not obtain minimum enrollment will not be processed and will not be available to new hires later during the policy year. At renewal, any option with zero enrollment will automatically be cancelled and renewal rates will not be produced for this option.
Networks	Multi options must include the same network (i.e. all options must have the VisionBlue network or all options must have the VisionBlue Insight network.) Network combinations are not allowed.

Plan Year Administration

- Available for all new groups and existing business at renewal only.
- Effective/Renewal date must be 1st of the month.
- Groups may switch between Plan Year and Calendar Year if requested.
- Accumulators will start over when a group moves from Calendar year to Plan year Administration or vice versa (i.e. deductible, out of pocket and any other benefit limit accumulators reset to zero). Accumulators will also start over if a group with Plan Year changes their effective date in the same plan year.
- Groups with 3rd party vendors must be evaluated on a case-by-case basis by Product Development.
- If multi options are offered, all options must be on the same basis (i.e. all calendar year or all Plan Year).
- 4th quarter deductible carry over not allowed with Plan Year administration
- If group has an HRA, it must be on the same basis as medical (i.e. all calendar year or all plan year).
- Medical and Dental are not required to be on the same basis (i.e. Medical can be Plan Year and Dental on Calendar Year)
- Plan Year is not available to groups with an overall annual benefit maximum (unless the group does not have Rx benefits and doesn't plan to add Rx benefits.)
- Retro effective dates/late renewals on transition from calendar year to plan

Coverage Continuation

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides employees (or former employees), their spouses and dependents with a temporary extension of group health insurance when coverage is lost due to certain qualifying events. Generally, COBRA Continuation Coverage must be identical to the coverage provided to current employees.

COBRA Continuation applies to all employer groups (with the exception of church and federal government groups) with 20 or more employees on a typical business day regardless of their eligibility for your group health plan. For purposes of determining employee count, include part-time employees as "fractional" employees.

> Example: Two part-time employees working 15 hours per week would be counted as one full-time employee if 30 hours per week is considered full-time employment.

COBRA continuation gives employees and their eligible dependents who are covered on the date coverage would otherwise end (qualified beneficiaries), the option, under certain conditions, of continuing their group health care coverage beyond the date they would otherwise be ineligible under the group agreement. This provision includes health coverage as well as dental, vision and prescription drug coverage (if these coverages are offered).The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added employees' COBRA rights. If an employee loses his or her job because of import competition or shifts of production to other countries, he or she may have a second COBRA continuation election period.

Qualified Beneficiary

A qualified beneficiary is an employee, his or her spouse, or dependent child who is covered under the employer's group health plan and who has had a qualifying event. The qualified beneficiary must be covered under the plan on the day before the qualifying event. Any child born to or placed for adoption with a qualified beneficiary during the period of continuation coverage will also be eligible for continuation coverage.

Qualifying Events

Qualifying events are instances that would cause individuals to lose health coverage if COBRA Continuation Coverage were not available. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that you must offer the coverage to them under COBRA. Qualified beneficiaries have 60 days from the date of the qualifying event, or the date they are notified of their rights (whichever is later), to elect continuation coverage.

Domestic Partners

Because a domestic partner is not the legal spouse of an employee, domestic partners are not considered qualified beneficiaries for COBRA continuation coverage. If an employee elects COBRA, we will allow a currently covered domestic partner and children to continue on the employee's COBRA coverage. However, a domestic partner and their children (that are not also the employee's children) may not make an independent election for COBRA.

Duration of Coverage
Qualified beneficiaries must be offered continuation coverage for up to 18 months after coverage would otherwise end because:

- Employment is terminated for any reason other than gross misconduct.
- Hours of employment are reduced.

Continuation coverage must be provided for up to 29 months if the member is considered disabled under Title II or Title XVI of the Social Security Act (within 60 days of the qualifying event) and coverage would otherwise end because:

- Employment is terminated for any reason other than gross misconduct.
- Hours of employment are reduced.

Continuation coverage must be provided for up to 36 months for:

- Surviving legal spouse or children.
- A separated or divorced spouse, and/or dependent children who are ineligible for Medicare.
- Children who have reached the limiting age or who no longer meet the definition of an eligible dependent as stated in the group agreement.

End of Coverage
COBRA Continuation Coverage begins on the date that coverage would otherwise have ended due to a Qualifying Event and will terminate:

- At the end of the applicable 18, 29 or 36-month period.
- If and when all health plans you provide to all of your employees are canceled.
- Generally, if the Qualified Beneficiary stops paying the premiums.
- If the Qualified Beneficiary becomes eligible for Medicare (after COBRA continuation has begun).
- If the Qualified Beneficiary obtains other group coverage and satisfies the pre-existing condition limitations, if any, which apply to the other coverage.
- If the Qualified Beneficiary is no longer considered disabled for Social Security purposes (if coverage was continued due to disability).

Paying for Coverage
If a Qualified Beneficiary elects COBRA Continuation Coverage, he or she is responsible for paying for such coverage. The group is, however, responsible for billing the Qualified Beneficiary. On a monthly basis, COBRA participants may be billed up to 102 percent of their premium. Qualified Beneficiaries continuing coverage based on disability may be billed up to 150 percent of the applicable premium for such coverage (after the first 18 months of continuous COBRA Continuation Coverage).

Qualified Beneficiaries have 45 days after the date on which they chose COBRA Continuation Coverage to pay the initial premium. A group health plan is not required to provide coverage to a potential Qualified Beneficiary until after the individual elects and pays for the coverage. If the individual does not immediately elect COBRA Continuation at the time of the Qualifying Event, the first payment must be made retroactive to the Qualifying Event. Most employers collect the COBRA Continuation premium in advance. However, at least a 30-day grace period for a COBRA Qualified Beneficiary to pay the premium must be allowed. If payment due from the Qualified Beneficiary is late, please code the Qualified Beneficiary as canceled due to nonpayment until payment is received in order to prevent claims from being paid.

State Continuation Coverage

BlueCross is required by law to offer State Continuation Coverage to all members of a fully insured group of any size. A qualified beneficiary may elect State Continuation Coverage instead of COBRA, but typically, members who want State Continuation Coverage are those who do not have access to COBRA – those employed by a group with fewer than 20 employees or who were covered under a church plan. BlueCross is not required to offer State Continuation Coverage to self-funded groups.

Administrative Procedures

The member must notify the employer of the change in status within 31 days of the date their coverage would otherwise end, or the date they were notified of this, whichever is later.
The member must remit the full month's group premium payment to the employer in advance, on or before the beginning of each month's coverage, for the coverage.

Eligibility Requirements

- Employees and Dependents
  An employee may elect to continue group coverage for three months when no longer eligible for coverage because of a reduction of hours or non-payment. To receive this three-month extension of group benefits, the employee must have been covered by the group plan for the three months immediately preceding termination of the coverage. Payment for such coverage must be made in advance to the employer within 30 days of the employee's ineligibility for coverage or was notified of the termination of such coverage, whichever is later. These payments may be made on a monthly basis.

- Dependents of Employees
  When an employee dies, becomes divorced or legally separated, his or her dependents are eligible for continued coverage for 15 months. Only those dependents covered under the group plan for at least three months prior to termination and as of the qualifying event, are eligible.

- Pregnant Members
  If a member (employee or dependent) is pregnant at the time her health coverage would otherwise terminate under the plan (for any reason other than replacement of group coverage), she may continue coverage through such plan for a period up to six months after pregnancy ends. Coverage continuation will cease if the member does not pay the premium, becomes eligible for another group plan or becomes eligible for Medicare.

Family Medical Leave Act (FMLA)

The FMLA requires covered employers to grant eligible employees up to 12 weeks of unpaid leave each year because of:

- The birth, adoption or placement in foster care of a child.
- The employee's own serious health condition.
- The care for a child, spouse or parent with a serious health condition.

A serious health condition is a period of incapacity of more than three consecutive calendar days that also involves:

- Treatment by a health care provider two or more times.

- Treatment by a health care provider on at least one occasion which results in a regimen of continuing care.

A condition lasting fewer than four days is also considered to be a serious health condition if it involves:

- Inpatient care.
- Any period of incapacity due to pregnancy (pre-natal care).
- A serious or ongoing condition that may cause periodic absences of less than four days such as migraines, asthma, chemotherapy, diabetes, etc.

The employer must maintain any group health benefits as if the employee had not taken any leave and restore the employee to the same or an equivalent position if and when the employee returns to work. Covered employers are those with 50 or more employees within a 75 mile radius of the employer's work site. Eligible employees must have worked for the employer for at least 12 months and have worked at least 1,250 hours.

Leave of Absence (other than FMLA)

Coverage for an employee and dependents can be continued during a leave of absence if:

- The employer continues to consider the subscriber as an employee and all other group benefits are continued as well as the medical benefits.
- The leave of absence is for a specific period of time established before the leave of absence began.
- The purpose of the leave of absence is known.
- **The leave of absence does not last longer than six months. If the leave lasts longer, the employee should be offered COBRA or State Continuation Coverage.**
- The leave of absence is for military service covered under USERRA. For detailed information on USERRA, refer to Employees Returning from Military Service/Reinstatement of Coverage section.

Benefits after Coverage Ends

An employee or dependent may receive benefits after his or her coverage ends due to termination of an employer's group agreement and he or she is hospitalized on the day coverage ends. Under most EOCs, he or she will receive hospital benefits for up to 60 days or until the member is discharged, whichever occurs first.

Funding Options and Related Underwriting Guidelines

BlueCross offers a variety of funding options that large employers may utilize to fund their group medical, dental and vision coverage including fully insured, self-funded and dual-funding. Availability of funding options is based on the ACA definition of group size, the number of participating employees and the type of coverage.

Fully Insured Funding Arrangements

Six fully insured funding arrangements are available to large groups based on the number of participating employees and type of coverage:

- Standard Fully Insured
- Risk Share Participating Arrangement/Threshold Risk Share Participating Arrangement
- Limited Participating Arrangement/Threshold Limited Participating Arrangement
- Surplus Reward Participating Arrangement/Threshold Surplus Reward Participating Arrangement
- Deferred Premium
- Delayed Premium

Rate Tier Structure for Fully Insured Groups

Fully insured large employer group plans include composite rating. Plans with less than 26 subscribers are required to have a four-tier composite rate structure (i.e. employee only, employee/spouse, employee/child(ren) and family). Plans with 26+ subscribers may also request two-tier (employee only and family) and three-tier (employee only, two person for employee and one dependent, and family) composite rates. Renewals are produced with the plan's current rate tier structure unless the group has dropped below 26 subscribers. If this happens, the renewal will be produced with a four-tier rate structure. Plans with 26+ subscribers may change rate tier structure at renewal. For groups with multiple products (i.e. medical, dental and/or vision) and differing number of subscribers, a group my desire to have all products with the same rate tier. Requests to match rate tiers requires Underwriting approval. Rate tier changes are not allowed off renewal.

Employer Contribution Requirements / Employee Participation Requirements for Groups with Fully Insured Coverage

Refer to the chart below for complete guidelines.

Fully Insured Contribution and Participation Requirements for 2025

Medical	Contribution Requirement	Participation Requirement
Small Employer EHB New Groups with January Effective Date	0% [1]	No minimum requirement[1]
Small Employer EHB New Groups with February – December Effective Dates	0% [2]	50% of net eligible [5]
Small Employer EHB Existing Groups	0% [2]	50% of net eligible [5]
Large Employer NonEHB New Groups	0% [3]	No minimum requirement[3]
Large Employer NonEHB Existing Groups	50% of employee only rate [4]	50% of net eligible [5]

Dental Plans	Contribution Requirement	Participation Requirement
Small Employer EHB Supplemental Plans New and Existing Groups	25% of the employee only rate for Non-Voluntary plans 0% for Voluntary plans	No minimum requirement
Large Employer NonEHB New and Existing Groups	For Traditional plans, 50% of the employee only rate for virgin groups and 0% for takeover groups. For Select plans, 0%.	For Traditional plans, 50% of total eligible and for Select plans, 20% of total eligible both with an absolute minimum of –two subscribers (or five subscribers for stand-alone coverage)

Vision Plans	Contribution Requirement	Participation Requirement
Small Employer EHB Supplemental Plans New and Existing Groups	50% of the employee only rate for Non-Voluntary plans 0% for Voluntary Plans	No minimum requirement
Large Employer NonEHB New and Existing Groups	50% of the employee only rate for Non-Voluntary plans 0% for Voluntary plans	For groups with 10 or less employees, 50% of total eligible. For groups with 10+ employees, minimum of two subscribers. (For stand-alone coverage, an absolute minimum of five subscribers required)

[1]Since the Affordable Care Act (ACA) requires that all new small employer group business is guaranteed issue during an open enrollment period each year (November 1 – December 15), carriers may not impose contribution or participation requirements during this time.

[2]The ACA permits carriers to impose contribution requirements for small employer new groups with February – December effective dates and existing groups; however BlueCross has elected not to do so.

[3] The ACA requires that all new large employer group business is guaranteed issue. Carriers may not impose contribution or participation requirements.

[4]For groups with more than one medical plan, the contribution requirement is 50 percent of the employee only rate for the lowest priced plan.

[5] Valid waivers include group coverage through a spouse or parent, Medicare, TennCare, military coverage or individual coverage (on or off the Marketplace). New small employer groups with February through December effective dates should provide waivers at initial enrollment if enrollment is less than 50- percent of total eligible employees.

Example Participation Calculation:
30 total eligible employees
10 employees waive because of group coverage through a spouse
20 net eligible employees

(30 – 10) x 50% = 10 Participation requirement: 10 employees

Standard Fully Insured Funding Arrangement	
Group Availability	**The standard fully insured funding arrangement is available to any new or renewing large group with medical, dental and/or vision coverage.**
Description/ Rate Calculation	BlueCross assumes all risk and the group pays a pre-determined, fixed monthly premium which covers all claims, expenses and taxes incurred during the policy period. Groups will incur no liability due to run-out claims if the group changes carriers. Medical The rating methodology used is based upon the number of participating employees. Premiums are developed based on adjusted community rating with a two-year credibility adjustment until a group's claims experience becomes 100 percent credible. Once full credibility is attained, rates are based solely on the group's own experience. Due to the amount of credibility assigned, groups with 151+ subscribers are referred to as individually experience rated groups (i.e. IER). Dental For groups with less than 151 participating employees, premiums are developed based on adjustment community rating. For groups with 151 – 499 participating employees, premiums are developed based on adjusted community with a two-year creditability adjustment. For groups with 500+ participating employees, this same method is used until a group's claims experience becomes 100 percent credible (i.e. 750 members and two full years of claims experience). Once full credibility is attained, rates are based solely on the group's own experience. Vision VisionBlue rates are pooled rates.
Rate Guarantee/Term of Arrangement	Medical Rates for new groups and renewals are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. Dental Rates for new and renewing groups with less than 151 participating employees are guaranteed for 24 months assuming no benefit or significant enrollment changes occur. For new and renewing groups with 151+ participating employees, dental rates are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. Vision Rates for new and renewing groups are guaranteed for 24 months assuming no benefit or significant enrollment changes occur. For All Coverages The fully insured arrangement is considered an on-going arrangement. Groups will automatically renew as fully insured unless they request to convert to another funding arrangement.
Special Premium Agreement	No additional or special agreement is required other than the standard fully insured group agreement
Penalties for Late Premium Payments	BlueCross may impose a finance charge of one and one-half percent per month. The finance charge applies to the amount of any premium not remitted on or before the first day of any billing period after the expiration of the grace period.
Initial Payment Required	An initial payment equal to the first month's premium is required. An advance deposit may also be required based upon the group's financial status.

Risk Share Participating/Threshold Risk Share Participating Arrangement	
Group Availability	**The Risk Share Participating/Threshold Participating arrangements are available to new and renewing large groups with 100+ participating employees for medical coverage only. This arrangement is not available for dental and vision coverage.**
Description/Rate Calculation	The Risk Share Participating funding arrangement maintains all the features and characteristics of a standard fully insured arrangement except as noted below. The billed rate* is set at 5% - 10%** *lower* than the standard fully insured rate while a maximum contract rate is established at 5% - 10%** *higher* than the standard fully insured rate. At year-end, an annual settlement is performed which compares the amount of incurred claims and administrative costs to the amount of discounted premium paid. If incurred claims and administrative costs are less than discounted premium paid, the group *is not* charged additional premium. If incurred claims and administrative costs are more than discounted paid premium, the group *is* charged additional premium. The additional premium charged is the *lesser* of the difference between incurred claims/administrative costs and discounted paid premium or the maximum liability amount (i.e. the amount of premiums that would have been paid if the maximum contract rates were billed instead of the discounted rates). The Threshold Risk Share Participating is the same as the Risk Share Participating except for the way the annual settlement is calculated. In the Threshold Participating arrangement, claims for members that exceed a set pooling level are excluded from the annual settlement. **Note: COBRA beneficiaries are billed the standard fully insured rate plus 2% each month.* ***BlueCross assigns the discounted rates and maximum contract rates based on group specifics.*
Rate Guarantee / Term of Arrangement	Medical rates for new and renewing groups are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. The Risk Share Participating arrangement is a one-year arrangement. Upon renewal, the Risk Share Participating arrangement will automatically convert to a standard fully insured arrangement. However, with BlueCross approval, groups may renew with a new Risk Share Participating arrangement for one additional year only.
Special Agreement Required	In addition to the standard fully insured group agreement, a special premium agreement is required and must be signed prior to the effective/renewal date.
Additional Charges	Retention is increased to include an additional risk charge and a charge for the loss of investment income. There is also the potential that the group may be billed additional premium up to the maximum liability amount after the year-end settlement is prepared.
Penalties for Late Premium Payments or Premature Termination of Agreement	Should the group fail to timely remit the premium due at any time during the term of arrangement, BlueCross shall have the right to immediately terminate the arrangement and demand payment of the maximum contract rate amount from group. The amount due at this time shall be the contract rate amount, less the billed rate amount already paid by group and received by BlueCross. The amount due shall include only monies that are due and payable to BlueCross from the beginning of the term of arrangement through the date of termination. Premiums shall be deemed timely if received by BlueCross within the established grace period. Premature termination of the agreement shall trigger an early settlement calculation to determine if additional premium is due to BlueCross.
Initial Payment Required	An initial payment equal to the first month's premium is required. An advance deposit or ACH Debit payment may also be required based upon the group's financial status.

Surplus Reward Participating/Threshold Surplus Reward Participating Arrangement	
Group Availability	**The Surplus Reward Participating/Threshold Surplus Reward Participating arrangements are available to new and renewing large groups with 100+ participating employees for medical coverage only. This arrangement is not available for dental and vision coverage.**
Description/Rate Calculation	The Surplus Reward Participating funding arrangement maintains all the features and characteristics of a standard fully insured arrangement except as noted below. The billed rate* is set at 5% - 10%** *higher* than the standard fully insured rate while a minimum contract rate is established at 5% - 10% *lower*** than the standard fully insured rate. At year-end, an annual settlement is performed which compares the amount of incurred claims and administrative costs to the amount of premium paid. If incurred claims and administrative costs are more than the premium paid, the group *is not* charged additional premium. If incurred claims and administrative costs are less than the paid premium, the group is eligible for a refund. The amount of refund is the *lesser* of the difference between incurred claims/administrative costs and paid premium or the minimum liability amount (i.e. the amount of premiums that would have been paid if the minimum contract rates were billed). The Surplus Reward Threshold Participating is the same as the Surplus Reward Participating except for the way the annual settlement is calculated. In the Threshold Surplus Reward Participating arrangement, claims for members that exceed a set pooling level are excluded from the annual settlement. **Note: COBRA beneficiaries are billed the standard fully insured rate plus 2% each month.* ***BlueCross assigns the billed rates and minimum contract rates based on group specifics.*
Rate Guarantee / Term of Arrangement	Medical rates for new and renewing groups are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. The Surplus Reward Participating arrangement is a one-year arrangement. Upon renewal, the Surplus Reward Participating arrangement will automatically convert to a standard fully insured arrangement. However, with BlueCross approval, groups may renew with a new Surplus Reward Participating arrangement for one additional year only.
Special Agreement Required	In addition to the standard fully insured group agreement, a special premium agreement is required and must be signed prior to the effective/renewal date.
Penalties for Late Premium Payments or Premature Termination of Agreement	Should the group fail to timely remit the premium due at any time during the term of arrangement, BlueCross shall have the right to immediately terminate the arrangement and demand payment from group. Premiums shall be deemed timely if received by BlueCross within the established grace period. Premature termination of the agreement shall trigger an early settlement calculation.
Initial Payment Required	An initial payment equal to the first month's premium is required. An advance deposit or ACH Debit payment may also be required based upon the group's financial status.

Limited Participating/Threshold Limited Participating Arrangement	
Group Availability	**The Limited Participating/Threshold Limited Participating arrangements are available to new and renewing large groups with 100+ participating employees for medical coverage only. This arrangement is not available for dental and vision coverage.**
Description/Rate Calculation	The Limited Participating funding arrangement maintains all the features and characteristics of a standard fully insured arrangement except as noted below. The billed rate* equals the standard fully insured rate. BlueCross will also establish minimum contract rates that are 5% - 10% *lower* than the standard fully insured rates and maximum contract rates that are 5% - 10% *higher*** than the standard fully insured rate. At year-end, an annual settlement is performed which compares the amount of incurred claims and administrative costs to the amount of premium paid. If incurred claims and administrative costs are more than paid premium, the group *is* charged additional premium. The additional premium charged is the *lesser* of the difference between incurred claims/administrative costs and paid premium or the maximum liability amount (i.e. the amount of premium that would have been paid if the maximum contract rates were billed). If incurred claims and administrative costs are less than the paid premium, the group is eligible for a refund. The amount of refund is the *lesser* of the difference between incurred claims/administrative costs and paid premium or the minimum liability amount (i.e. the amount of premiums that would have been paid if the minimum contract rates were billed). The Limited Threshold Participating is the same as the Limited Participating except for the way the annual settlement is calculated. In the Limited Threshold Participating arrangement, claims for members that exceed a set pooling level are excluded from the annual settlement. **Note: COBRA beneficiaries are billed the standard fully insured rate plus 2% each month.* ***BlueCross assigns the minimum and maximum rates based on group specifics.*
Rate Guarantee / Term of Arrangement	Medical rates for new and renewing groups are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. The Limited Participating arrangement is a one-year arrangement. Upon renewal, the Limited Participating arrangement will automatically convert to a standard fully insured arrangement. However, with BlueCross approval, groups may renew with a new Limited Participating arrangement for one additional year only.
Special Agreement Required	In addition to the standard fully insured group agreement, a special premium agreement is required and must be signed prior to the effective/renewal date.
Penalties for Late Premium Payments or Premature Termination of Agreement	Should the group fail to timely remit the premium due at any time during the term of arrangement, BlueCross shall have the right to immediately terminate the arrangement and demand payment of the maximum contract rate amount from group. The amount due at this time shall be the contract rate amount, less the billed rate amount already paid by group and received by BlueCross. The amount due shall include only monies that are due and payable to BlueCross from the beginning of the term of arrangement through the date of termination. Premiums shall be deemed timely if received by BlueCross within the established grace period. Premature termination of the agreement shall trigger an early settlement calculation.
Initial Payment Required	An initial payment equal to the first month's premium is required. An advance deposit or ACH Debit payment may also be required based upon the group's financial status.

	Deferred Premium (For School Groups Only)
Group Availability	**The Deferred Premium arrangement is only available to large school groups with 100+ participating employees. It may be offered with medical, dental and/or vision coverage.**
Description/Rate Calculation	The Deferred Premium funding arrangement (i.e. 12 paid in 10) maintains all the features and characteristics of a standard fully insured arrangement except as noted below. School groups may request this arrangement due to the school year being set on a 10-month basis instead of a 12-month basis like other employer groups. The highlight of the deferred premium arrangement is that the school group will pay no premium for two consecutive months (i.e. deferral months) during the contract year. The group may choose the two consecutive months for which premiums do not have to be paid. The premium paid for the remaining 10 months of the contract year is increased to cover the two-month loss of premium**.**
Rate Guarantee/Term of Arrangement	Medical rates for new and renewing groups are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. Dental rates for new and renewing groups with less than 151 participating employees are guaranteed for 24 months assuming no benefit or significant enrollment changes occur. For new and renewing groups with 151+ participating employees, dental rates are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. With BlueCross approval, dental rates may be extended to 24 months. Vision rates for new and renewing groups are guaranteed for 24 months assuming no benefit or significant enrollment changes occur. For all coverage, the Deferred Premium arrangement is considered an on-going arrangement. Groups will automatically renew with this arrangement unless they request to convert to another funding arrangement.
Special Premium Agreement	In addition to the standard fully insured group agreement, a special premium agreement is required and must be signed prior to the effective date. A new agreement is also required at each renewal if the deferred premium arrangement is renewed.
Penalties for Late Premium Payments or Premature Termination of Agreement	Should the group fail to timely remit the premium due at any time during the term of arrangement, BlueCross shall have the right to immediately terminate the arrangement and demand total payment from group. The amount due at this time shall be the 12-month premium amount less the 10-month premium amount already paid by the group and received by BlueCross. The amount due shall include only monies that are due and payable to BlueCross from the beginning of the term of arrangement through the date of termination. Premiums shall be deemed timely if received by BlueCross within the established grace period. BlueCross shall also have the right to demand payment of the contract rate from the group for premature termination of the agreement by the group.
Initial Payment Required	An initial payment equal to the first month's premium is required. An advance deposit may also be required based upon the group's financial status.

Delayed Premium	
Availability	**The Delayed Premium arrangement is available to new and renewing large groups with 100+ participating employees with medical coverage only. The Delayed Premium arrangement is not available for dental and vision coverage.**
Description/Rate Calculation	This funding arrangement maintains all the features and characteristics of a standard fully insured arrangement except as noted below. The Delayed Premium arrangement allows a group to pay no health premiums (including COBRA administration fees and the medical portion of the binder check) for the first two months of the contract year. Beginning with the third month of the plan year, the group is billed for the current 12-month fully insured rates plus 10 percent of the total outstanding balance from the first two months of the plan year. This arrangement is especially advantageous for a group that is converting from a self-funded arrangement to a fully insured arrangement and has run-out claims.
Rate Guarantee/Term of Arrangement	Medical rates for new and renewing groups are guaranteed for 12 months assuming no benefit or significant enrollment changes occur. The Delayed Premium arrangement is a one-year arrangement only. Upon renewal, the delayed premium arrangement will automatically convert to a standard fully insured arrangement.
Special Premium Agreement	In addition to the standard fully insured group agreement, a special premium agreement is required and must be signed prior to the effective date.
Additional Charges	Retention is increased to include a charge for the loss of investment income.
Penalties for Late Premium Payments or Premature Termination of Agreement	Should the group fail to timely remit the health premium due at any time during the term of arrangement, BlueCross shall have the right to immediately terminate the arrangement and demand the total payment from the group. The amount due at this time shall be the 12-month health premium amount less any health premium already paid by the group and received by BlueCross. The amount due shall include only monies that are due and payable to BlueCross from the beginning of the term of arrangement through the date of termination. Health premiums shall be deemed timely if received by BlueCross within the established grace period. BlueCross shall also have the right to demand payment of the contract rate from the group for premature termination of the agreement by the group.
Initial Payment Required	An initial payment *is not* required for health premiums. However, an initial payment equal to the first month's ancillary premium (if any) *is* required. An advance deposit may also be required based upon the group's financial status.

Self-Funded Arrangements

Five self-funded arrangements are available to large groups based on the number of participating employees and type of coverage:

- Self-Funded Traditional
- Self-Funded with Mandatory Stop Loss Coverage
- Performance Based Administration
- Fixed Funding
- Fixed Funding with Mandatory Terminal Liability Coverage
- Intermediate Level Funding

Self-Funded Billing

ACH Debit, or Automated Clearing House Debit, is the required self-funding billing option. This billing option is an automatic weekly debiting arrangement that allows BlueCross to debit any federally chartered bank account or credit union authorized by the group within 24 hours of initiation. BlueCross is authorized to directly debit the group's account for the weekly invoiced amount. Each week, BlueCross will submit an invoice to the group, which lists the amount of claims paid the prior week, and simultaneously initiate an ACH Debit for the amount due. The debit will clear the group's account the following business day. Administrative fees are invoiced monthly.

	Self-Funded Traditional
Availability	**Available to new or renewing large groups with 50+ participating employees with medical, dental and/or vision coverage.**
Description / Fee and Funding Level Calculation	The self-funded arrangement is an arrangement in which BlueCross acts as a claims administrator and in return, the group reimburses BlueCross monies to cover incurred claims plus an administrative fee. As opposed to a fully insured arrangement, the group assumes all the risk in a self-funded arrangement. Groups who choose a self-funded arrangement are not required to meet certain ACA mandates or pay certain taxes. Administration fees and any BlueRe stop-loss coverage premiums are billed monthly. Claims are billed weekly. Administrative services are calculated via BlueCross's expense recovery formula and based on requested services. Funding levels are developed solely on the most recent 24 months of group claims experience (90 percent weight is assigned to the most recent 12 months of experience and 10 percent weight assigned to the oldest 12 months of experience).
Stop Loss Coverage	For groups with 151+ employees: Recommended but not required. For groups with 50 – 151 employees: Proof of both specific and aggregate stop loss coverage required. Both specific and aggregate stop loss coverage is available through BlueRe.
Fee Guarantee / Term of Arrangement	Unless otherwise noted, administrative fees for new groups and renewals are guaranteed for twelve months (assuming no benefit/service changes or enrollment changes greater than 10 percent). BlueCross may extend the fee guarantee beyond 12 months on a case by case basis. The traditional self-funded arrangement is considered an on-going arrangement. Groups will automatically renew with this arrangement unless they request to convert to another financial arrangement.
Special Premium Agreement	Administrative Services Agreement required.
Penalties for Late Premium Payments	If BlueCross does not receive the full amount of administrative fees and/or claim payments by the due date, BlueCross may immediately suspend payment of all approved claims on behalf of the group; regardless of the date claims were incurred, until all amounts due are received by BlueCross. If BlueCross does not elect to suspend claim payments on behalf of the group, the group shall pay a late payment penalty of one percent per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.
Initial Payment Required	An initial payment equal to the first month's administrative fees is required. An advance deposit may also be required based upon the group's financial status.

Performance Based Administration (PBA)	
Availability	**This arrangement is available to new and renewing large groups with 151+ participating employees who have a traditional self-funded arrangement. Performance Based Administration only applies to medical coverage.**
Description/Fee and Funding Level Calculation	With Performance Based Administration, the group pays an administrative fee based on provider contract savings (i.e. discounts) delivered by BlueCross. An administrative fee scale is developed based on estimated savings – the higher the estimated savings, the higher the administrative fee. Each month during the plan year, the group remits a base administrative fee, which approximates the current fee or "market levels." At the end of the plan year, the actual savings delivered by BlueCross are determined. If BlueCross delivered greater savings than the original estimated savings associated with the base administrative fee, the group must remit the difference in administrative fees between the base fee and the fee associated with actual savings. Claims billing and funding levels are handled the same as a traditional self-funded arrangement.
Stop Loss Coverage	Not required but recommended through BlueRe
Fee Guarantee / Term of Arrangement	Performance Based Administration is considered a one-year arrangement only. Groups will automatically convert to a standard self-funded arrangement at renewal.
Special Premium Agreement	In addition to the standard Administrative Services Agreement (ASA), a special exhibit to the ASA is required and must be signed before the effective date.
Penalties for Late Premium Payment	If BlueCross does not receive the full amount of administrative fees and/or claim payments by the due date, BlueCross may immediately suspend payment of all approved claims on behalf of the group; regardless of the date claims were incurred, until all amounts due are received by BlueCross. If BlueCross does not elect to suspend claim payments on behalf of the group, the group shall pay a late payment penalty of one percent per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.
Initial Payment Required	An initial payment equal to the first month's administrative fees is required. An advance deposit may also be required based upon the group's financial status.

	Fixed Funding Arrangement	Fixed Funding with Terminal Liability
Availability	**Available to new and renewing large groups with 100+ participating employees with medical coverage only.**	**Available to new and renewing large groups with 51 – 99 participating employees with medical coverage only.**
Description/ Fee & Funding Level Calculation	The Fixed Funding Arrangement is a self-funded arrangement with a special billing design similar to that of a fully insured account. Instead of the traditional self-funded billing arrangement where claims are reimbursed weekly and administrative fees paid monthly, groups with a Fixed Funding Arrangement pay a pre-established, fixed claim funding amount (i.e. monthly funding rate), an administrative fee (and a stop-loss fee if purchased form BlueRe) each month. Like fully insured rates, the funding rates are per contract per month rates and available in a two-, three- or four-tier rate structure. A settlement is conducted on a quarterly basis to reconcile the paid funding rates versus claims paid by BlueCross on the group's behalf. The monthly funding rates only include the estimated amount necessary to fund the group's claims. Reserves and administrative fees are not included in the monthly funding rates. If reinsurance is purchased through Blue Re (or BlueCross is provided with this claims information), claims reimbursed by aggregate or specific insurance are not used to determine the funding rates. Monthly funding rates are set at the beginning of the contract year and will not change during the initial 12-month contract year unless benefits change or a subsidiary, operation or class of employees is added, terminated or the number of employees fluctuates by more than 10 percent. The monthly rates may be adjusted at renewal. The monthly funding rates for renewals are based 100% on the group's own claims utilization. The quarterly settlement is conducted to reconcile gains or losses accumulated during the settlement period. Gains (i.e. fixed claim funding amounts paid by the group that are in excess of claim amounts paid by BlueCross on the group's behalf) are credited on the next monthly invoice. Losses (i.e. fixed claim funding amounts paid by the group that are less than claim amounts paid by BlueCross on the group's behalf) are billed on the next monthly invoice, as well. Reserves for incurred, but unpaid claims in the event of termination are not held by BlueCross and not included in the funding rates. The group is responsible for run-out claims liability. An estimate of run out reserves is provided with each Fixed Funding Arrangement quote. BlueCard fees are billed monthly ***in addition to*** the funding rates and administrative fees. However, BlueCard fees may be included in the self-funded administrative fee if requested and approved by BlueCross.	Fixed Funding with Terminal Liability is the same as regular Fixed Funding except as noted below: Groups must set up a terminal liability fund to pay run-out claims at the end of the contract. The terminal liability is collected during the first three months of the contract. The settlement is conducted only at year end. If there is a surplus, the group will only receive 80 percent of the difference. BlueCross keeps the remaining 20 percent to cover additional administrative expenses. A loss is billed on the next monthly invoice.
Stop Loss Coverage	Specific and aggregate stop loss coverage required through BlueRe for groups with 100 – 150 participating employees. Stop loss coverage is recommended but optional for groups with 151+ participating employees.	Specific and aggregate stop loss coverage as well as terminal liability is required through BlueRe.
Term of Arrangement	The Fixed Funding Arrangement is considered a one-year arrangement only. Groups will automatically convert to a standard self-funded arrangement at renewal. However, with approval, groups may renew with a new Fixed Funding Arrangement.	Same
Special Premium Agreement	In addition to the standard Administrative Services Agreement (ASA), a special exhibit to the ASA is required and must be signed before the effective date.	Same
Penalties for Late Premium Payments	If BlueCross does not receive the full amount of administrative fees, monthly funding rates, and/or the settlement amount by the due date, BlueCross may immediately suspend payment of all approved claims on behalf of the group; regardless of the date claims were incurred, until all amounts due are received by BlueCross. If BlueCross does not elect to suspend claim payments on behalf of the group, the group shall pay a late payment penalty of one percent per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.	Same
Initial Payment Required	An initial payment equal to the first month's administrative fees, stop-loss fees and monthly funding rates is required. An advance deposit may also be required based upon the group's financial status.	Same

Intermediate Level Funding

The following information provides a general overview of the intermediate level funding arrangement. For complete information regarding level funding, please refer to your BlueCross Sales or Account Executive.

Intermediate level funding is a special financial arrangement offered to healthy groups that meet certain criteria established by Actuary and Underwriting and the following eligibility requirements:

- For employer groups located in Tennessee: intermediate level funding is available to ACA large employer groups with a minimum of 10 enrolling employees with a maximum of 150 enrolling employees.

- For employer groups located in Walker, Dade and Catoosa counties in north Georgia: intermediate level funding is available to ACA large employer groups with a minimum of 5 enrolling employees and a maximum of 150 enrolling employees.

Intermediate level funding, which applies to medical and pharmacy coverage only, combines the advantages of being self-funded (i.e. less premium taxes and fewer benefit mandates) with the stability of a fully insured plan. Groups will pay one fixed payment each month that incorporates all the components required for self-funded (i.e. administrative expenses, stop loss protection and claims funding). If the group elects an HRA, HRA claims will be billed as usual. Tennessee employers may also purchase ancillary coverage such as dental or vision coverage; but those coverages must be on a traditional fully insured arrangement. With level funding, groups have the potential to share in a surplus at the end of the contract period if the group renews with BlueCross.

Stop Loss Protection

Stop loss protection is required through BlueRe and includes the following:

- Specific stop loss protection for a catastrophic claim from a single employee or dependent. Attachment point varies based on the number of enrolling employees.
- Aggregate stop loss protection against group level claims that exceed 120% of expected annual claims

Claims Funding

As noted above, with level funding, groups pay one fixed payment each month that incorporates claims funding. If at the end of the contract year, actual claims are less than expected, the group will share in the savings and receive money back after renewing. If actual claims are higher than the group's monthly payments, BlueCross will pay the difference. Please refer to the settlement section below.

Benefits

Medical

Groups with intermediate level funding may choose from any benefit plan that is available on the intermediate fully insured NonEHB platform. Benefit customization is not allowed. Pharmacy benefits may not be carved out. Plan year or calendar year benefit administration is available.

Level funding benefits include medical, pharmacy and wellness coverage with the same access to clinical management programs and consumer tools as our fully insured plans.

If the group elects an HRA, HRA claims will be billed as usual. For BlueCross' in house solution, claims will be billed for ACH Debit on a weekly basis (for the claims paid the prior week). Our preferred vendors offer HRA replenishment options that will be discussed during onboarding, and the most popular option is weekly replenishments. The vendors will bill for all HRA administration fees and claims per the agreed upon schedule.

Multi option guidelines apply and are the same guidelines for fully insured NonEHB groups. Intermediate level funding groups may only offer up to three medical benefit options. However, four options may be offered if two different benefit plans are offered on both networks P and S. For groups offering multi network, out of state members must select the rates associated with Network P. The same benefit differentials also apply for fully insured NonEHB group:

- The maximum allowed differential for options with the *same* network is 35%.
- The maximum allowed differential for *dual* options with *different* networks is 43%.

Dental and Vision

Tennessee employers who desire to purchase dental and vision coverage may purchase NonEHB DentalBlue and/or VisionBlue coverage on a fully insured arrangement. Standard underwriting guidelines such as participation, contribution, etc. apply. EHB supplemental dental and/or vision coverage may not be purchased if medical coverage is on the level funded arrangement. Fully insured dental plans are not available to Georgia employers.

Underwriting Guidelines

The following guidelines apply to intermediate level funded quotes:

- Underwriting approval is required before a level funding quote may be issued.
- Groups must meet the following eligibility requirements:
  - For Tennessee employers - ACA large employer groups with a minimum of 10 enrolling employees and a maximum of 150 enrolling employees
  - For Georgia employers located in Walker, Dade or Catoosa counties, ACA large employer groups with a minimum of 5 enrolling employees and a maximum of 150 enrolling employees
  - ERISA qualified plans only
  - Less than 10% COBRA enrollment
- Level funding quotes are not available to existing groups off renewal.
- Underwriting will review groups each year at renewal to determine if the level funding arrangement may continue for the next plan year.
- Level funded groups will be rated based on the group's previous claims experience.
- Good candidates for level funding include healthy groups seeking lower premiums.
- Groups will be medically underwritten. Prospect groups must submit a medical questionnaire. The questionnaire not required for renewing groups as current claims information will be utilized.
- **Underwriting may revise or withdraw the proposal if any of the information upon which these rates or benefits were based changes or is inaccurate. This includes**

Medical History and census changes (if number of employees who enroll are 15% different than the number of employees who were quoted)

- ACH Debit billing required
- Broker commissions follow the standard fully insured commission schedule based on the number of employees and is included in the group's monthly payment as part of the administrative fee.
- No other carriers/coverage will be offered to employees. No supplemental or gap plans will be offered which reduce any portion of the member out of pocket liability.
- **Underwriting reserves the right to either decline to quote or revise the monthly rate if any of the following occur at initial enrollment of the level funding arrangement:**
    - **Less than the minimum number of employees enroll**
    - **A 15% difference in census when comparing the number of employees used to generate the level funded quote and the number of employees who enroll**
- Participation requirements – Intermediate level funding participation requirements are the same as intermediate fully insured NonEHB except for the following:
    - For Tennessee employers - minimum of 10 enrolling employees required
    - For Georgia employers - minimum of 5 enrolling employees required

- Employer Contribution requirements – Intermediate level funding contribution requirements are the same as intermediate fully insured NonEHB.
- For quotes that include multiple businesses, Underwriting approval is required and submission of the Single Employer Verification Form.

Audit

All intermediate level funding sales will be audited by Underwriting Policy & Procedure staff to ensure compliance with all general and level funded specific underwriting guidelines. Underwriting reserves the right to either decline to quote or revise the monthly rate if any of the following occur:

(1) Less than minimum number of employees enroll
(2) A 10% or more increase in employees when comparing the actual employees used to generate the level funded quote and the actual employees who enroll
(3) A 15% or more decrease in employees when comparing the actual employees used to generate the level funded quote and the actual employees who enroll
(4) Any gross violation of underwriting guidelines as deemed necessary by Underwriting and Audit staff

Billing

A binder check is required for new to Blue groups. A binder check is not required for an existing group converting to the level funded arrangement.

ACH Debit billing required for both new groups and existing groups. BlueCross will generate the monthly bill around the 15th of the month for the following month due date. The ACH direct debit for the monthly payment will take place on the first business day of the following month. Along with the monthly bill, a YTD reconciliation of claims experience vs payments will be provided. If fully insured dental and/or vision coverage is purchased, these coverages will be set up on ACH debit billing as well. If the group elects an HRA, HRA claims will be billed as usual.

Settlement Process
The final reconciliation process will occur during the fourth month after the end of the contract year (or during the 16th month after the coverage begin date). The group will receive an email notification after the 16th month indicating if they earned a surplus. The group must still be in force with BlueCross in order to receive the surplus, which will be in the form of a credit on their next monthly bill. The group will share in a percentage of the surplus amount (i.e. 50%) according to their contract. The group has no further obligations if they are not in a surplus position.

BlueCross will compare the group's total net paid claims and the groups total aggregate funding to determine if there is a surplus. After the three-month run out period, net paid claims will be adjusted by enrollment retroactivity and the terminal reserve fee.

Terminal reserves are calculated and retained by BlueCross to pay for claims that were incurred during the contract year but are not paid until after the settlement. The terminal reserve will be used to cover the run out claims from the 16th month onward so that the group has no further liability for runout claims for the contract year.

> *Example: If a hospital claim was incurred in June 2023, the last month of the contract period, and it was not processed until October 2023, the group will not be responsible for the claim. BlueCross assumes the liability and will use the terminal reserves to pay the claim.*

Dual Funding

A dual-funded arrangement is a financial arrangement in which certain products or benefits are fully insured and others are self-funded *under a single group number with one group billing and one ID card.* A dual-funded arrangement can take many forms. For example, a group can fully insure their medical coverage and self-fund their dental coverage. The following guidelines apply:

- Only large groups with a minimum of 151 participating employees are eligible for a dual-funded arrangement.

- The following benefits may be dual-funded (subject to approval):
    - Medical
    - Dental
    - Vision

- BlueCross approval is required.

- Standard underwriting guidelines based on the specific type of funding apply to *each* dual funded product/benefit (i.e. If medical coverage is self-funded and dental is fully insured, participation/contribution, etc. guidelines apply to dental, but not to medical.)
- Available benefit options based on the specific type of funding apply to *each* dual funded product/benefit (i.e. If medical coverage is self-funded and dental is fully insured, any self-funded medical option may be quoted. However, only those benefit

options available to fully insured groups may be quoted for dental.)

- Required quote information based on the specific type of funding applies to *each* dual funded product/benefit (i.e. If medical coverage is self-funded and dental is fully insured, claims information is required for dental but not for medical.

Assessment of a Health Plan's Minimum Value for Fully Insured and Self-Funded Plans

For applicable large employers (i.e. those employers subject to the ACA Employer Responsibility play or pay penalties), a penalty or tax may be assessed by the government if the coverage offered to full-time employees does not meet the minimum value standard of 60% and/or does not include substantial coverage of inpatient hospital services and physician services. Minimum value is the expected percentage of medical claims that a plan will pay on average. Meeting the minimum value standard of 60% means the group health plan, on average, will cover at least 60% of eligible claims.

While the employer is ultimately responsible to determine if the group health plan meets the minimum value standard, BlueCross will assist fully insured plans when possible by using the MV Calculator, a calculator made available by HHS and the IRS that may be found on the Centers for Medicare and Medicaid Services website, to assess the plan's value. Self-funded plans will be responsible for determining if their plan meets the minimum value standard and will be responsible for indicating their result on the Summary of Benefits and Coverage (SBC).

For fully insured plans, a Minimum Value Reference Guide is available to help identify plan designs that meet minimum value. Please refer to the Large Group Product Guide for this reference information. In general, BlueCross will not provide actuarial certification of minimum value. However, an actuarial certification is available on request for plans identified in the Large Group Product Guide that meet the minimum value standard only if the preventive drug copay option is included. If an employer disagrees with BlueCross's assessment of their fully insured plan, the employer may input its information in the MV Calculator directly or contact a third party such as an actuarial consulting firm to value the plan.

Common Ownership / Single Employer Verification for Fully Insured and Self-Funded Plans

Establishing common ownership when quoting more than one business/group together under a single policy is essential in order to establish premium liability with a valid contract and comply with the ACA, ERISA and Internal Revenue Code (IRC) definitions of a single employer/control group, as well as BlueCross BlueShield Association marketing/national account guidelines (i.e. out of state locations, subsidiaries, etc. must be wholly owned by the policyholder).

In order to include more than one business on a single policy, the combined group must meet the requirements of a single employer/control group as defined by section 414 (b), (c), (m) or (o) of the IRC. These regulations are also referred to as the aggregation rules. The aggregation rules are very complex; therefore groups must consult their own tax/legal advisors regarding whether or not they qualify as a single employer. BlueCross cannot make this determination for them.

Verification of Common Ownership for Groups with Less Than 151 Employees

Any new group who wants to include more than one business under a single policy, as well as any existing group who wants to add a business to their policy, should submit the Single Employer Verification Form to BlueCross for review. This form should be completed and signed by the group administrator or officer. If any out of state businesses are included, BlueCross must also confirm that the policyholder has a headquarters in Tennessee via Dun & Bradstreet reports. Additional information may also be requested to verify ownership. Additional requirements and quote information apply to Affiliated Service Groups. Please see your BlueCross sales executive/account manager for more information.

Verification of Common Ownership for Groups with 151+ Employees

Any new or existing group that wants to include or add a commonly owned *small* employer group to their policy should submit the Single Employer Verification Form to BlueCross for review. This form should be completed by the group administrator or officer. For new and existing groups who want to include or add a commonly owned *large* employer group to their policy, the form may be required if BlueCross cannot verify ownership via D&B reports. If any out of state businesses are included, BlueCross must also confirm that the policyholder has a headquarters in Tennessee via Dun & Bradstreet reports. Additional information may also be requested to verify ownership. Additional requirements and quote information apply to Affiliated Service Groups and non-profit groups. Please see your BlueCross sales executive/account manager for more information.

Financial Review / Bankruptcy / Poor Payment History for Fully Insured and Self-Funded Groups

BlueCross must be notified if any existing or prospect group has filed for bankruptcy or is in bankruptcy. An advance deposit or ACH Debit billing may be required for any group in bankruptcy or with poor financials and/or poor payment history.

New Business Quote Requirements and Guidelines

Required Quote Information for Fully Insured Groups with less than 151 Enrolling Employees

The following underwriting information, which applies to new groups as well as existing groups adding coverage, is required for a fully insured large group quote with less than 151 enrolling employees. **Please note that prospect rates are not final until confirmed by BlueCross home office. BlueCross reserves the right to adjust rates if necessary if the enrolled census is +/-15 percent different than the quoted census.**

Required Quote Information for Fully Insured Large Employers with less than 151 Enrolling Employees	
Name and Address of Policyholder and All Other Businesses to be Included	• Group must have a business location and employees in Tennessee. • If including more than one business, the Single Employer Verification Form is required. • If quoting on the Tennessee location of a group with an out-of-state headquarters or if quoting on out-of-state employees/branches/businesses, etc., please see your BlueCross representative.
Number of Average Employees Employed During the Previous Calendar Year	Required to determine whether the group is a small or large employer so the appropriate rating and benefits are offered. This information will be verified by the Employer Group Application (EGA). **** Please note that if the employer attests in the EGA that they are a small employer; but a large employer Non-EHB quote was sold, the Non-EHB sale must be voided and an EHB quote issued. The reverse is also true.****
Census – For Medical and Dental only. Census not required for Vision only quotes. **All options should be rated with the same census.**	• **For Medical, need date of birth, gender and home zip code for all eligible employees. For Dental, need state of residence for all participating employees.** • Eligible employees include employees who have completed their waiting period, employees who are currently in their waiting period but will have completed their waiting period by the effective date, approved retirees and COBRA/State Continuation beneficiaries. • Carve out quotes (ex. Management-only quotes) should include only the eligible management employees in the census. • Rating is based only on those employees expected to enroll on the effective date**.** These employees are considered participating employees in the rating program and should be denoted by indicating coverage type. Non-participating employees should be denoted as life-only employees.

Required Quote Information for Fully Insured Large Employers with less than 151 Enrolling Employees (cont.)	
Census (cont.)	• Employees in their eligibility period would normally not be included as participating employees unless their eligibility period will be completed by the effective date and they desire to enroll. If the employee eligibility period will be waived on initial enrollment, include all new employees expected to enroll on the effective date as participating.
SIC (Standard Industrial Classification) – **Medical and Dental Only**	The SIC code that best reflects the group's nature of business should be used for rating purposes. If the DUNS SIC is not available or does not accurately reflect the group's nature of business, please contact your representative.
Underlying Plan / Funding Arrangement Verification Form – **Medical only**	For each medical quote, brokers/agents should complete and submit the Underlying Fund & Plan Verification Form at the beginning of the quoting process. Underlying plans or funding arrangements are any plan or funding arrangement that pays for or subsidizes any portion of member cost sharing for medical coverage. This would also include a Health Savings Account (HSA) and Health Reimbursement Account (HRA). If any information disclosed on the original form changes during the quoting process, a new form should be submitted.
Tax Certification	Required for groups with two to five enrolling employees. Refer to the Required Tax Documentation reference section for complete information.
Additional Medical Quote Information for Fully Insured Large Groups with less than 151 Enrolling Employees - The information listed below is not required for a quote to be issued. However, if it is not provided, BlueCross reserves the right to adjust quoted rates due to unknown risk.	
For Groups with Less than 26 Enrolling Employees: **Health Information for all employees enrolling for coverage** **Additional information such as medical records or attending physician statements may also be requested.**	• **Completed and signed Small Group Health Questionnaire (SGHQ)* for all employees and dependents enrolling for coverage**. The SGHQ should be completed, signed and dated by the employee. Marketing staff, brokers and group administrators may not complete or write on the SGHQ. A newly completed form is required if the original SGHQ is written on by any other person except the employee. Any explanations or additional information provided by Marketing staff, brokers, etc. must be noted on a separate sheet of paper and submitted with the SGHQ. Changes to the SGHQ may only be made by the employee and each change should be signed and dated. • **Completed and signed Diagnosis Detail Medical Questionnaire (DDMQ) for any employee or dependent with a "Yes" answer in Part A of the SGHQ or for any Part B conditions requiring three or more prescription medications or for which hospitalization was required during the past 12 months.** The DDMQ may be signed and dated by the employee broker or officer/authorized employee of the group. Any changes to the DDMQ must be initialed and dated. If changed by someone other than the original signor, the name and title of the person making the change must be included as well. Any explanations or additional information provided by Marketing staff, broker or group representative must be noted on a separate sheet of paper and submitted with the DDMQ. • Medical questionnaires with greater than 90 days between the employee signature date and the BlueCross received date may not be accepted. It is preferred that either a new questionnaire is obtained or a current signature and date on the old questionnaire must is obtained from the employee to ensure the information is still accurate and complete. • Employees and dependents with prior or current BlueCross coverage are still asked to complete the medical questionnaires.
For Groups with 26 – 150 Enrolling Employees:	• **Completed and signed Intermediate Group Medical Questionnaire (IGMQ) for all employees and dependents enrolling for coverage**. The IGHQ should be completed, signed and dated by an officer or authorized employee of the group (not the broker). Any changes to the questionnaire must be initialed and dated. If changed by an officer or authorized employee that was not the original signor, the name and title of the person making the changes must be included as well. Any explanations or additional information from the ASE or broker must be noted on a separate sheet of paper and

Health Information for all employees enrolling for coverage	submitted with the questionnaire. • **Completed and signed Diagnosis Detail Medical Questionnaire (DDMQ) for any group members with any conditions listed on the IGMQ.** The DDMQ should be signed and dated by the employee broker or officer/authorized employee of the group. Any changes to the DDMQ must be initialed and dated. If changed by someone other than the original signor, the name and title of the person making the change must be included as well. Any explanations or additional information provided by Marketing staff, broker or group representative must be noted on a separate sheet of paper and submitted with the DDMQ. The DDMQ is still requested for employees and dependents with prior or current BlueCross coverage. • An updated questionnaire may be requested if 90 days has expired from the original signature date of the questionnaire and the effective date of the group. If health conditions have changed, a new questionnaire will be requested. If health conditions have not changed, the original questionnaire may be resigned and dated by the original signor. • For groups with no current or prior coverage, BlueCross may request additional information such as **Abbreviated Health Questionnaires.** **Additional information such as medical records or attending physician statements may also be requested.**
Prior Carrier Renewal – For Groups with 26 – 150 Enrolling Employees	**The most recent prior carrier's renewal** should be submitted.
Experience Information – For groups with 26 – 150 Enrolling Employees	If **any** experience information is available, please submit for review, along with the **Group Health Questionnaire** (and **Detail Diagnosis** forms if applicable). <u>Experience Information List:</u> • A minimum of 8 months (18 months preferred) of claims experience (not older than six months) with contract counts and benefits for the period • Large claim information for all claims over $25,000 from the current carrier with diagnosis and any information to help determine the prognosis or status of individuals with conditions • A copy of the group's complete renewal package including current rates, renewal rates, and benefits <u>If a group is currently self-funded, please also provide the information below:</u> • Two policy years of paid claims (minimum of 18 months of experience information through the current month) • Two policy years of enrollment data (i.e. agg. report) • Large claims report reflecting claims at 50 percent of the group's specific stop loss level including diagnosis and prognosis for each member on the report. (If the current carrier does not provide this information or the information provided is not sufficient to evaluate potential future claims, drill downs will be required.) • Network information (if available) The above information should be provided on current carrier letterhead and specify the coverages included in the aggregate and specific and the contract type for each policy year (i.e. 12/12, 15/12, paid, etc.).

Additional Dental Quote Information for Fully Insured Large Groups with less than 151 Enrolling Employees - The information listed below is not required for a quote to be issued. However, if it is not provided, BlueCross reserves the right to adjust quoted rates due to unknown risk.	
Detailed Description of Current Benefits	• Covered services for Classes A – D • Coinsurance and deductible for each class A – D • Annual Maximum • Benefit waiting periods – length and applicable classes/benefits • Orthodontia – child only or child/adult, lifetime maximum, child age limit
Current and Renewal Rates	Especially important if experience information not available
Claims Experience	• Minimum of 12 consecutive months of claims experience no older than six months. • Number of enrolled employees by month to match the claims experience. If enrolled employees by month are not available, the number of enrolled employees at the beginning, middle and end of the experience period.
Employer Contribution	Current and proposed employer contribution for employee (and dependents if applicable)

Required Quote Information for Fully Insured Groups with 151+ Enrolling Employees

The following underwriting information, which applies to new groups as well as existing groups adding coverage, is required for a large group fully insured quote with 151+ enrolling employees. **Please note that prospect rates are not final until confirmed by BlueCross home office. Rating caveats may apply (i.e. BlueCross reserves the right to revise the quoted rates if enrollment increases or decreases by 10% or more). Please refer to the rate sheet for specific rating caveats.**

Fully Insured Required Quote Information for Large Employers with 151+ Enrolling Employees	
Name and Address of Policyholder and All Other Businesses to be Included	• Group must have a business location and employees in Tennessee. • If quoting on the Tennessee location of a group with an out-of-state headquarters or if quoting on out-of-state employees/branches/businesses, etc., please notify your BlueCross representative. • If including more than one business, please notify your BlueCross representative so common ownership/qualification as a single employer may be established. Additional information such as the Single Employer Verification Form may be required.
Number of Average Employees Employed During the Previous Calendar Year	Required to determine whether the group is a small or large employer so the appropriate rating and benefits are offered. This information will be verified by the Employer Group Application (EGA). **** Please note that if the employer attests in the EGA that they are a small employer; but a large employer Non-EHB quote was sold, the Non-EHB sale must be voided and an EHB quote issued. The reverse is also true.****
Census - For Medical and Dental. Census not required for Vision	• Need date of birth, gender and home zip code for all participating employees • All locations including in state and out of state with number of subscribers in each location and the city name
Underlying Plan / Funding Arrangement Verification Form – For Medical Only	For each medical quote, brokers/agents should complete and submit the Underlying Fund & Plan Verification Form at the beginning of the quoting process. Underlying plans or funding arrangements are any plan or funding arrangement that pays for or subsidizes any portion of member cost sharing for medical coverage. This would also include a Health Savings Account (HSA) and Health Reimbursement Account (HRA). If any information disclosed on the original form changes during the quoting process, a new form should be submitted.

Additional Medical Quote Information for Fully Insured Large Groups with 151+ Enrolling Employees - The information listed below is not required for a quote to be issued. However, if it is not provided, BlueCross reserves the right to adjust quoted rates due to unknown risk.	
Experience Information	• Eighteen consecutive months of claims experience no older than six months. If 18 months of experience is not available, then a letter on the current carrier's letterhead stating that the carrier does not provide experience must be provided along with current and renewal rates AND a completed Group Medical Questionnaire • Benefit description to match the experience periods • Number of subscribers (exposure) by month to match the experience period. If subscribers by month are not available, the minimum is subscriber count at the beginning, middle, and end of the experience period. • All claims over $25,000 with diagnosis (also prognosis if available) • Individuals not actively at work with claims amount and diagnosis/prognosis • Any participant (employee or dependent) with the following medical condition (whether or not they had claims that exceeded $25,000 – Do not provide names or identification): Hemophilia Transplant (potential, pending, active or recent) Neonatal Disorder High-Risk Pregnancy Renal Failure (acute or chronic) Brain or Spinal Injury Severe Burn or Trauma • Additional information may be requested based on group specifics. In certain situations, individual health questionnaires may be requested instead of the group health questionnaire when experience information is unavailable.

Additional Dental Quote Information for Fully Insured Large Groups with 151+ Enrolling Employees - The information listed below is not required for a quote to be issued. However, if it is not provided, BlueCross reserves the right to adjust quoted rates due to unknown risk.	
Detailed Description of Current Benefits	• Covered services for Classes A – D • Coinsurance and deductible for each class A – D • Annual Maximum • Benefit waiting periods – length and applicable classes/benefits • Orthodontia – child only or child/adult, lifetime maximum, child age limit
Current and Renewal Rates	Especially important if experience information not available
Claims Experience	• Minimum of 12 consecutive months of claims experience no older than 6 months. • Number of enrolled employees by month to match the claims experience. If enrolled employees by month are not available, the number of enrolled employees at the beginning, middle and end of the experience period.
Employer Contribution	Current and proposed employer contribution for employee (and dependents if applicable)

Required Self-Funded Quote Information for Large Groups for Medical, Dental and Vision Coverage

- Name and address of policyholder and all other businesses to be included
- Total number of eligible employees
- Census including date of birth, gender and home zip for all enrolling employees
- All locations including in state and out of state with the number of subscribers in each location and the city name
- Claims experience (i.e. 18 months of including matching benefits and enrollment is strongly encouraged if Performance Based Administration is quoted or if projected claims/suggested funding levels are requested.

Please note that BlueCross reserves the right to decline to quote a self-funded arrangement for any group if the group fails to provide the minimum quote information or has poor financial status (including but not limited to bankruptcy or poor payment history). Group specific quote caveats may apply such as changes in census.

Required Tax Documentation for Fully Insured Sales with 2 – 5 Enrolling Employees

Which Groups Must Be Certified?

- New groups purchasing medical coverage with less than 6 enrolling employees
- Existing groups adding medical coverage with less than 6 enrolling employees
- Existing Group Splits – If an existing group splits (on or off renewal) and any of the "new" groups have less than 6 enrolled employees; the "new" groups must be certified if medical benefits are offered

Who Must Be Certified?

- All subscribers enrolling in medical coverage must be certified.
- For groups enrolling 2 or less subscribers, all eligible and enrolling employees/owners must be certified.

What Documentation is Required?

Groups Enrolling 2 or Less Subscribers

- Groups should submit the most recent business tax documents and quarterly wage and tax report for *all enrolling and eligible subscribers*. A complete list of required information is outlined below.
- Groups should submit the Employee Certification Form for owners, 1099 workers and newly hired w2 employees not listed on the quarterly wage and tax report.

Groups Enrolling 3 – 5 Subscribers

- Groups should submit the Employee Certification Form for *all* enrolling subscribers.
- Groups should submit the most recent business tax documents and/or quarterly wage and tax report if only owners are enrolling.

For All Groups Enrolling Less than 6 Subscribers

- Groups with new hires (W2 employees and 1099 workers) not listed on the most recent tax documentation will be asked to complete a follow up audit at a later date to verify employee eligibility. New businesses who have not yet filed their annual business tax documentation at the time of sale may also be asked to complete a follow up audit at a later date, especially if only owners/partners/shareholders or husbands/wives enroll.
- If a payroll is required in addition to other documentation, the payroll must show all current employees and include the time frame of the payroll, wages and tax deductions. Handwritten payrolls or checks/check stubs are not acceptable. Handwritten quarterly wage and tax reports are also not accepted as the state of Tennessee requires electronic filing of all quarterly wage and tax reports.

Please note that our underwriting guidelines, in accordance with federal law, ***will require that a plan must have at least one common law employee (i.e. W2 employee) among its participants in order to be considered a group health plan.*** *Sole proprietors and his/her spouses, partners in a partnership (who do not qualify as a bona fide partner* pursuant to 45 CFR 146.145(c)(2)),and their spouses; as well as shareholders of a corporation (who do not also qualify as common law employees by also being considered a W2 employee), are not considered common law employees. Therefore, a plan whose enrollment consists only of sole proprietors, partners in a partnership (who do not qualify as a bona fide partner* pursuant to 45 CFR 146.145(c)(2), and their spouses; or shareholders of a corporation (who do not also qualify as common law employees by also being considered a W2 employee), is not eligible for group coverage.*

**A bona fide partner is a partner that performs services on behalf of the partnership.*

Tax documentation submitted should be the most recently filed information. Quarterly state wage and tax reports and federal 941 quarterly filings are due to the state/IRS as follows:

- 1st Quarter – Due April 30th
- 2nd Quarter – Due July 31st
- 3rd Quarter – Due October 31st
- 4th Quarter – Due January 31st

Business tax returns (including Schedule C for a sole proprietorship) are due by April 15th or March 15th depending upon the type of business. Six month tax extensions are generally available, which would extend the filing due date to September 15th or October 15th.

Confidentiality

All forms and tax documents submitted are considered confidential and proprietary and afforded the same protection and privacy as required by HIPAA for personal medical information. Tax information is reviewed only by Underwriting staff and used solely for verification of eligibility and participation guideline compliance. Documents are managed via a retention schedule developed and approved by BlueCross Legal department according to applicable state and federal laws. Documents are kept in secure storage facilities with limited access only by Underwriting. Once documents are no longer needed, they are destroyed. Duplicate copies of documents are destroyed prior to being placed in storage.

Required Tax Documentation Based on Type of Business/Employee	Existing Business *(In business one or more years)*	Newly Formed Business *(In business less than one year and not yet required to file tax documents)*
Employees *Employees must show earnings equivalent to 30 hours per week at minimum wage (or 20 hours per week if part-time employees covered) to be eligible for coverage.* *The Group Administer should mark employees as full-time, part-time, termed, etc. Job titles/classifications should also be listed for each employee for carve out/class outs.* *After all required notations are made; the Group Administrator should sign and date the tax form.* *Employer identification number / Federal Tax I.D. required.*	**One** of the **most recently filed** following documents required: • **Quarterly wage and tax report filed with the state** • **Outside vendor (ex. ADP) quarterly tax and payroll summary** • **IRS Form 941 *with matching payroll***	• **Employee Certification Form** *A follow-up audit is required to verify eligibility of employees of new businesses unable to provide tax documentation at time of sale.*
New Hires (W2 employees) *A follow-up audit is required to verify eligibility of new hires.*	• If not listed on the quarterly wage and tax report or 941 or if not showing full-time wages on these forms, **Employee Certification Form**	• **Employee Certification Form**
Sole Proprietor or Single Member LLC ***A non-spouse W2 employee must enroll for business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	• **Employee Certification Form** **and** • **Schedule C, E or F of IRS Form 1040** *The most recently filed tax form should be submitted. After April 15t, prior year's tax information must be accompanied by a copy of the filed IRS Form 4868 Application for Automatic Extension of Time to File.*	**Employee Certification Form and one** of the following documents: • **Business License** *(certain businesses may be exempt from obtaining a business license)* • **State of Tennessee or IRS letter assigning account/Employer Identification number** • **Cancelled business check** with the business name and address • **Copy of most recent bank statement with business name and address** *(account balances may be marked through for privacy)* • **Signed/dated LLC Operating Agreement** *A follow up audit may be required to verify eligibility of owners of new businesses unable to provide tax documentation at time of sale.*

Required Tax Documentation Based on Type of Business/Employee	Existing Businesses *(In business one or more years)*	Newly Formed Businesses *(In business less than one year and not yet required to file tax documents)*
Partner of a Partnership (including LLC member treated for tax purposes as a Partner of a Partnership) ***If only partners are enrolling, the partners must qualify as a bona fide partner pursuant to 45 CFR 146.145(c)(2)). Otherwise, a non-spouse W2 employee must enroll for business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	• **Employee Certification Form** **and** • **IRS Form 1065 with Schedule K-1** *The most recently filed tax form should be submitted. After April 15th, prior year's tax information must be accompanied by a copy of the filed IRS Form 7004 Application for Automatic Extension of Time to File.*	**Employee Certification Form and one** of the following documents: • **Signed/dated LLC Operating Agreement or Partnership Agreement** listing each partner and percentage owned • **Filed/stamped one page State of Tennessee Partnership form and a letter** on the group's letterhead listing each partner and percentage owned *A follow up audit may be required to verify eligibility of partners of new businesses unable to provide tax documentation at time of sale.*
Shareholder of a Corporation (including an LLC member treated for tax purposes as a shareholder of a corporation) *The most recently filed tax form should be submitted. After April 15t, prior year's tax information must be accompanied by a copy of the filed IRS Form 7004 Application for Automatic Extension of Time to File.* ***If only shareholders are enrolling, shareholders must also be W2 employees. Otherwise, a W2 employee must enroll for the business to be eligible for group coverage.*** *In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.*	**Employee Certification Form and one** of the following forms depending upon how the business files: • **<u>If a C corporation:</u> IRS Form 1120** *(If owners/officers with percentage of ownership not listed on Schedule E, include Articles of Incorporation or filed/stamped State of Tennessee Charter listing owners and percentage of ownership*) • **<u>If an S corporation:</u> IRS Form 1120-S with Schedule K-1** • **<u>If only shareholders enrolling,</u> shareholders should be listed on the quarterly wage and tax report filed with the state** or outside vendor (ex. ADP) quarterly tax and payroll summary	**Employee Certification Form and one** of the following documents: • **Signed/dated Articles of Incorporation or LLC Operating Agreement** listing each owner and percentage of ownership • **Filed/stamped one page State of Tennessee Charter** and letter on the group's letterhead listing each shareholder/member and percentage owned *If only shareholders are enrolling, they must attest on the Employee Certification Form that they are also W2 employees and a follow up audit will be conducted to verify eligibility.*
Independent Contractor *Must be considered a common law employee or Underwriting approval required.* *Must show earnings equivalent to 30 hours per week at minimum wage to be eligible for coverage.* ***A W2 employee must also enroll for the group to be eligible for coverage.***	• **Employee Certification Form** **and** • **IRS Form 1099-NEC**	**Employee Certification Form and one** of the following documents: • **Current payroll** • **Copy of work contract/agreement** *A follow up audit may be* required *to verify eligibility of 1099 workers unable to provide Form 1099-NEC at time of sale.*

The following special groups are required to submit the same information as a new or existing business listed above EXCEPT as noted below:

Farms	Groups with Leased Employees	Section 501(c)(3) Organizations
Farms may submit IRS Form 943 **with current payroll** in lieu of quarterly wage and tax report or IRS Form 941.	If a group with leased employees is unable to provide standard tax documentation for these employees, a letter on company letterhead explaining the employer/employee relationship and a current payroll should be submitted. The employer must be the common law employer of the leased employees. *A follow up audit is required to verify eligibility of employees of new businesses unable to provide tax documentation at time of sale.*	Groups should submit IRS Form 941 **with matching payroll** since they are exempt from unemployment taxes. Churches that are also exempt from FICA taxes as well as unemployment taxes should submit the most recent quarterly payroll *and* a copy of the filed IRS Form 8274. **If enrolling pastors only, pastors *must* be common law/W2 employees.**

Husband/Wife Group Eligibility and Required Tax Documentation

Husband/wife groups (i.e. a group with only a husband and wife enrolling) require approval from BlueCross prior to quoting. A follow up audit may be conducted for a new business. In general, owners must show earnings at least equivalent to minimum wage at 20 hours per week to be eligible for coverage with exceptions made for new businesses.

		If group is eligible, what tax documentation is required?	
How does the husband/wife business file its taxes?	**Is the group eligible for BlueCross group medical, dental and/or vision coverage?**	**If business has been in existence 1+ years**	**If business has been in existence less than 1 year and not yet required to file tax documents**
Sole Proprietorship	**No**	na	na
Partnership	Yes, if both spouses are bona fide partners	**IRS Form 1065 and Schedule K1** **Employee Certification Form**	**Partnership Agreement** listing partners and percentage owned *or* filed/stamped state of TN partnership form and letter listing partners/percentage owned **Employee Certification Form**
	Yes, if one spouse is a bona fide partner and one spouse is a W2 employee	**IRS Form 1065 and Schedule K1** **Employee Certification Form** **Most recent quarterly wage and tax report filed with state**	**Partnership Agreement** listing partners and percentage owned *or* filed/stamped state of TN partnership form and letter listing partners/percentage owned **Employee Certification Form** *A follow up audit will be conducted for the most recent quarterly wage and tax report.*
Corporation *A follow up audit will be conducted for the most recent quarterly wage and tax report.*	Yes, if both spouses are also W2 employees	**Most recent quarterly wage and tax report filed with state**	**Articles of Incorporation** listing each owner and percentage owned **Employee Certification Form**

Large Group Renewal Process and Guidelines for Existing Business

Large group renewals will be released in accordance with ACA benefit and rating guidelines including guaranteed renewability guidelines and based on two factors – the current product and employer group size (i.e. ACA small or large employer). Group size is determined by employer attestation. For existing groups, the most recent ACA/Medical Loss Ratio (MLR) employer size certification will be used to determine group size. For existing groups that do not respond to the certification, the average number of subscribers enrolled during the previous calendar year will be used to determine the group size.

Groups with Less than 151 Enrolled Employees

For large groups with less than 151 enrolled employees, renewal preparations begin approximately five months prior to the renewal date. Once renewal preparations begin, benefit changes are not allowed. Renewals are released approximately 90 days prior to the renewal date.

As part of the renewal process, brokers should submit an Underlying Plan/Funding Arrangement Verification form to BlueCross for each of their renewing groups. The form should be submitted to BlueCross prior to finalization of the renewal if the group has an underlying plan or funding arrangement as the renewal rates may need to be adjusted due to the underlying plan or fund. Otherwise, the Underlying Plan/Funding Arrangement may be submitted at renewal via the Renewal Response Form.

Groups with 151+ Enrolled Employees

For large employer groups with 151+ employees, renewal preparations begin approximately six months prior to the renewal date. The full renewal rate analysis and reporting packages are released to the AEs approximately 120 days prior to the group's renewal date except for groups with a first year renewal. First year renewals are released approximately 60 days prior to the renewal date.

As part of the renewal process for 151+ fully insured accounts, groups will be asked to complete two forms, the Competition/Participation form and the Underlying Plan/Funding Arrangement Verification form. The Competition/Participation form allows BlueCross to determine if the group still meets participation requirements and if BlueCross is competing against another carrier in the same group. The Underlying Plan/Funding Arrangement Verification form discloses any underlying plan or funding arrangement with a third party that could have a rate impact on the renewal.

Adding Coverage to Existing Business

Existing large employer groups may add coverage (i.e. an existing group with medical only coverage desires to add dental and vision coverage) on or off renewal. All coverages should be set up with the same group number, billing cycle and renewal date. For groups with less than 151 enrolled employees, the new coverage may only be added up to five months before the next renewal date. For groups with 151+ enrolled employees, underwriting approval is required to add coverage off renewal.

Benefit Changes to Existing Groups

For groups with less than 151 enrolled employees:
Renewing groups may make any available benefit and/or network change including adding or deleting options. Multi option guidelines apply.

Existing groups may make buy down changes (i.e. changes to create a less rich benefit plan or adding a less rich medical plan) up to five months before the next renewal date as long as employees are given a minimum 60 day notice to comply with ACA regulations. Benefit buy ups (i.e. changes to create a richer benefit plan or adding a new, richer medical benefit plan) are not allowed off renewal. Please note that if a group is adding a new, less rich medical plan off renewal, only those employees currently enrolled may switch to the new benefit option. Addition of a new option will not constitute an open enrollment for all employees. Multi option guidelines apply. Network changes are only allowed off renewal for groups with 51+ enrolled employees if all subscribers change to the new network and the change is not made within five months of the group's renewal.

For groups with 151+ enrolled employees:
Existing groups may make any available benefit and/or network change including adding or deleting options at renewal. BlueCross approval is required for existing groups to make benefit changes off renewal.

Changing Renewal Dates

A group may request to change their renewal date. Requests to change a group's renewal date should be submitted to BlueCross. All products must move to the new renewal date. A change in renewal date should also correspond with the same change in the group's ERISA plan year anniversary date.

Client Reporting

BlueCross provides medical reporting packages to large employer groups along with their annual renewal as follows:

- For fully insured and level funded groups with 2 – 25 subscribers: Package S1 with limited interactive reporting
- For fully insured and level funded groups with 26 – 99 subscribers: Package I1 with limited interactive reporting
- For fully insured groups with 100 – 150 subscribers: Package B with limited interactive reporting
- For level funded groups with 100+ subscribers: Package B with limited interactive reporting
- For fully insured groups with 151 – 499 subscribers: Package B with limited interactive reporting
- For self-funded groups with 151 – 499 subscribers: Package B with interactive reporting
- For fully insured groups with 500+ subscribers: Package R with limited interactive reporting
- For self-funded groups with 500+ subscribers: Package R with interactive reporting

Nonstandard Reports
Requests for nonstandard reports require Underwriting approval and may require an additional charge.

ERISA Form 5500/Schedule A

BlueCross provides fully insured and self-funded groups with 100+ employees information to help them complete Schedule A of the ERISA Form 5500 approximately four months after the end of the contract year. This information is available for medical, dental, vision and BlueRe benefits. Upon request only, BlueCross will provide Schedule A information to groups with less than 100 employees.

Existing Groups with Name, Address, Ownership and/or Census Changes including Group Splits

Please contact your representative if an existing group incurs a name, address, ownership and/or census change. Changes such as these may require underwriting review of benefits and rating to ensure ACA compliance. BlueCross approval is required to add new businesses/subsidiaries/locations, especially those out of state, to the policy. BlueCross also reserves the right to adjust fully insured rates and self-funded administrative fees for census changes greater than 10 percent* for groups with 151+ enrolled employees and 25 percent* for groups with less than 151 enrolled employees. For census changes including adding or dropping businesses, locations, employees, etc. please provide quote information as outlined in the Required Quote Information for New Business section.

**The 10 percent and 25 percent limits include the accumulation of changes throughout the year.*

Group Failure to Comply with Underwriting Guidelines

BlueCross regularly reviews the enrollment of groups to confirm that underwriting requirements such as eligibility, single employer/control group, Tennessee headquarters and participation requirements are being followed. These requirements are in place to ensure compliance with state and federal regulations as well as to better control the cost of coverage we provide to our customers. Groups are required to comply with underwriting guideline requirements when they are first enrolled and to continue to remain in compliance for as long as their coverage remains in effect.

If our records indicate that a group may not be in compliance, the group will be notified via certified letter and asked to provide documentation such as quarterly tax documentation and payroll to verify compliance. If the group does not respond to the audit request, their coverage with BlueCross will be termed as of the date indicated in the audit letter. If the group does respond to the audit request but is found out of compliance, their coverage with BlueCross will be termed as of the date indicated in the audit letter. Any ineligible subscribers identified in an otherwise compliant group will be termed as of the date indicated in the audit letter.