

Independence Blue Cross Underwriting Guidelines Manual



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield – independent licensees of the Blue Cross and Blue Shield Association.

Underwriting Guidelines Manual

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Davis Vision is an independent company that administers the IBC Vision Program.
UCCI is an independent company that administers or provides dental benefits.

Latest update 02/09

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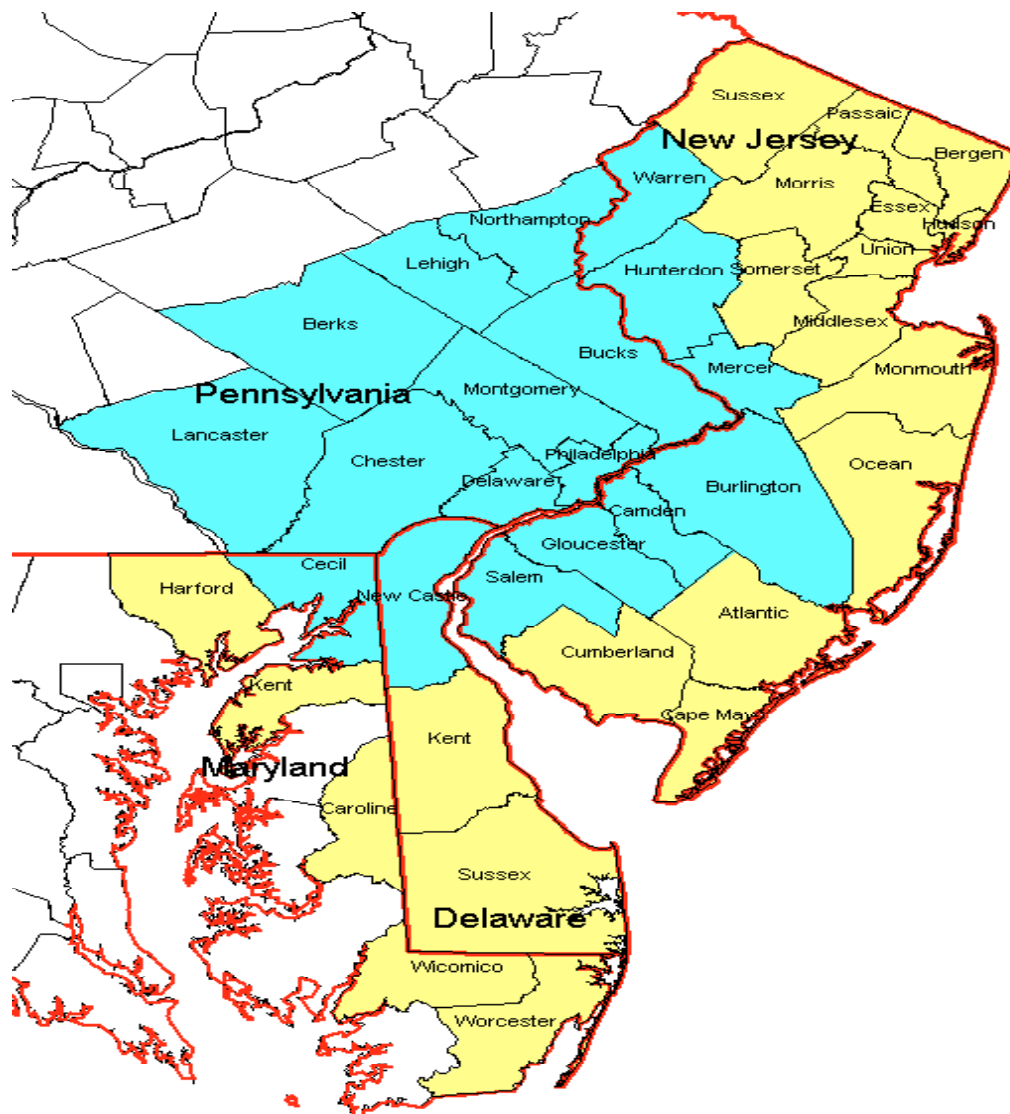
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Section 1 – Eligibility

In the application of the general principles of health insurance to our specific company criteria and policies, Independence Blue Cross's (IBC) Underwriting Guidelines require that certain conditions be met before considering a group for coverage.

IBC/Keystone Health Plan East service area. The IBC/Keystone Health Plan East service area includes the Greater Philadelphia five counties of Philadelphia, Montgomery, Bucks, Chester, and Delaware and the respective contiguous counties that border the five counties. Those contiguous counties are: Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil. (Note: A group must have its corporate headquarters or an entity located in the Greater Philadelphia five-county area). In view of Blue Cross and Blue Shield Association requirements, if a local group's members live in noncontiguous counties and have HMO/POS coverage, those members must be covered under and issued booklets by an affiliate of IBC.



Section 1 — Eligibility *(continued)*

Excluded classes. Classes of employees excluded for coverage by the employer will not be counted in determining participation requirements.

Participation requirements. For groups of fewer than ten subscribers, 100 percent of eligible subscribers must be enrolled. For groups of ten or more subscribers, the minimum participation is 75 percent of eligible subscribers. Credit will be given for those eligible subscribers who opt out because they have coverage elsewhere with subsidiaries of IBC or who are covered through their spouse. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 100 percent participation requirement.

For groups of 2 – 9 eligible contracts, IBC requires full participation to assure an equitable spread of risk across the population. Failure to do so may give rise to an adverse experience situation whereby only those who are sick will choose to enroll.

To ascertain whether IBC will be willing to accept a given group for coverage, it is necessary to determine the total number of eligible employees and calculate the percentage of the total group that will be receiving insurance through IBC. This stipulation is in place to restrict the funneling of “high-risk” cases to IBC while diverting a “low-risk” population to another carrier — resulting in an adverse experience situation for IBC. When determining the number of eligible employees, it is necessary to deduct those individuals who have coverage through a spouse or other employer.

Eligible employees. All individuals who are active employees are eligible to apply for coverage provided they have fulfilled the waiting periods. Contractors, 1099s, and members of boards of directors who are not employees of the group are not eligible for coverage. An *eligible employee* is defined as someone who:

- is benefit-eligible according to the employer;
- meets all requirements as defined in each carrier’s plan document;
- resides or works in the HMO’s defined service area (for HMO products).

IBC considers all active employees as eligible for coverage and uses this number as the basis for determining participation criteria. An enrolled contract is defined as an eligible employee who has coverage in force within a particular line of business within IBC and its subsidiaries (including IBC non-group coverage).

Section 1 — Eligibility *(continued)*

Eligible dependents (including domestic partners). Only the spouse (married or common-law), the natural or adopted children of the employee or the employee's spouse, or those children legally placed in the employee's home for purposes of adoption will be recognized as belonging to the regular class of eligible dependents. In addition, the Pennsylvania Insurance Department has approved IBC allowing groups to add coverage for unmarried opposite-sex and same-sex "domestic partners." (Self-insured groups may add "domestic partners" coverage for same-sex partners only.) There will be no initial rate impact; however, subsequent renewals will include the domestic partner's claims experience.

This does not apply to our nongroup (individual or Medicare) business. Domestic partners would continue to be enrolled separately under our nongroup products.

Over-age student standards. Coverage is available for dependents 19 or older if the child continues as a full-time student in an accredited institution. The maximum age for covered students is typically 23.

Handicapped dependents. Unmarried dependent children 19 or older who, in the judgment of IBC, are incapable of self-support due to mental or physical incapacitation may continue group coverage. These dependents must be supported continuously by the employee-subscriber, and the rate paid must include such dependents. Coverage of the dependent child will terminate upon marriage of the dependent.

Common ownership

The definition of ownership is a single person or business entity having greater than 50 percent (controlling majority) interest in a business, subject to verification.

Multiple businesses may be combined as a common ownership affiliation based on the following requirements:

- Under the combined arrangement, the group must also have a common policymaker who is legally authorized to make benefits/human resources decisions for the combined businesses.
- The group must be able to provide verifiable proof of ownership to support the common ownership of the businesses (i.e., tax/legal documentation).
- Existing groups wishing to add other businesses under a common ownership arrangement are also subject to the above requirements (e.g., newly acquired companies, mergers, or businesses that were previously enrolled through another carrier). Changes of this nature are subject to review and approval for participation and rate adequacy.
- Groups electing to combine their businesses under a common ownership arrangement do not have the option of breaking the group apart at a later date to obtain more favorable rates. If the group later elects to cover one or more of its businesses through another carrier, the remainder of the group will be subject to cancellation.
- Common ownership groups may be separated for group coverage based on verifiable legitimate business reasons (e.g., one of the businesses was sold, etc.).

Section 1 — Eligibility *(continued)*

Eligibility and COBRA

The federal government recognized the need to create legislation that assured the continuation of health insurance coverage to individuals who had lost benefits through work-related or life-change events.

As a result, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) was enacted. COBRA extends the eligibility provisions for coverage under group health insurance plans to include qualified beneficiaries. Qualified beneficiaries include the spouse and dependent children of the covered employee and — in the case of a reduction in hours, layoff, or termination of employment — the covered employee. Generally, the company must have 20 or more full- and/or part-time employees to be required to offer COBRA continuation coverage to qualified beneficiaries. These qualified beneficiaries must be permitted to elect continued coverage under a group's health plan. Should these individuals elect continued coverage, they may be — and, most often, are — responsible for reimbursing the group for premium payments (although usually these payments are substantially less than the price of similar benefits outside the group coverage).

These qualified beneficiaries include:

- widowed spouses and dependent children;
- employees (and their spouses and dependent children) who have been terminated from employment — either voluntarily or involuntarily¹ — or who have experienced a reduction in hours that places them below a group's eligibility threshold;
- divorced or separated spouses and their dependent children;
- Medicare-ineligible spouses (that is, an individual and his or her eligible dependents whose coverage terminated because his or her spouse became eligible for Medicare);
- dependent children no longer meeting the plan's definition of a dependent child (for example, an overaged dependent or a dependent who no longer qualifies as a full-time student).

Upon the occurrence of a “COBRA qualifying event” — such as termination of employment, death of a covered employee, reduction in employment hours, divorce/legal separation, Medicare eligibility, etc. — the qualified beneficiary is entitled to continue coverage for up to either 18 or 36 months. If the loss of health coverage is due to reduction in work hours, retirement, voluntary resignation, layoff, or employment termination other than for gross misconduct, 18 months applies. If the loss of health coverage is due to death of covered employee, divorce or legal separation, a dependent child ceasing to be a dependent, or a covered employee becoming entitled to Medicare, 36 months applies. In return for providing these extended benefits, the employer may charge the individual a maximum 2 percent administration fee above the actual premium rate charged to the group to partially compensate for the additional administrative work involved with keeping this individual under the group coverage.

¹The exception to this stipulation would be those individuals who have been terminated for gross misconduct.

Section 2 — Types of rating and rating components

IBC determines rates using several types of rating mechanisms. They are: community rating, demographic rating, experience rating (including prospective, retrospective, and group-specific), and types of self-funding, including Cost-Plus.

TYPES OF RATING

■ Community (or pooled) rating

Pure community rating is the development of rates so that all subscribers pay the same rate for the same level of benefits. Small groups are not individually underwritten but are given the opportunity to purchase products that blend the experience of many small groups to achieve a reasonable amount of credibility. The total anticipated costs are spread evenly over all contracts — all contracts with the same family status and benefits pay the same rate.

■ Demographic rating

The rating methodology for Personal Choice®, Keystone Health Plan East, and Drug Rider groups of 2 to 99 contracts is *demographic rating*. For new groups, the determination for demographic rating is based on eligible contracts; for existing groups, determination is based on enrolled contracts. Under demographic rating, community-based rates are *adjusted* for age and gender factors through the application of a “*demographic factor*.”

■ Experience rating

Experience rating uses each group’s own historical experience multiplied by a trend factor to estimate the claims that will be incurred during a future rating period. This new rating period is, most often, one year. The trend factor takes into account anticipated increased benefits costs (inflation) and increased incidence of care (utilization). In addition, for PPO and HMO, because groups with fewer than 500 contracts cannot generate claims experience that is fully credible, a credibility adjustment may be applied. The credibility threshold may be different for the other product lines.

These calculations (with the addition of retention dollars and, if necessary, broker commissions) derive the *required income* amount for the group. This required income level is compared to the *premium at the latest rate level (or income at current rates)* to determine the rate change (or *rate multiplier*) that is necessary.

Section 2 – Types of rating and rating components *(continued)*

Types of rating

(required enrollment is by product)

Line of Coverage	Community	Demographic	Experience
Traditional Hospitalization	2 – 50 enrolled	n/a	51+ enrolled
Traditional Medical/Surgical	2 – 50 eligibles	n/a	51+ eligibles
Traditional Major Medical	2 – 99 enrolled	n/a	100+ enrolled
CompSelect®	n/a	n/a	51+ enrolled
Freestanding Prescription Drug	n/a	n/a	51+ enrolled
Personal Choice®	n/a	2 – 99 enrolled	100+ enrolled
Personal Choice Rx rider	n/a	2 – 99 enrolled	100+ enrolled
Keystone Health Plan East HMO/POS	n/a	2 – 99 enrolled	100+ enrolled
Keystone Health Plan East Rx, Dental, and Vision riders	n/a	2 – 99 enrolled	100+ enrolled
Freestanding Dental (UCCI)	2 – 49 enrolled	n/a	50+ enrolled
Freestanding IBC Vision	2 – 99 enrolled	n/a	100+ enrolled
All national account coverages	n/a	n/a	1,000+ total enrolled in medical lines
Self-funded HMO/POS/PPO	n/a	n/a	250+ eligible (PPO + HMO/POS); 100+ enrolled in self-funded product line

TYPES OF EXPERIENCE RATING

Prospective rating

Under this arrangement, the entire risk is assumed by the carrier. The group pays a fixed rate for the entire contract period and there is no after-the-fact financial settlement between carrier and group. Once the rate has been established via the rating formula, the group is obligated to pay that level amount throughout the rating period, and the carrier is obligated to pay all claims covered under the terms of contract. Neither party has recourse to collect surpluses or deficits from the other party; surpluses are not returned to the group, and deficits are not loaded into the renewal rates or billed to the group.

Section 2 — Types of rating and rating components *(continued)*

TYPES OF EXPERIENCE RATING

Retrospective funding

Unlike prospective rating, under this arrangement, a financial settlement is made after each contract period (normally, one year), at which time a surplus (excess premium funds over incurred claims plus retention and broker commissions) may be returned by the carrier to the group. Any year-end deficit (where claims plus retention plus broker commissions exceeds premium) is carried forward one or more years for possible recovery from future surpluses. For retrospectively funded local groups, Personal Choice, Blue Cross® Hospitalization, CMM, and prescription drug deficits are carried forward for one year for possible recovery. For national Blue Cross groups and local and national lines of Blue Shield® and Major Medical, deficits are carried forward indefinitely for possible recovery. Keystone Health Plan East lines of business are not eligible for retrospective rating.

Cost-Plus / Self-funded / Self-insured

Cost-Plus is a rating arrangement (not an alternative funding arrangement) that shifts the burden of financial risk (payment obligations) from the carrier to the group itself. The group is responsible for payment of claims plus retention fee. Under a Cost-Plus arrangement, a financial settlement is normally calculated after each contract period, at which time any surplus is returned to the group and any deficit is due and payable to the carrier. The billing under a Cost-Plus arrangement can be based either on a predetermined rate (rate basis) or on the actual claims of the group (claims reimbursement basis). An IBC group under a Cost-Plus arrangement may or may not have state-mandated benefits and/or hold its own claim reserves.

HMO Self-funded

HMO Self-funding is a rating arrangement that shifts the burden of financial risk from the carrier to the group itself. Under this arrangement, the customer may choose either a premium equivalent or claims reimbursement method of payment. Under the premium equivalent, the customer pays an estimated rate. A financial settlement is made after six months of run-out for each contract period, at which time any surplus is returned to the group and any deficit is due and payable to the carrier. Under claims reimbursement, the customer pays claims cost plus retention each month, and there is no financial settlement.

Section 3 – Alternative funding arrangements

COST-PLUS PAYMENT VARIATIONS

Rate basis

Under this arrangement, monthly payments would be based on a predetermined monthly premium rate. Since the cash flow of premium payments is stable and predictable, the risk associated with managing the budgeting of expenditures for health care benefits is simplified for the customer. However, there is no maximum exposure on the final cost for the program since the financial settlement is based on actual claims experience. Any surplus is returned with the settlement. Any deficit is invoiced and payable within 30 days of the date of the settlement invoice.

Claims reimbursement

Under the claims reimbursement arrangement, remittance takes place with either a monthly bill or a weekly wire based on claims paid, adjusted for discounts, plus retention charge and broker commission (if applicable).

- **Advance deposit:** For new Cost-Plus customers, an advance deposit is required. Since invoices are presented to the group based on prior paid claims, there will be a delay between the time IBC pays the claim and the time IBC receives reimbursement from the group. Accordingly, the group will provide advance deposit monies, as identified by IBC, representing costs that are anticipated to be incurred by IBC on behalf of the group. The advance deposit is reviewed annually for adequacy and either increased or decreased accordingly.
- **Bank letter of credit (BLOC):** When a group elects to hold its own reserves for claims incurred but not reported, upon execution of this Cost-Plus arrangement the group will provide IBC with an irrevocable BLOC. The initial BLOC should be for an 18-month period and will be renewed by the group annually with no lapse in coverage and must be in an amount as determined by IBC to cover IBC's obligations under the financial arrangement.

Section 3 — Alternative funding arrangements *(continued)*

90-PERCENT CONTINGENCY PREMIUM — MINIMUM 300 ENROLLED CONTRACTS

Under a 90-percent contingency premium arrangement (a 95-percent arrangement is also available), accounts may choose to pay 90 percent of the calculated monthly premium if it meets a **minimum enrollment of 300 contracts in the coverage being considered for a contingency premium program.** (The 300-contract minimum requirement cannot be met by aggregating contracts from other coverages, and the size requirement is based on enrolled contracts and not eligible contracts.) Groups with a contingency arrangement must have the same contingency percentage for all lines of coverage.

Upon completion of the year-end settlement, should the year-end claims experience exceed the 90-percent contingency amount paid, IBC will collect up to the remaining 10 percent as is necessary to satisfy the maximum premium liability plus any existing deficit carry-forward. Any year-end claims experience that exceeds the 100-percent-maximum premium cannot be recovered in the current year but will be carried forward as a deficit for possible recovery from future periods.

This funding mechanism is particularly useful for those accounts that believe the projected premium is too high and wish to improve their cash flow through the reduced monthly payment. Prior to the start of the contract period, IBC will request a bank letter of credit in the amount of the 10 percent unpaid premium to assure that the funds will be available upon completion of the contract-year settlement. A BLOC is a guarantee by the group's financial institution of choice that, in the event the group defaults on its payment obligations to IBC, the financial institution will be contractually obligated to pay those obligations. The term of the initial BLOC must be for an 18-month period. The amount is reviewed annually by IBC and, upon being notified of the new amount by IBC, the group must renew the BLOC accordingly.

IBC also assesses an interest charge on the deferred premium that is recalled based on the U.S. Treasury Bill rate (for 13-week issues) plus one percent. This amount is due at the time of year-end settlement.

Some important considerations concerning contingency premium include:

- An account must be retrospectively funded to be eligible for a contingency premium arrangement.
- Accounts currently on a contingency premium arrangement that incur a deficit during the period are subject to review on a case-by-case basis and may or may not be renewed under this arrangement.
- The account is required to pay IBC any settlement monies due within 20 days of invoice. Failure to pay within 20 days will result in additional interest charges and potential cancellation of the contingency premium arrangement.
- An account on a contingency premium arrangement will receive the contingency premium rates (but not the full premium rates) as a part of its rate renewal notification. Acknowledgment of the rate renewal notification will constitute acceptance of the contingency premium arrangement for the upcoming period.
- A financial agreement, which sets forth the basic terms of the contingency premium arrangement, will be issued by IBC to the group for sign-off.

Section 3 — Alternative funding arrangements *(continued)*

When a group or an affiliation is comprised of a single entity, the annual financial settlement is calculated as follows (This example is based on a 90-percent contingency premium arrangement):

- If the group's contract-year required premium amount, as determined by the settlement, exceeds the 90-percent contingency annual premium payments paid by the group but is less than the maximum (100 percent) annual premium, *and there is no carryover deficit from previous contract periods*, the group is liable to IBC for the required premium amount that exceeds the 90-percent annual premium payments (i.e., the additional premium amount).
- If the group's contract-year required premium amount as determined by the settlement exceeds the 90-percent contingency annual premium payments paid by the group but is less than the maximum (100 percent) annual premium, *and a deficit carryover exists from previous contract periods*, IBC may collect up to the remaining 10-percent amount to apply to the required premium amount that exceeds the 90-percent annual premium payment (i.e., the additional premium amount) as well as to the existing carryover deficit. Depending on the coverage, any remaining deficit not recovered may be carried over to future contract periods.
- For local accounts, Personal Choice, traditional hospitalization, CMM, and prescription drug retrospectively rated coverages contain a one-year deficit carry-forward provision. All other retrospectively rated coverages and all national accounts (regardless of line of coverage) have indefinite carry-forward provisions.

60-DAY DELAYED PREMIUM — MINIMUM 300 ENROLLED CONTRACTS

Under a 60-day delayed premium arrangement, fully insured accounts may choose to delay their monthly premium payment by two months if they meet a **minimum enrollment of 300 contracts in the coverage being considered for a 60-day delayed premium program**. (The 300-contract minimum requirement cannot be met by aggregating contracts from other coverages, and the size requirement is based on *enrolled* contracts and not eligible contracts.)

This delay enables the account to hold outstanding reserves — which generally equate to approximately two months of premium — and to improve its cash flow. IBC considers these delayed premium amounts as a due and unpaid premium, and interest is charged for the 60 days of this delay based on the U.S. Treasury Bill rate (for 13-week issues) plus one percent. Should the account fail to pay on schedule, additional interest is assessed.

The interest charged for this special arrangement is billed as a separate expense above the maximum premium at settlement time, even though the account may be in an overall deficit position. Failure to pay the applied interest charges will result in termination of the delayed premium arrangement.

Section 3 – Alternative funding arrangements *(continued)*

- Accounts currently on a delayed premium arrangement, that incur a deficit during the period are subject to review and may not be renewed under this arrangement.
- A financial agreement, which sets forth the basic terms of the 60-day delayed arrangement, will be issued by IBC to the group for approval.
- The financial settlement will be prepared using the 12 months of premium applicable to the account's contract period. The account is required to pay IBC any settlement monies due within 20 days of invoice. Failure to pay within 20 days will result in additional interest charges and potential cancellation of the delayed premium arrangement.
- The account is required to furnish IBC with a BLOC for the amount of the deferred premium. The term of the initial BLOC must be for an 18-month period. The amount of the BLOC will be reviewed annually and, upon being notified of the new amount by IBC, the group must renew the BLOC accordingly.

Section 4 — Product regulations and size requirements

Guidelines for new business are based on eligible contracts. Guidelines for existing business are based on enrolled contracts.

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 2 – 99 COVERED CONTRACTS

Type of rating: This segment is demographically rated, including prescription drug, Keystone Health Plan East Dental, and Keystone Health Plan East Vision riders (IBC Vision and UCCI Dental are community-rated). Rates for demographic groups are community-based rates updated quarterly. These rates are then adjusted for the specific age/sex makeup of the covered group. The group's rates will be based on the effective date of its Personal Choice or Keystone Health Plan East coverage and will change on its anniversary date.

Effective date: When an existing group *adds* Personal Choice or Keystone Health Plan East, the existing anniversary date will apply to the Personal Choice/Keystone Health Plan East coverage.

Tier type: A standard four-tiered rating structure is preferred. Tier structure must be the same throughout all medical products.

Quoting policy:

- For new business, Personal Choice or Keystone Health Plan East groups of fewer than 100 eligible contracts, only demographic rates will be issued.
- If the number of eligible contracts is greater than 100 and only Personal Choice or Keystone Health Plan East HMO/POS is being offered, only an experience rate will be issued.
- At the time of renewal, if the enrollment under the Personal Choice or Keystone Health Plan East line of coverage is 100 or more, the Personal Choice or Keystone Health Plan East will be renewed as an experience-rated coverage.
- All changes to medical benefits for existing customers will be to Flex products, with or without Select Drug Program[®] coverage, and/or one HSA-qualified high-deductible health plan, with or without integrated drugs. If the customer has current non-formulary drug coverage, he or she must move all prescription coverage to a Select Drug Program option when changing medical plans.
- Customers with existing plans may maintain a current medical plan option and add a Flex Series Medical plan (subject to dual-option guidelines). If prescription drug benefits are offered, then all drug benefits must be a Select Drug Program option. One HSA-qualified high-deductible health plan may be offered but only with integrated drug.

Section 4 – Product regulations and size requirements *(continued)*

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 2 – 99 COVERED CONTRACTS (cont'd)

Available benefits options:

New business, 2 – 9 eligibles; Existing enrolled business, 2 – 9 contracts

- All new business offerings and all changes to medical benefits for existing groups may select from the following:
 - Flex series medical products with or without Select Drug (Personal Choice or Keystone Health Plan East prescription drug rider);
 - HSA-qualified high-deductible health plans with or without integrated drug;
 - Keystone Health Plan East Dental and Vision riders;
 - Freestanding Dental (UCCI);
 - Freestanding IBC Vision.
- Groups of 2 – 9 (eligibles for new business, enrolled for existing business) may offer dual-options, but no more than one PPO, one HMO, and one POS, along with one Select Drug Program plan that would apply to both medical plans. Groups may also offer dual-options consisting of a medical plan (PPO, HMO, or POS) with an HSA-qualified plan. Thus, available offerings would include: PPO+POS+HSA, PPO+HMO+HSA, HMO+POS+HSA, PPO+HSA, HMO+HSA, POS+HSA.
- Groups may choose from six Select Drug Program options (\$10/\$20/\$35, \$15/\$35/\$50, \$20/\$40/\$60, \$0/\$25/\$50, \$5/\$40/\$60, \$250/\$20/\$40/\$60). If a group selects an HSA-qualified high-deductible health plan with drug coverage, this coverage may be offered only with integrated drug.
- All prescription drug options must include oral contraceptives. There are no options without oral contraceptives.
- Customers currently offering prescription drug options other than these six Select Drug Program options will be able to continue with their current (grandfathered) program *until such a time when they make any medical or drug benefit change*. At that time, they will need to change from the grandfathered drug option to a Select Drug option from our current product portfolio.

Section 4 — Product regulations and size requirements *(continued)*

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 2 – 99 COVERED CONTRACTS (cont'd)

Available benefits options:

- If prescription drug rider benefits are offered, they must be offered with *all* medical products, with the following exceptions:
 1. When one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans are not required to include drug coverage.
 2. When one option is an HSA-qualified HDHP with no drug, other non-HSA-qualified plans may either all include or all exclude drug coverage.
- Different copayment options may be selected for each of the medical plans, but different drug, dental, and/or vision options may not be offered with identical medical plans.
- Medicare products will not be counted toward the maximum number of benefits levels.

New business, 10 – 99 eligibles; existing enrolled business, 10 – 99 contracts

- All new business offerings and all changes to medical benefits for existing groups may select from the following:
 - Flex series medical products with or without Select Drug (Personal Choice or Keystone Health Plan East Rx Rider);
 - HSA-qualified high-deductible health plans with or without integrated drug;
 - Keystone Health Plan East Dental and Vision riders;
 - Freestanding Prescription Drug (51+ enrolled);
 - Freestanding Dental (UCCl);
 - Freestanding IBC Vision.
- Groups of 10 – 99 (eligibles for new business, enrolled for existing business) may select up to *three* medical benefits plans (no more than two from each product line, PPO versus HMO/POS) and up to two Select Drug Program options. In addition, groups may add an HSA-qualified plan. Permissible variations of medical benefits options that are available to the 10 – 99 segment are:
 - two PPO, one HMO, and one HSA-qualified plan;
 - one PPO, one HMO, one POS, and one HSA-qualified plan;
 - one PPO, two HMO, and one HSA-qualified plan;
 - one PPO, two POS, and one HSA-qualified plan.

Section 4 — Product regulations and size requirements *(continued)*

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 2 – 99 COVERED CONTRACTS (cont'd)

Available benefits options:

- The combination of offerings for groups of 10 – 99 will be limited to three total packages of combined medical and drug options, plus one HSA-qualified plan.
- If prescription drug plans are offered, they must be offered along with all medical benefits (maximum of two drug options), with the following exceptions:
 1. When one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans are not required to include drug coverage.
 2. When one option is an HSA-qualified HDHP with no drug, other non-HSA-qualified plans may either all include or all exclude drug coverage.
- The customer may select differing prescription drug copayment options with each of the medical plans (HMO/POS and PPO), subject to a maximum of two Select Drug options.
- A group may not offer different drug, dental, and/or vision options if identical medical products are offered.
- Groups may choose from six Select Drug Program options (\$10/\$20/\$35, \$15/\$35/\$50, \$20/\$40/\$60, \$0/\$25/\$50, \$5/\$40/\$60, \$250/\$20/\$40/\$60).
- All prescription drug options must include oral contraceptives. There are no options without oral contraceptives.
- Customers currently offering prescription drug options other than these six Select Drug Program options will be able to continue with their current (grandfathered) program *until such a time when they make any medical or drug benefit change*. At that time, they will need to change from the grandfathered drug option to a Select Drug option from our current product portfolio.
- If a group chooses an HSA-qualified high-deductible PPO plan, integrated drug coverage is available.
- Medicare products will *not* be counted toward the maximum number of benefits levels.

Section 4 — Product regulations and size requirements *(continued)*

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 100+ COVERED CONTRACTS

Type of rating: This segment is experience-rated for Personal Choice and Keystone Health Plan East HMO/POS. Self-funding is available if the group meets eligibility and enrollment requirements.

Tier type: A four-tiered rating structure is standard, but other rating structures may be available in competitive situations. The tiered rating structure must be consistent between Personal Choice and Keystone Health Plan East products.

Quoting policy:

- Rates are adjusted annually on the anniversary date of the group.
- For new groups, rates are guaranteed for 90 days from the quoted effective date. (If HMO, rates change quarterly.)
- New business rates for groups of 100+ contracts may be wholly or partly based on the group's own experience.
- If there are more than 100 eligible contracts, an experience rate will be issued.
- At renewal, if the group has maintained an average of fewer than 100 covered contracts per month for the experience period for the Personal Choice or Keystone Health Plan East line of coverage, the affected line of coverage will be converted to demographic rating.
- New business Personal Choice and Keystone Health Plan East rates are guaranteed for 90 days (subject to Keystone Health Plan East quarterly rate changes) and are typically quoted on a 12-month contract basis. Extended rating periods exceeding 12 months may be considered for off-anniversary requests, depending on the circumstances of the request.
- Personal Choice and Keystone Health Plan East lines of coverage should have the same anniversary dates. When an existing Keystone Health Plan East group adds Personal Choice, the existing anniversary date will apply to the new Personal Choice coverage, and vice versa.

Section 4 — Product regulations and size requirements *(continued)*

The funding arrangement must be consistent among all in-force medical coverages. Split funding (insured medical and self-insured prescription drug) will be permitted for groups for which IBC has the insured medical only with at least 300 medical contracts enrolled.

PERSONAL CHOICE/KEYSTONE HEALTH PLAN EAST, 100+ COVERED CONTRACTS (cont'd)

Available benefits options:

- A maximum of *three* total benefits levels among all in-force medical coverages are permitted, plus one HSA-qualified plan. All three benefits levels may be within one product line. If multiple product options are offered, they must all include or all exclude prescription drug coverage (up to a maximum of two drug options).
- One HSA-qualified plan may be offered along with other products as long as the customer does not exceed the maximum number of product offerings. For example, a customer may offer a standard HMO, a PPO, a POS, and one HSA-qualified plan.
- When multiple options are offered, the following prescription drug coverage rules apply:
 1. When one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans are not required to include drug coverage.
 2. When one option is an HSA-qualified HDHP with no drug, other non-HSA-qualified plans may either include or exclude drug coverage.
 3. When one option is a Flex HDHP with freestanding or PPO rider drug, then all other non-Flex HDHP options should include drugs.
 4. When one option is a Flex HDHP with integrated drug, then all other non-Flex HDHP options should include drug.
- All Flex HDHP products will be considered downgrades from all current product offerings, including HSA-qualified HDHPs, and can thus be offered off-cycle.
- One HSA-qualified HDHP may be offered alongside a Flex HDHP as long as the maximum number of product offerings is not exceeded.
- A group may not offer different drug, dental, and/or vision options if identical medical products are offered.
- Medicare products will not be counted toward the maximum number of benefit levels.

Section 4 — Product regulations and size requirements *(continued)*

FREESTANDING PRESCRIPTION DRUG, 51+ COVERED CONTRACTS

Type of rating: Experience rating. For groups of 2 – 50, freestanding drug coverage is not available.

Tier type: Four-tier is standard.

Quoting policy:

- Rates are adjusted annually on the anniversary date of the group.
- For new groups, rates are guaranteed for 90 days from the quoted effective date.
- New business rates may be based wholly or partly on the group's own experience.
- Prescription drug coverage for groups of 51 – 99 covered contracts may be offered on a prospective rating basis only.

Discounts for Medical/Rx package offering:

Existing business:

- Group already has experience-rated medical and experience-rated prescription drug coverages — no additional discount
- Group has experience-rated medical or experience-rated prescription drug coverages but not both — 1 percent overall discount

New business:

- Group has experience-rated medical and experience-rated prescription drug coverages already with same carrier — no additional discount
- Group has experience-rated medical or experience-rated prescription drug coverages but not with same carrier — 1 percent overall discount

Surcharges for terminating medical or prescription drug from package offering:

- Group keeping experience-rated medical and experience-rated prescription drug coverages — no surcharge
- Group canceling experience-rated medical or experience-rated prescription drug coverages — 1 percent overall surcharge

Section 4 — Product regulations and size requirements *(continued)*

IBC VISION

IBC Vision may be offered on a freestanding basis or as a Keystone Health Plan East rider.

Type of rating: Community rating, 2 – 99 enrolled contracts; experience rating, 100+ contracts (if there are fewer than 100 enrolled at renewal, the vision product will be converted to community rating).

Tier type: All rate tiers are available. The standard structure is four-tier.

Quoting policy:

- Community rates are filed and approved on a periodic basis as warranted.
- New business community rates will be based on the group's effective date of coverage.
- Experience-rated vision rates are adjusted annually on the anniversary date of the group.
- For new experience-rated groups, rates are guaranteed for 90 days from the quoted effective date.

Available benefits options 2 – 99:

- Maximum of one freestanding offering per customer.
- Freestanding vision is not available in conjunction with an HMO/POS vision rider.
- Freestanding vision-only offerings are not permitted. Vision must be offered in conjunction with a medical program.
- Unequal vision riders (different options) within a line of business (LOB) are permitted (e.g., in conjunction with two different HMO offerings or two different POS offerings).
- Biannual and annual vision benefits are available with freestanding products. Standard HMO/POS vision riders are biannual for groups of all sizes.
- Annual benefits may not be offered in conjunction with a biannual offering.
- Voluntary Davis Vision benefits are not available.

Section 4 — Product regulations and size requirements *(continued)*

Available benefits options, 100+:

- Maximum of one freestanding offering per customer.
- Freestanding vision is not available in conjunction with an HMO/POS vision rider.
- Freestanding vision-only offerings are not permitted. Vision must be offered in conjunction with a medical program.
- Unequal vision riders (different options) within a LOB are permitted (e.g., in conjunction with two different HMO offerings or two different POS offerings).
- Unequal vision riders (different options) across LOBs are permitted (e.g., in conjunction with one HMO and one POS).
- Vision may be offered on one LOB and not the other.
- Annual and biannual benefits are available.
- Voluntary and non-voluntary vision benefits are available. Annual benefits are not available in conjunction with a biannual offering.

ASSOCIATION BUSINESS PLAN OFFERINGS

Association plan offerings for new business will follow the above guidelines with the following exceptions:

- Rate tiers for new business will be at the standard four-tier levels.
- Sole proprietors will be offered HMO Flex Copay Series C3F4 Medical Plan with the Select Drug Program option \$20/\$40/\$60 Prescription Drug (with oral contraceptives) benefit; or the HSA-qualified Personal Choice PPO Option: HD2-HC1 (\$2,000/\$4,000/100 percent) with integrated Rx (after deductible) Formulary Plan \$5/\$20/\$45. Dental and Vision Care benefits are also available to sole proprietors, following the same guidelines outlined on page 15 for groups of 2 to 99.
- PC Prime is available to any association member.

Section 5 — HRA, FSA, and HSA

BLUE SAVER HEALTH REIMBURSEMENT ACCOUNT (HRA):

- The HRA product is available to the 51+ (eligibles) market segment only. This product may be offered only in conjunction with an approved high-deductible plan. It may not be sold as a stand-alone product.
- The 75-percent participation guideline will be enforced for any customer offering an HRA.
- The HRA/high-deductible plan may be offered along with other products as long as the customer does not exceed the three-plan maximum offering. For example, a customer may offer a standard HMO, a standard PPO, and an HRA/high-deductible PPO plan.
- The HRA product may be offered only on the customer's anniversary date.
- Multiple options within the HRA are not permitted. The customer may make only one choice with regard to debit card, auto rollover, and how benefits will be applied to the HRA. **Note:** Debit card is not an option for 51 – 99 groups.
- For fully insured accounts, the maximum employer contribution to the HRA will be 50 percent of the annual employee deductible. Self-funded customers may alter the contribution percentage upon underwriting approval.
- The prescription drug plan selection will follow the high-deductible plan rules. Any requested variations, such as “drug only,” will require prior underwriting approval.

BLUE SAVER FLEXIBLE SPENDING ACCOUNT (FSA):

- The FSA product is available to the 51+ (eligibles) market segment only. It may be offered in conjunction with any medical plan, but it is not available as a stand-alone product.
- The FSA product may be offered only on the customer's anniversary date.
- Multiple options within the FSA product are not permitted. The customer may make only one choice with regard to debit card, auto rollover, and how benefits will be applied to the FSA. **Note:** Debit card is not an option for 51 – 99 groups.

BLUE SAVER HEALTH SAVINGS ACCOUNT (HSA) SOLUTION:

- New business: 2+ (eligibles)
- Existing business: 2+ (enrolled by line of business)
- The HSA must be offered with a federally qualified high-deductible health plan (HDHP).
- HSA plans may be offered with or without integrated drug coverage.

Section 5 — HRA, FSA, and HSA *(continued)*

- HSA-qualified HDHP products will be considered downgrades from all current product offerings and may be offered off-cycle. The HSA-qualified HDHP product will renew upon the customer's current renewal date with any other product offerings.
- The HSA-qualified HDHP may be offered along with other products as long as the customer does not exceed the maximum number of product offerings. For example, a customer may offer a standard HMO, a standard PPO, and an HSA-qualified HDHP.
- Subject to benefits exception approval, prior-carrier deductible credit may be given to an HSA-qualified high-deductible health plan when prior group coverage was also an HSA-qualified HDHP. Prior-carrier deductible credit will not be permitted when prior group coverage was not an HSA-qualified HDHP.
- Groups adding or changing to an HSA-qualified plan with a contract plan year will be permitted to change anniversary. The anniversary change is applicable to all products under the group, and the group will receive a re-rate at the time of the anniversary change.
- Fourth-quarter deductible carryover credit is not available with HSA-qualified HDHP offerings.

CONSUMER-DRIVEN HEALTH CARE TOOL KIT:

For additional information on HRAs, FSAs, and HSAs, the link below will connect to the Consumer-Driven Health Care Tool Kit on the IBC website:

[Consumer-Driven Health Care Tool Kit](#)

Section 6 — National accounts

A **national account** is a non-KHPE group that has employees located in more than one plan area but chooses to cover its employees through a single national contract executed with a control (home) plan. Businesses that qualify for national account consideration must be domiciled in the Greater Philadelphia five-county area of Philadelphia, Delaware, Montgomery, Bucks, and Chester counties.

Underwriting and participation requirements for national accounts:

- **Minimum enrollment** — A national account must have a minimum of 1,000 enrolled contracts for their PPO and HMO medical products.
- **Out-of-area location** — A national account must have at least one location outside of the IBC service area.

Key rating characteristics — PPO and HMO/POS lines of business:

- Excess claims provision: Inpatient/outpatient pooling points based on group size.
- Provider discount: For all national account claims, regardless of where incurred, discounts are based on the actual IBC contractual savings or as reported by participating plans for the account. For all HMO/POS claims, discounts are based on the actual IBC contractual savings. Discounts for those members who are located outside IBC's service area are based on the actual contractual savings reported by participating plans for the account.
- At least 75 percent of all eligible in-area, as well as 75 percent of all eligible out-of-area, contracts *in each location* must enroll in an IBC or subsidiary product.

Section 7 — When a rate quote is not available through ROAM

There are situations where the type of quote you are requesting is not available through the ROAM system, and you will need to submit a rate request through the IBC account executive. This section will identify those situations and provide you with a list of the documentation that may be required at the time you submit a request.

WHEN MUST A RATE REQUEST BE SUBMITTED THROUGH THE IBC ACCOUNT EXECUTIVE?

Demographic groups (new business groups with 2 – 99 eligible employees, or existing groups with 2 – 99 enrolled contracts):

A rate request is required when the following types of quotes are requested:

- a nonstandard rate tier (to match existing carrier's tier structure; proof required);
- a nonstandard dependent age;
- a change in anniversary date;
- a material change in the census (e.g., purchasing new entity, total takeover, or combining with another entity);
- the out-of-area population is more than 50 percent;
- domestic partner coverage requested.

Traditional Groups and all Groups 100+ and Cost-Plus

A rate request must be submitted regardless of funding arrangement.

WHAT DOCUMENTATION IS REQUESTED WHEN ROAM QUOTE IS NOT AVAILABLE?

Existing IBC groups:

- requested plan design
- marketing strategy (if applicable)

Note: For existing IBC groups adding new contracts, if the number of new contracts is greater than 10 percent of the existing population, refer to “new business group” requirements outlined on the following page.

Section 7 — When a rate quote is not available through ROAM

WHAT DOCUMENTATION IS REQUESTED WHEN ROAM QUOTE IS NOT AVAILABLE? (cont'd)

New business groups (including existing IBC groups adding new contracts totaling more than 10 percent of the existing population):

- name of existing insurance carrier;
- length of time with current carrier;
- claims data — if available, three years of claims data is preferred;
- enrollment for the claims period (breakdown of contracts by month);
- shock claims information (individual claims in excess of \$50,000);
- diagnosis and prognosis for excess claims;
- summary of current plan design (source documentation);
- current renewal, including premium rates (source documentation);
- employee contribution (the amount of premium contributed by the employee toward his or her benefits program; it can be expressed as a percentage or dollar value);
- detailed census — Excel formatted. The census must include the following:
 - employee name
 - date of birth (month, day, year)
 - current program enrollment (i.e., HMO, PPO, Rx, Vision)
 - number of insured lives during experience period (contracts by month)
 - ZIP code of current residence
 - employee gender
 - coverage status (i.e., enrollment by coverage tier)
 - waivers — eligible employees not electing coverage because they are covered under another plan (i.e., spouse's coverage)
 - opt-outs — eligible employees not electing coverage and who are *not* covered under another plan
 - date eligible for coverage if employees are in a probationary period

Section 7 — When a rate quote is not available through ROAM)

WHAT DOCUMENTATION IS REQUESTED WHEN ROAM QUOTE IS NOT AVAILABLE? (cont'd)

Additional required information, where applicable, would include:

- request for proposal (RFP) request and attachments;
- union agreement (if applicable).

THE RIGHT TO DECLINE TO QUOTE

Subject to applicable law, Underwriting reserves the right to decline to quote any group deemed to be an unsatisfactory risk. However, such a decision will not be based in any way on the medical condition of the group's members.

Section 8 – Group terminations and reinstatements

TERMINATION OF COVERAGE

The terms and conditions of coverage termination are as follows:

- Generally for fully insured PPO or HMO customers, the group may terminate coverage on the contract anniversary date by giving the other party no less than 30 days' advance written notice. IBC or KHPE may terminate the group's coverage for nonpayment of premium upon written notice effective the last day of the 30-day grace period.
- For self-insured / Cost-Plus groups, IBC / KHPE may terminate the ASO agreement immediately upon prior written notice for nonpayment. Either party may terminate the ASO agreement on 90 days' prior written notice for any reason.
- Upon termination of coverage, the group is responsible for all due but unpaid premiums. IBC will not be responsible for collecting any premium dollars from individual group members, even if the group members were responsible for the cost-sharing of the premium with the group.
- Upon termination of the group's coverage, all COBRA groups must be terminated by IBC / KHPE. COBRA-only groups are not allowed.
- If an account that is on a special premium payment schedule (such as contingency, delayed premium, or staggered premium arrangement) cancels either on anniversary or off-anniversary, the unpaid premiums are due immediately.
- If a group account terminates in order to purchase nongroup coverage, it will not be eligible for group benefits or rates for 12 months from the date of the termination.
- IBC reserves the right to cancel a group's coverage off-anniversary if the group fails to meet IBC's underwriting guidelines, including but not limited to minimum participation requirements.
- If a group that currently has Blue Cross (hospitalization), Blue Shield (medical/surgical), and Major Medical coverage decides to cancel either the Blue Cross or Blue Shield component, or both, it must also cancel the Major Medical program.
- If a group cancels Freestanding Prescription Drug coverage and has Major Medical coverage, the Major Medical rates must be adjusted to include drug coverage unless the group furnishes proof of purchasing a Freestanding Prescription Drug program from another carrier.
- Vision, prescription drug, and dental programs (except for those offered as an HMO rider) may continue to be offered to the group on a freestanding basis.

Section 8 — Group terminations and reinstatements *(continued)*

REINSTATEMENT OF COVERAGE

Whenever a previously enrolled group wishes to return to active coverage under IBC, this restoration is termed a “reinstatement.” Often, this reinstatement occurs after a termination from coverage due to failure to promptly pay premiums. In order to maintain continuity of coverage and avoid exposure to preexisting condition waiting periods, groups may seek to regain their active status through a reinstatement. Some points to consider are:

- The reinstatement must occur within 60 days of the effective date of the cancellation, and the reinstatement must be retroactive to the cancellation date;
- Any past-due premium must be collected prior to reinstatement.

When the above conditions have been met and a reinstatement form has been completed by Marketing, Underwriting will review the case and make a final determination as to whether the group should be reinstated and at what rate level.

Section 9 — Individual medically underwritten products

For more than 70 years, Independence Blue Cross has offered quality health care products and services designed specifically to meet the changing health care needs of its customers.

With Individual HMO from Keystone Health Plan East, members select a primary care physician from IBC's expansive network to coordinate all of their care.

These are medically underwritten programs, so coverage is not guaranteed and some applications may not be approved based on medical conditions. As a medically underwritten product, acceptance and rates are based on an applicant's health status. There is no automatic transfer from any existing Keystone Health Plan East, Personal Choice, or other Independence Blue Cross plan into the Individual Medically Underwritten Programs.

In addition, the HMO plans are subject to a preexisting condition exclusion. Coverage for any preexisting condition, illness, or injury for which medical advice or treatment was recommended or received within the 90-day period that precedes the effective date of coverage is excluded for the first 12 months.

There is no waiver of the preexisting exclusion provision. Certificates of Creditable Coverage from a group plan are not applicable for these products. Even if an applicant has been continuously insured under another plan prior to applying with us, the preexisting exclusion provision will apply to any approved application.

For more information, please view the [Individual Broker Tool Kit](#).

Section 10 – Group Medicare products

MEDICARE ADVANTAGE, GROUP PRESCRIPTION DRUG PLAN, MEDICARE SUPPLEMENT

What is Medicare Advantage?

Medicare Advantage Plans are health plan options that are part of the Medicare program. When someone joins one of these plans, he or she generally gets all Medicare-covered health care through that plan. This coverage may include prescription drug coverage.

To be eligible and join a Medicare Advantage plan, the applicant must have Medicare Part A and Part B. An applicant will have to pay the monthly Medicare Part B premium to Medicare. In addition, he or she might have to pay a monthly premium to the Medicare Advantage plan for the extra benefits that are offered.

When someone joins a Medicare Advantage plan, his or her Medigap policy will not work. Medigap will not pay any deductibles, copayments, or other cost-sharing under the Medicare health plan. Therefore, the applicant may want to drop his or her Medigap policy when joining a Medicare Advantage plan. However, the applicant has a legal right to keep the Medigap policy.

What Medicare Advantage products are offered by Independence Blue Cross?

Independence Blue Cross offers Personal Choice 65SM and Keystone 65 as Medicare Advantage products.

Underwriting guidelines for Medicare Advantage

- **Eligibility:** In order for Personal Choice 65 and Keystone 65 to be sold on a group basis, the group customer must be located, and the members of the PC65/KS 65 group must reside, in the IBC service area (counties of Bucks, Chester, Delaware, Philadelphia, or Montgomery). National accounts may elect to offer Personal Choice 65/KS 65 to their members residing in the IBC service area. No out-of-area contracts may enroll.
- **Minimum group size:** An account must have a minimum of two contracts (Medicare and commercial combined) in order for PC 65/KS 65 to be offered.
- **Multiple retiree products per customer:** Underwriting rules allow an account to offer all four types of Medicare products at the same time: Security 65[®] (Medicare Supplement), Personal Choice 65 (PPO), Keystone 65 (HMO) or one of the Keystone 65 Point-of-Service plans, and Keystone 65 Direct (Open Access POS).
- **75 percent rule:** Personal Choice 65 and Keystone 65 members will be counted toward meeting the 75 percent participation requirement for the entire customer.

MEDICARE ADVANTAGE, GROUP PRESCRIPTION DRUG PLAN, MEDICARE SUPPLEMENT

Underwriting guidelines for Medicare Advantage (cont'd)

- **Retiree-only accounts:** Retiree-only accounts will not be permitted. If the group's active contracts cancel, coverage for early retirees, as well as Medicare coverage, may not remain in force. In such accounts, dependents may be offered one of our individual community-rated products.
- **New accounts — Medicare Advantage only (no commercial coverage):** New Medicare Advantage groups may be sold without the requirement of having a commercial plan in place.
- **Early-retiree-only accounts:** Coverage for *early-retiree-only* group accounts (under age 65 non-Medicare eligible retirees) will not be offered. Early retirees may not represent more than 10 percent of a commercial group.
- **Rating status:** For PC 65 and KS 65 — Community rated for all new business. For renewals, groups with an average of 50 or fewer enrolled contracts in the 12 months preceding the renewal preparation will be community-rated. Groups with an average of 50 or more enrolled contracts in the 12 months preceding the renewal preparation will be experience-rated. For Medicare Supplemental plans, all programs are community-rated.
- **Tier structure:** Single rate only.
- **Rate renewal period:** Rates will be published and adjusted on an annual basis, subject to approval by CMS (Centers for Medicare & Medicaid Services). Rates are expected to be adjusted on January 1 of each year. A group's PC 65/KS 65 rate change date may not match its commercial anniversary date. (If the group has commercial drug, dental, or vision coverage, those rates will change on the group's commercial business anniversary date.)
- **Medicare supplement:** For Medicare Supplement coverage, there must be an active under-65 population in order to set up this coverage line, and there must be at least one enrolled life to set up the group coverage. Traditional Major Medical may be offered with Personal Choice 65 (as has been permitted with Security 65® and 65 Special).

Section 10 — Group Medicare products *(continued)*

MEDICARE ADVANTAGE, GROUP PRESCRIPTION DRUG PLAN, MEDICARE SUPPLEMENT

Ancillary product options for Medicare Advantage

Personal Choice 65:

- Rx — Part D, freestanding (rating follows commercial), or PDP
- Vision — community-rated plan (when no commercial coverage is offered) or a freestanding plan (rating follows commercial)
- Dental — no IBC coverage is available

Keystone 65:

- Rx — Part D rider, freestanding (rating follows commercial), or PDP
- Vision — rider or freestanding (rating follows commercial)
- Dental — rider

Personal Choice 65 and Keystone 65:

- 75 percent participation requirements apply to all freestanding ancillary coverage programs.

Section 11 – IBC/KHPE underwriting guidelines summary

Note: For clarification of policies and guidelines, please refer to the specific topic section within the guidelines manual.

Market Segment ¹	Available Benefits	Dual Option Offerings	Participation Requirement	Employment Contribution Requirements	Rate Tiers	Submission Guidelines	Off-Cycle Benefit Changes
2 – 19 eligible employees	Medical: Flex Deductible and Copay Plans, HSA-Qualified HDHP PPO Rx: Select Rx Plans (HDHP may offer only Integrated RX) Restrictions apply to some medical/Rx offering combinations ²	2-9 lives: 2 medical benefits plans 10-19 lives: 3 medical benefits plans See topic section for limitations.	100% participation with a minimum of 2 subscribers enrolled	25% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier basis	New business quotes will be handled through the Account Installation Process	Only benefits downgrades will be permitted off-anniversary
20 – 99 eligible employees	Medical: Flex Deductible and Copay Plans, HSA-Qualified HDHP PPO Rx: Select Rx Plans (HDHP may offer only Integrated RX) Free-Standing Rx available to groups of 51+ Restrictions apply to some medical/Rx offering combinations ²	3 medical benefits plans. See topical section for limitations.	75% participation required	25% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier basis	New business quotes will be handled through the Account Installation Process	Only benefits downgrades will be permitted off-anniversary
PPO 100+ eligible employees	Medical: Underwriting discretion Rx: Underwriting discretion Restrictions apply to some medical/Rx offering combinations ²	3 medical benefits plans 2 Rx benefits plans *Exceptions per Underwriting discretion	75% participation required	25% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier basis	New business quotes will be handled through the standard enrollment process.	Only benefits downgrades will be permitted off-anniversary
HMO 100+ eligible employees	Medical: Underwriting discretion Rx: Underwriting discretion Restrictions apply to some medical/Rx offering combinations ²	3 medical benefits plans 2 Rx benefits plans *Exceptions per Underwriting discretion	75% participation required	25% of gross monthly premium or 75% of the single tier rate for each plan offered	Standard 4 tier basis	New business quotes will be handled through the standard enrollment process	Only benefits downgrades will be permitted off-anniversary

¹ Guidelines within grid apply to the quotation of new business. For applicable guidelines for existing business, assume enrolled employees instead of eligible.

² The following Rx offering restrictions apply when offered in conjunction with certain medical plan offerings. The medical plan, Rx plan combination restrictions are the following:

- Flex Copay Series Medical (C1-F1): non-formulary plans, even if standard benefit designs, must be quoted only after benefit exception approval received, due to coverage of certain injectibles under both the medical and prescription
- Direct POS Medical: 0/25/50, 5/30/50, 5/10/25, 5/15/25, 5/20/35, 10/20/35, 10/30/50, 15/35/50, 20/40/60 (all with and without orals)
- Flex Deductible Series Medical: 0/25/50, 5/30/50, 10/20/35, 15/35/50, 20/40/60 (all with and without orals)
- HSA-Qualified PPO programs may be offered only with integrated Rx program

* Quotes for Religious Exclusion and Elective Abortion Exclusion riders must be submitted via benefit exception process when they are to be offered in conjunction with a POS program.

** The HSA option must be offered with a Flex Deductible Series Medical (e.g., D1N1)

2009-0019 (03/09)