Small Group Underwriting Guidelines

(*Groups of 2-50 Full-time equivalents*)

Broker Edition

Independence Blue Cross Underwriting Department

Effective 2025

Independence

Contents

Eligibility and enrollment requirements

Please note: *These guidelines are applicable to new and renewing customers. IBX reserves the right to decline to quote new business groups or to terminate a group at renewal that is not in compliance with the underwriting guidelines. Any termination will be in compliance with the federal Patient Protection and Affordable Care Act (PPACA). Unless indicated otherwise, the guidelines in this document are applicable to Independence Assurance Company (IAC), QCC Insurance Company, Keystone Health Plan East (KHPE), and Independence Hospital Indemnity (IHIP) and existing groups with IBX coverage.*

Employer eligibility	• An employer must employ, on average at least one **but not more than 50 employees, including full-time and full-time equivalents (FTEs)** on business days during the preceding calendar year to be considered for IBX *small employer coverage. • New group applicants not meeting this definition of a small employer are not eligible for group coverage under the Small Employer plans. The following customers do not meet the definition of small employer: – Owner and spouse only businesses (including same sex marriage spouses) are no longer eligible for small group coverage. (Note: Spouse is excluded from the federal definition of employee). – Owner only groups, where there is not at least one common-law employee; this includes partner only groups. • Customers comprised of family members only may be eligible if there is at least one common law employee. • Organizations must not be formed solely for the purpose of obtaining health coverage. • A customer of one is permitted, provided that the customer consists of at least *one* owner and *one* employee. ***Note***: (An owner(s) cannot be the only individuals *offered* coverage). **IBX defines small employer consistent with the Internal Revenue Service guidance on defining small employer.*
IBX service area	• Greater Philadelphia five-county area: Philadelphia, Bucks, Montgomery, Chester, and Delaware. • Contiguous counties (counties that border the five counties): Warren, Northampton, Lehigh, Berks, Hunterdon, Lancaster, Mercer, Burlington, Camden, Gloucester, Salem, New Castle, and Cecil. • Five-county rating area for PA is rating area 8, per federal geographical requirements.
Location requirements	• The customer must be located within the Greater Philadelphia five-county area, as defined above. ***Note***: In accordance with regulation 147.104, employers with a business address outside of the IBX service area, but headquartered within the state of Pennsylvania, may be eligible for coverage ***only*** if at least one enrolling employee, lives, works, or resides within the IBX service area. A post office box does not fulfill location requirements; employers must maintain a physical corporate business address to be eligible for group coverage with IBX. • Members enrolling in HMO/POS coverage must reside within the IBX service area, except for members covered by an IBX affiliate as indicated below. • Members who live in non-contiguous counties and have HMO/POS coverage must be covered under and issued booklets by an affiliate of IBX.

Participation requirements	• Must have a minimum of 70 percent participation which includes all medical product lines of business. • For customers covering early retirees (under age 65), 100 percent participation of the early retiree population is required. The customer must consist of a minimum of 70 percent participation for the active employees. • Group Medicare coverage may be available for Medicare-eligible retirees; please refer to the Independence Medicare guidelines for eligibility, participation requirements and other guidelines. • Early retirees (under age 65 retirees not eligible for Medicare) cannot represent more than 10 percent of the customer's total enrollment. • Valid waivers: – employees with group coverage through IBX subsidiaries, Medicare or Medicaid, Veteran or other government issued coverage; – employees covered through their spouse; – employees covered as an eligible dependent to age 26 or age 30, in accordance with the federal Patient Protection and Affordable Care Act; ***Note***: Coverage through an individual "direct pay" plan is not a valid waiver. Federal/state exchange plans, including Individual Coverage Health Reimbursement Agreement plans (ICHRA) are not considered valid waivers.
Employer contribution requirement	• For contributory plan offerings, the employer must contribute a minimum of 25 percent of the lowest cost option's gross monthly premium.
Coverage classes	• Definition: Distinct categories (classes) within the customer, where these classes will receive different levels of health care coverage. • Classes must be determined by conditions relating to employment; must be clearly identifiable; and must exist for purposes other than insurance risk (for example, union/non-union, salaried/hourly, full time/part time). • Excluding a class from coverage within a customer is **not** permitted. • Existing customers may not split into multiple customers to obtain multiple benefit levels. • Qualifier: Subject to the above conditions, IBX will comply with the coverage classifications requested by the customer, **but approval of such request is not a representation by IBX to the customer that the requested classifications comply with applicable laws/regulations.** The customer should consult with its own legal counsel or tax advisor to determine if the coverage classification is permissible under applicable laws/regulations.
Employee eligibility	• Eligible employees include all active employees and owners, or partners actively engaged in the business who: – are deemed benefit-eligible according to the employer; – meet all requirements as defined in the carrier's plan documents and fulfilled any authorized probationary period requirements; and – reside or work in the applicable service area when electing HMO/POS coverage. ***Note***: To minimize adverse risk selection, it is recommended that employees work at least 25 hours per week. • **Ineligible Employees**: – Independent contractors (1099) and Leased employees are not eligible for group coverage unless they are reclassified as eligible employees based on the IRS common-law test as defined in Reg. § 31.3401(c)–1(b). – Employers are responsible for determining the employee classification for Independent Contractors and Leased employees. – IBX reserves the right to perform periodic audits to assure continued compliance with the above requirement.

	• **Other Ineligible employees include:** – Owners, officers or managing members who are not active, permanent, full-time employees, may not be eligible for coverage, this includes silent partners, shareholders, or investors only. – In addition, temporary, substitute, uncompensated workers and volunteers are also ineligible. • ***Off-cycle additions*:** Employees who initially waive coverage because they are covered under a spouse's medical plan may be added off-cycle to the customer's benefit plan upon the occurrence of a life event (for example, spouse's employment is terminated). • ***Probationary Period*:** In accordance with PPACA laws, employee probationary periods cannot exceed 90 calendar days from the hire date.
Dependent eligibility	• Employee's spouse. • Dependent children of the employee (natural, adopted, under legal guardianship or court-ordered custody), as defined in plan documents and in accordance with state and federal laws, are eligible for coverage up to age 26. • At employer's request, medical coverage for dependent children may be extended to age 30, if the dependent child meets the following criteria (*Pennsylvania State Insurance Mandate*): – is not married and does not have dependents (need not be a full-time student); – is a resident of the Commonwealth of PA or enrolled as a full-time student in an institution of higher education; – is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program. • An overage disabled dependent child is one who is incapable of self-support due to mental or physical incapacitation. IBX will review the required disabled documentation to determine eligibility for overage disabled coverage (coverage will terminate upon marriage of the dependent). • Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan. • Dependents must enroll in the same benefit option as the employee.
COBRA and Pennsylvania State continuation coverage (referred to as mini-COBRA)	• COBRA coverage will be extended in accordance with the federal law. • Employers with 20 or more employees (full/part time) are eligible to offer COBRA coverage. • Employers with less than 20 employees (full/part time) are eligible to offer mini-COBRA coverage. • Employers with 2-10 employees are allowed one COBRA enrollee. • For employers with 10 or more employees, the number of enrollees in COBRA and/or Pennsylvania mini-COBRA coverage is limited to 10 percent of the total enrollment. ***Note***: COBRA/Mini-COBRA members are not to be included for purpose of counting employees to determine the size of the group. Once the size of the customer has been determined, and it is determined that the law is applicable to the customer, COBRA/Mini-COBRA members can be included for coverage subject to the normal underwriting guidelines.
Common ownership affiliation (two or more companies affiliated or associated)	• Employers who have more than one business with different tax identification numbers (TINs) may be eligible to enroll as one customer if the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below): – For small employers, one owner must have at least 80 percent controlling interest of all businesses to be included. ***Note***: Customers requesting to combine small businesses with *mid-sized or **large businesses as common ownership, must provide proof that one owner has at least 80 percent

	controlling interest for all small businesses and at least 51 or more percent controlling interest for all mid/large businesses. – Employer provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 - Schedule K-1, 1120S – Schedule K-1, or SS4 – Application for Employer ID, and/or a copy of latest federal tax return -- all businesses filed under one combined tax return must be enrolled as one group). – Employer provides UC2A Employer's Quarterly Report of Wages for each entity and combined census with all eligible from all entities. – Entities must have a common policymaker legally authorized to make benefits decisions for the combined business. – Employer must submit letter indicating desire to combine the commonly owned entities. • Acceptance is subject to underwriting review and approval on case-specific basis. • These requirements also apply to existing groups wishing to add new businesses under common ownership arrangement (i.e., acquisitions, mergers). • Once common ownership is established, and premium rates are provided, the rates must be accepted as presented. • Common ownership businesses may later be separated for group coverage only when based on verifiable legitimate business reasons. **Mid-sized business is defined as employers with 51-99 employees.* ***Large business is defined as employers with 100 or more employees.*
Independent Contractor (1099) /Leased Employees	• Independent contractors (1099) and leased employees are not eligible for coverage unless they are reclassified as eligible employees based on the IRS common-law test as defined in Reg. § 31.3401(c)–1(b). • Employers are responsible for determining the employee classification for independent contractors and leased employees. • IBX reserves the right to perform periodic audits to assure continued compliance with the above requirement.

Product regulations and requirements

Benefit plans available	• Small group offerings are limited to the Blue Solutions® product suite. • HSA-qualified high-deductible products – with integrated drug • Adult dental product • All small group benefits will include Domestic Partner coverage and Autism benefits
Quoting Policy	• Maximum Product Offerings: • Small groups are allowed a maximum of four complete packages (medical with drug, pediatric and adult vision, and pediatric dental benefits). • If offering four packages, the combination must consist of at least one HMO/DPOS and one PPO/EPO benefit. • Medicare products are not counted toward maximum number of products. • For customers with out-of-area (OOA) employees: – If a customer is offering a PPO plan for out of area enrollment, the PPO benefit level must be equivalent to the benefit plans offered to the in-area employees. – Group offerings may not exceed four plans, including an out-of-area PPO coverage. ***Note***: If a PPO plan is added off-anniversary to accommodate new hire out of area enrollment, the rates and benefits will be based on the quarter corresponding to the effective date of the newly added PPO plan. The anniversary date for the PPO Plan added will be the same as the group's original anniversary date.
Rating Structure	• All small group medical, prescription drug, vision and pediatric dental plans will be calculated on a member-level build-up rating structure.
Mandated benefits	• Definition: Benefits that are required to cover the treatment of specific health conditions, certain types of healthcare providers, and some categories of dependents, such as children to a certain age. Health care benefits may be mandated by state and/or federal law. • An example of a mandated benefit implemented for IBX health benefit plans is the Mental Health and Substance Abuse (MHSA) Parity benefit.

Benefit Plan Changes	• Small groups will not be permitted to change benefits until their anniversary date. • Benefit changes requested ***after*** the renewal date will not be permitted.
Collective bargaining/ union agreements	• The Patient Protection Affordable Care Act federal guidelines will supersede any Collective bargaining/union agreements.
High deductible health plans (HDHPs), including HSA-qualified HDHPs	• Definition: – For calendar year 2025, a "high deductible health plan" is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,650 for self-only coverage or $3,300 for family coverage, and for which the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $8,300 for self-only coverage or $16,600 for family coverage. – HSA-Qualified HDHP – Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS. • Guidelines for funding deductibles: – Per the Affordable Care Act regulations, employers should not fund more or less than the federally mandated standards for funding employee deductibles. – The high deductible plan design selected will specify the funding requirement; please refer to each plan design for specific funding requirements. • An HSA-qualified HDHP may be offered along with other products, up to the maximum plan offerings (dual plan options) for the size of group. • HSA-qualified HDHPs: Health Savings Account (HSA) regulations have distinct requirements for prescription drug coverage. Federal requirements for HSA-qualified HDHPs do not allow a separate prescription drug program (or rider) to provide benefits before the HDHP annual deductible is satisfied; therefore, if a plan provides any prescription drug benefit before the annual deductible is met (except in the case of preventive drugs), it is not a qualifying HDHP for a Health Savings Account.
Health Reimbursement Account (HRA)	• Definition: Health reimbursement accounts (HRAs) are personal accounts funded solely by an employer used to reimburse employees for qualified medical expenses. Employer contributions are tax deductible for employers and generally excluded from an employee's gross income. • May be offered only: – On customer's anniversary date; – With an HRA-designated medical plan. • Prescription drug plan selection will follow high deductible plan rules. • Employer should not fund more or less than the federally mandated standards for funding employee deductibles. • Only one HRA option per customer is permitted.
Health Savings Account (HSA)	• Definition: A tax-exempt trust or custodial account created to pay for qualified medical expenses of the employee and their dependents. • Available only with a federally qualified high deductible health plan (HDHP) with integrated prescription drug benefit. • Customers adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.

IBX Blue Branded Small Group Dental Guidelines

- Overview:
  - Underwriting assumes that IBX dental is the sole carrier.
  - Dental Programs assume dependent children are eligible to age 26.
  - Dental coverage must be offered along with an IBX Fully Insured Medical plan.
  - All dental plans are offered on calendar year basis.

- Product Types
  - The following product types are available for purchase:
    - Preferred Provider Organization (PPO)
    - Exclusive Provider Organization (EPO)
    - Managed Dental Care Plans

- Quoting Policies
  - A maximum of one plan may be included in the accepted proposal.
  - Each dental plan offered must be paired with a specified medical plan.
  - All dental plans may be paired with any IBX medical plan.
  - Off anniversary plan changes are not allowed.
  - All dependent enrollment must be consistent between the dental plan and the medical plan.
  - Returning groups to IBX must be in compliance with the Underwriting guidelines prior to coverage being issued.

- Orthodontia
  - Orthodontia coverage is only available with specific plans.
  - Orthodontia coverage is not available for employer with under 10 enrolled.
  - For employers with under 25 enrolled subscribers, proof of prior coverage is required for orthodontia coverage.
  - Proof of prior Orthodontia coverage should include the following:
    - Name of carrier
    - Effective/end date of coverage
    - Plan summary reflecting orthodontia coverage.

- Participation Requirements
  - Minimum 2 enrolled contracts.
  - Dental participation requirements must match the medical participation requirements.
  - When a dental plan is offered, employees and their eligible dependents enrolled in the medical plan must also enroll in the dental plan.
  - In group coverage, dependents may enroll only if the subscriber is enrolled (unless eligible under COBRA or other law). Domestic Partners are considered Spouses for purposes of Underwriting, and coverage for Domestic Partners is optional to the group with no rate impact.
  - There must be enrollment in each plan offered.

- Employer Contributions
  - Employers must contribute a minimum of 50 percent of the calculated gross monthly premium for employee-only coverage or at least 25 percent of premium for employee-plus dependent coverage.

- Employee Eligibility
  - IBX assumes that coverage is offered to all employees meeting probationary and weekly work hours criteria. Employee waiting periods and/or orientation periods cannot exceed 90 calendar days.

- Rate Guarantee
  Small Groups have a twelve-month rate guarantee.

Rating information

Rating programs	• For new and existing customers, applicable rating methodology will be as defined by the federal Affordable Care Act guidelines.
Underwriting rating for small groups	• Definition of small group new business and renewal rating: As allowed under the Affordable Care Act, customers will be given community-based member level rates adjusted for the following factors: age, tobacco status, family size and employer geography. ***Note***: According to the U.S. Food and Drug Administration (FDA), E-cigarettes, vaping products, and nicotine/tobacco pouches are considered tobacco products. Therefore, tobacco rating will apply for Individuals utilizing these products.
Changes in customer size – effect on rating	• The employer is responsible for notifying IBX if the employee count has changed from small employer to mid-market, or vice versa. • If an employer group was previously rated as a small employer and increases in size to 51 or more total employees at renewal, the employer group will continue to be rated as small group until: – The customer requests to be re-rated based on new group size – Proof is submitted confirming the new employee count • Retroactive changes in rating methodology will not be permitted. If an employer group was renewed as a small employer and subsequently informs us that their employee count was 51+, the renewal rates would stand until the next anniversary date. • Employer groups can only change from small employer to mid-market or vice versa on anniversary date.
Change in Anniversary	• Requests to change a customer's anniversary may be allowed only for valid business reasons such as: o consolidating businesses o merger o to align with an anniversary for other lines of business • Underwriting Director approval is required for a request to change a customer's anniversary date. • Proof of valid business reason is required. • Requests must be received at least 180 days in advance of the customer's current anniversary and submitted to management for approval. • Benefits must reset within 12 months or less. • The requested anniversary date must be after the current anniversary date.
Situations requiring a requote by an IBX Account Executive or Broker	**Existing business:** • A change in anniversary date – Documentation required: letter from employer (on customer letterhead) – Requires approval by Underwriting Director • A material change in the census (for example, purchasing a new entity) – Documentation Required: Proof of common ownership (see "Common Ownership" rules under Eligibility Requirements section of this document) – Requires approval by Underwriting

	Note: Documentation required for new business quoting may be requested for specific situations requiring a requote.
Documentation required for New Business quote	• Broker will submit the following group census information through ROAM to receive an initial sample rate based on group characteristics. **Group census for all eligible employees, dependents, and COBRA participants, to include:** – Employee name (surname required) – Date of birth (MM/DD/YYYY) – Relationship to employee – Employees waiving coverage (eligible employees not electing coverage because they are covered under another plan) – Employee opt-outs (eligible employees not electing coverage and who are not covered under another plan) – Zip code (if available) – Tobacco status ***Note:*** Submission of paper waiver forms are not required, but employers should be sure to keep a copy of waiver forms on file for auditing purposes.
Right to decline to quote	• Subject to applicable federal and state laws, IBX reserves the right to decline to quote any customer deemed to be in violation of our underwriting guidelines. Such a decision will not be based in any way on the medical condition of the group's members. • IBX reserves the right to perform periodic audits to assure continued compliance with the underwriting guidelines.
EIN and Name Changes	• Customers requesting a name change in addition to an EIN change will require Sales and Underwriting management review. • Proof of new EIN and name change should be sent to Underwriting for review and approval to determine any material changes to the census and/or employer group. • Documentation required: o A signed letter from a CPA* on their letterhead, including their license number, and should include the following: a) Reason for the EIN and name change b) Date of the EIN and name change c) Any changes to the employees/census - IRS EIN Verification Notice (CP 575 or 147C) must be submitted as proof of the EIN and name change. *The CPA cannot be part of the employer group and the CPA license must be active. A letter from an attorney may be accepted in lieu of the CPA letter. The attorney's license must be active and cannot be part of the employer group. ***Note:*** IBX Underwriting reserves the right to perform periodic audits to assure continued compliance with the above requirement.

Post-sale submission requirements

Post-sale enrollment requirements	Rates quoted are conditional pending receipt, review, and acceptance of the standard submission requirements. ***Note:*** All offerings are subject to final underwriting review and acceptance. Additional guidelines and policies may apply.
Documents required with customer submission	• The following documentation must be provided for consideration: – Application for New Employer Health Benefits (front and back) – Universal Enrollment Forms (one for each employee enrolling) – Rate Quote – Both pages of the most recent PA UC-2A Form (Unemployment Compensation Tax Form) to include group name, address, and employee listing; if a UC2A is e-filed by a third party, the e-filed UC-2A should include verification of the filing. • ***Note:*** If the first page of the UC-2A (which should include name and address of the business) is not submitted, additional proof of business is required. If the second page (which should include the employee listing) is not submitted, additional proof of employment is required. (See below for acceptable forms of proof of business and proof of employment). – Small Employer Certification (front and back) – required for newly-formed or family-owned business when a PA UC-2A form is not available • Employers that do not have/file a UC-2A because they are a newly formed company, family-owned business, or a non-profit entity, must provide **one proof of business *and* one proof of employment** from the list below. Documentation should confirm that the business is active and the location of the business. ***Note***: A post office box does not fulfill location requirements; employers must maintain a physical corporate business address to be eligible for group coverage with IBX. • **Proof of business: (provide one)** – current business license (not a professional license) – Corporate Tax Form (Form 1120) – partnership agreement, articles of organization or articles of incorporation – official document with Employer Identification Number/federal tax ID number – Federal Form 990 or IRS Exemption letter (for non-profit entities) ***AND:*** • **Proof of employment: (provide one)** – payroll record (Paychex, ADP, Quick Books, etc.) – W-2 for all employees – IBX Eligibility Form for Owners/Partners completed and signed by each owner/partner (requires tax documentation) – letter from *Certified Public Accountant listing the names of all employees (full and part time), number of hours worked each week, dates of hire, and weekly salary **The CPA cannot be part of the employer group and the CPA license must be active. A letter from an attorney may be accepted in lieu of the CPA letter. The attorney's license must be active and cannot be part of the employer group.*

Customer terminations and reinstatements

Termination process	• Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act. • Customer may terminate coverage with at least 30 days advance written notice of the effective date to IBX. • IBX may terminate coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period. • IBX reserves the right to terminate coverage off-anniversary if the customer fails to meet IBX's underwriting guidelines.
Terms and conditions upon termination of coverage	• The customer is responsible for all due but unpaid premiums. • When the active commercial membership is terminated, all associated Medigap and Medicare Supplement plans will also be terminated; this excludes Medicare Advantage. ***Note***: A commercial medical plan or a Medicare Advantage plan is required if offering Medigap/Medicare Supplement plans.
Reinstatement of coverage	• Applies to customers terminated from coverage due to nonpayment of premium. • Reinstatement must occur within 60 days of the effective date of cancellation. • Must be retroactive to the cancellation date (i.e., no gap in coverage). • Unpaid premium (including paid to current) must be satisfied prior to being considered for reinstatement. • Limited to one reinstatement per rolling 12 months. • Reinstatements will be in compliance with Patient Protection Affordable Care Act regulations.
Former IBX coverage	• Customers that have been terminated for non-payment by IBX and are reapplying for coverage within 12 months, will be reviewed for ACA compliance prior to being offered coverage for a future effective date. • Customers returning at any time after voluntarily canceling coverage, will be considered new business. • Returning customers must be in compliance with the Underwriting guidelines prior to coverage being issued.
Guaranteed Availability and Renewability	• In accordance with federal requirement § 147.104 Guaranteed availability of coverage, IBX offers insurance coverage to individuals and employers, and will accept applications for its products from all individuals and employers in accordance with the ACA, state law, and its Underwriting Guidelines. • In accordance with federal requirement § 147.106 - Guaranteed renewability of coverage, IBX guarantees renewal or continued coverage in its individual or group insurance plan market.