BlueCross BlueShield Nebraska

BlueFreedom

2020 Group Underwriting Guidelines

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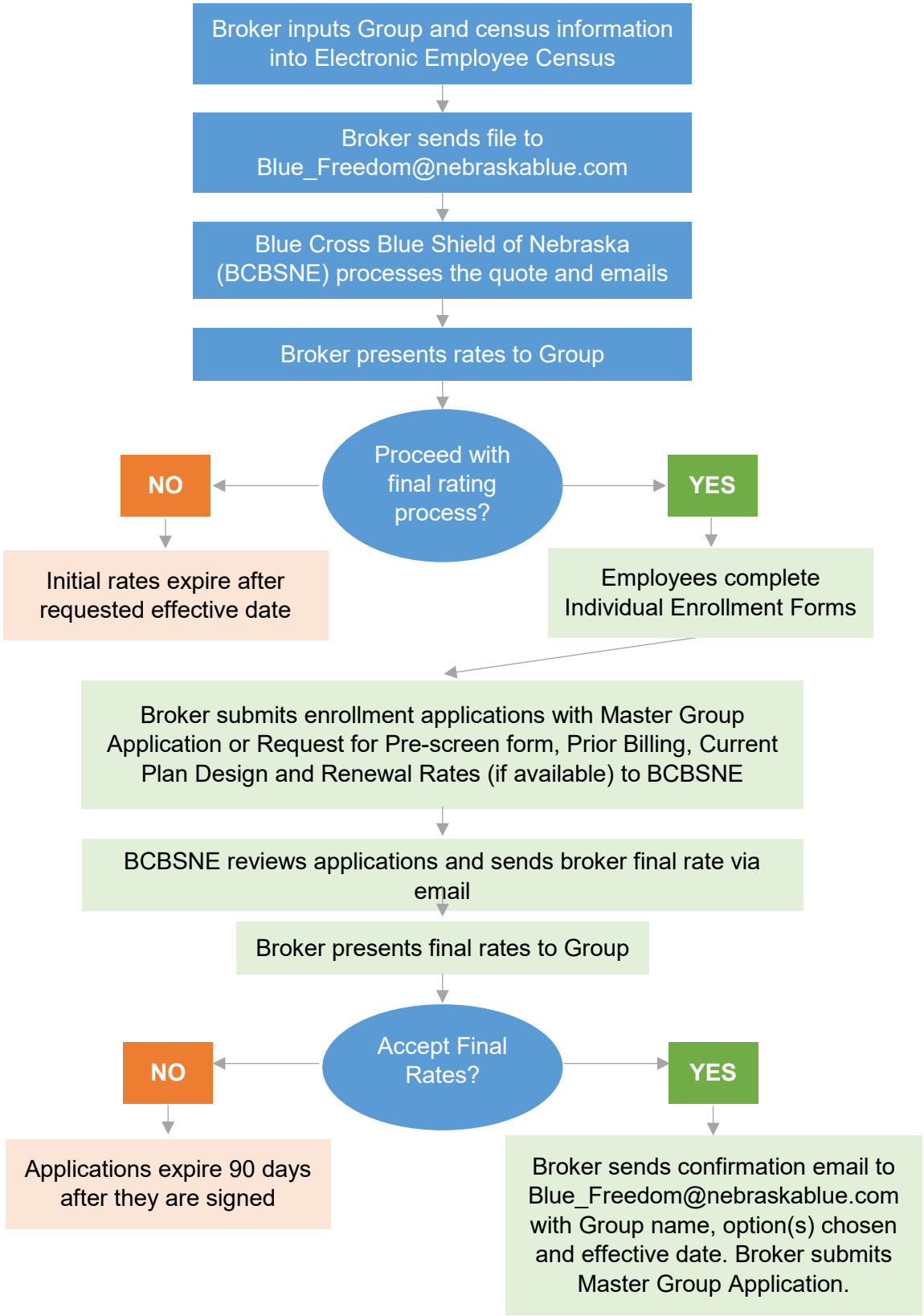
Preface: New Business Process



I. Eligibility

Definition

A mid-sized group (Group) shall mean an employer who has applied to Blue Cross and Blue Shield of Nebraska (BCBSNE) including any person, political subdivision, firm, corporation, limited liability company, partnership or association that is actively engaged in business that, on business days during the previous calendar year, employed an average of at least 51 total employees and no more than 150 eligible employees. For the purpose of counting total employees, part-timers are always each counted as one employee. The Group must be headquartered in the state of Nebraska. In certain situations, as determined solely by BCBSNE, in its discretion, it might be possible to obtain a cede for a group headquartered outside the state of Nebraska.

The Group may be formed by an employer as a business concern provided the business operates a minimum of six months per year on a regular basis and maintains a legitimate employer/employee relationship. The Group cannot be formed for the sole purpose of obtaining health insurance.

A Group is not considered new when the same management is involved and there is merely a transfer of the majority of members from one Group opportunity to another, or when the only change is in the ownership or the name of the business and the content of the Group has not changed materially in its characteristics or substantially in eligible employees.

A parent company must be a majority owner – 51% or greater – in any subsidiary in order to combine the subsidiary and parent into one group, provided the percentage of enrollment is met for the total group. The separate businesses must be identified on the proposal request and the application for Group contract.

Non-profit organizations cannot have common ownership and will not be able to combine with another organization for insurance purposes unless they are a part of the same non-profit organization.

Example:

Company Alpha	
Owner A	50%
Owner B	40%
Owner C	10%

Company Delta	
Owner A	50%
Owner B	25%
Owner D	25%

Company Omega	
Owner A	40%
Owner B	10%
Owner E	50%

In this example, Companies Alpha and Delta can be consolidated because Owner A and Owner B together own the majority interest (51% or more) in both companies. Company Omega cannot be consolidated with Alpha and Delta because there is not 51% common ownership with Companies Alpha and Delta.

General Eligibility Requirements

All regular full-time and permanent part-time employees, other than seasonal or temporary employees, who are actively performing the duties of their principal occupation, for the required minimum (17½ hours per week) are eligible for coverage through the employer Group.

Individuals not eligible for coverage in a group are those not actively employed by the Group, such as owners or part owners, members of the board of directors, trustees and shareholders and those who are employed for short periods of time such as Saturdays, holidays or summer vacations.

Retirees, aged 65 and older, are eligible as long as the employer contributes a minimum of 50% of the cost of the single premium, the Group has a formal retirement program and retirees don't make up more than 10% of the total Group. Retirees younger than age 65 are not eligible for coverage.

Independent contractors will be considered eligible for coverage as long as the contractor receives a 1099, is actively performing the primary duty of the principal occupation for a minimum of 17½ hours per week (unless a higher threshold is established by the Group) and meets all other eligibility requirements defined elsewhere in the guidelines. If the Group elects to provide coverage for independent contractors, all independent contractors who are working the required minimum number of hours per week and meet all other eligibility requirements shall be included for eligibility, participation and contribution requirements as defined within these guidelines. Independent contractors cannot make up more than 10% of the total Group.

Group contracts contain the following provision: "If two eligible persons in the same group are married to each other, each individual and/or their eligible dependents shall not enroll in more than one membership unit under this contract. Similarly, if two eligible persons have a parent/child relationship and both are employed by the same employer groups, the parent and child may elect to enroll one of two ways:

a. As two employees, or

b. The parent enrolls as an employee with dependent coverage

Enforcement of this provision is up to the Group since they control the initial enrollment of their employees.

COBRA participants are not considered eligible employees and are not counted toward participation and enrollment. COBRA participants must not make up more than 10% of the total Group.

Group is not eligible for BCBSNE group coverage when it is known that other health insurance coverage exists unless the employer agrees to replace the existing health insurance program in total.

Any exceptions to these general eligibility requirements require the approval of the Group Underwriting Department.

Eligibility Requirements for the Group

Group: See Definition section in Section I.

Group Size Requirement: A minimum Group size requirement of at least fifty-one total employees and no more than 150 eligible employees will be required to apply for coverage. A minimum group size of at least 2 enrolled employees is required.

II. Rating Factors

Industry Surcharge

Certain industries are subject to a risk load. Examples of these industries include, but are not limited to:

- Automotive repairs, rentals, parking
- Beauty and barber shops
- Business and professional organizations
- Construction
- Eating and drinking places
- Funeral services
- Gasoline service stations
- Health services
- Legal services
- Liquor stores
- Religious organizations
- Social services
- Trucking and warehousing services

Other Rating Factors

Groups are subject to other rating factors based on the following:

- Demographic composition of the Group
- Location within the state of Nebraska
- Number of employees residing outside Nebraska
- Participation
- Contribution
- Network
- Multiple options

Contribution: The amount an employer contributes toward the premium costs of the health insurance plan.

Participation: Participation will be determined by comparing the number of employees enrolling to the number of total eligible employees

Total Eligible Employees: Number of employees who meet the qualifications for health insurance coverage as defined in the General Eligibility section.

Valid Waivers – Other Qualifying/Creditable Coverage: Employees who have health insurance coverage elsewhere such as through a spouse, parent, Medicare, Medicaid or an individual policy.

Multiple Options: More than one benefit option

If additional applications are received after the initial medical review has been completed, Underwriting will need to review and update the rates based on demographic changes and the revised medical review. If the rates are not impacted by more than a 5% increase, in most cases there will be no adjustment to the rates.

Rating Disclosure

Individual Group rates are initially established based on the case characteristics of the Group, including the number of enrollees, age/sex composite of the members, location, industry, effective date and the benefit/network option selected. The rates initially provided to a Group are preferred rates. Groups will be evaluated to determine eligibility for preferred rates, and may subsequently be adjusted for participation and health status. In addition, BCBSNE reserves the right to recalculate and change the rates previously proposed based on inadequate or inaccurate disclosures during the RFP or application process which would affect BCBSNE's underwriting or rating decisions.

Subsequent rating actions are based primarily on the overall experience of the pool of Groups, and secondarily on the experience of each Group.

Any changes made to the census within 60 days of issue that date back to the original effective date may result in a rate adjustment.

Blue Cross and Blue Shield of Nebraska reserves the right to change rates on any due date after the first year or whenever the contract terms change.

Multiple Options

Groups are allowed to select up to three BlueFreedom benefit options as well as all three network options, if applicable. If the group elects to offer all three network options, employees who reside outside ZIP codes beginning with 680, 681, and 683-685, and outside of the Buffalo, Hall, Phelps, Kearney and Adams counties will only be eligible to enroll in the NEtwork BLUEnetwork option. Employees who reside in the ZIP codes starting with 680, 681, 683-685 may enroll in the Premier Select BlueChoice, Blueprint Health, or the NEtwork BLUEnetwork option. Employees who reside in Buffalo, Hall, Phelps, Kearney or Adams counties may enroll in either the Blueprint Health network or the NEtwork BLUE network option. Any employees residing outside the state of Nebraska are not eligible to choose the Premier Select BlueChoice network option unless prior approval is received from underwriting.

NEtwork BLUEis the only network option available to groups headquartered outside ZIP codes starting with 680, 681 and 683-685, and outside the Buffalo, Hall, Phelps, Kearney and Adams counties.

Blueprint Health, Premier Select BlueChoice, and NEtwork BLUE networks are available to groups who are headquartered inside ZIP codes starting with 680, 681 or 683-685. NEtwork BLUE and Blueprint Health networks are available to groups headquartered inside Buffalo, Hall, Phelps, Kearney or Adams counties.

III. New Business / Renewal Package

New Business Package

New Groups will be effective on the first of the month. The components of the new business package are as follows:

- The Master Group Application, fully completed and signed by an authorized representative of the company and the appointed agent/broker
- The individual enrollment forms

All components of the new business package must be received no later than the 15th of the month in which coverage is effective. The new business package is subject to approval by BCBSNE, and no commitments for acceptance should be made. When the new business package is approved, the appointed agent/broker will be notified in writing.

If the effective date, enrollment or other assumptions made at the time of proposal change when the proposal is sold, the Group Underwriting department reserves the right to retract the quote, or change rates, benefits and/or effective date of coverage.

Renewal Package

As a condition of renewal, Group employers are required to complete the Employer's Report of Employee Data for Group Health Insurance (survey). This is used to verify compliance with BCBSNE Underwriting Guidelines. Any subsequent information submitted after renewal rates are released will not be eligible for renewal revision.

The Group’s failure to provide necessary documentation, or noncompliance with the underwriting guidelines as a result of this review, will be treated as a failure to meet stated guidelines and the Group will be non-renewed. The Group and agent/broker will be notified of the termination of the contract.

Groups must submit acceptance of their renewal in writing to BCBSNE prior to the renewal date.

The Group’s contract will not be canceled based upon the health status of the Group. The contract shall be non-renewed or discontinued for Groups if:

1. BCBSNE has not received payment of premiums;
2. There is no longer any Subscriber who lives, resides or works in a Service Area where BCBSNE is licensed;
3. This contract form or particular type of contract is no longer offered in the 51-150 Group market applicable to this Contract;
4. The Group Applicant has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage
5. The headquarters of the Group are no longer located in the state of Nebraska; or
6. The contract is issued to an association, and membership in the association ceases. Coverage for that association subgroup and its covered persons may be terminated.
7. The group does not respond to survey requests by underwriting and the account management team 90 days prior to the effective date, the renewal package may be delayed.

Rate Guarantee

Group rates are guaranteed for 12 months, and any change of anniversary date must be approved by the Group Underwriting Department. However, if a Group changes to an anniversary date of January 1st before the next renewal due to election of a high deductible health plan, the Group will be subject to underwriting review and the anniversary date will be changed accordingly.

If the number of covered employees increases or decreases 5% or more, or the terms of the Contract are changed, BCBSNE reserves the right to change the rates.

IV. Signature Blue Dental Coverage

Dental coverage consists of the following four categories:

- Coverage A, Preventive and Diagnostic Dentistry
- Coverage B, Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Dentistry
- Coverage C, Complex Restorative Dentistry
- Coverage D, Orthodontic Dentistry

Dental coverage class selected is not required to match medical coverage class. Groups with prior group dental coverage may receive a rate discount.

Persons who do not enroll within 31 days of eligibility have only Coverage A benefits for the first 12 months of coverage. Exceptions are allowed for Special Enrollment due to marriage, newborns, adoptions, court orders, increases in employer contributions, death, divorce and involuntary terminations.

Dental Participation: Calculation used to determine if Group is eligible for coverage. Participation will be determined by comparing the number of employees enrolling to the number of Total Eligible Employees (excluding employees with other dental coverage).

If the employer is paying the entire premium for the employee, 100% participation will be required.

For Groups paying less than 100% of the employee premium, after excluding persons covered under creditable coverage, a minimum net participation of 60% of total eligibles is required. In addition, a Group must also have a minimum gross participation of at least 50% of all of their eligible employees enrolled, regardless of the number of or types of waivers.

The minimum employer contribution is 60% of the single membership rate for all covered employees.

V. Special Enrollment and Late Enrollment

Special Enrollment

Special enrollment periods can occur if a person loses eligibility for other coverage, employer contributions are terminated, or if a person becomes a dependent through marriage, birth, adoption and placement for adoption. The person must apply within 31 days of the qualifying event. Special enrollment is also available if a person loses eligibility for Medicaid or a State Child Health Insurance Program (SCHIP) or if a person becomes eligible for premium assistance under Medicaid or SCHIP. In those cases, the person must apply within 60 days of the qualifying event.

The special enrollment period for marriage, birth, adoption and placement for adoption applies also to the employee and spouse even if not previously covered through the Group.

Late Enrollment

Late enrollment periods can occur if persons (employees and/or dependents) do not apply for coverage within 31 days of eligibility and do not meet the definition of a special enrollee. A late enrollee will only be allowed to apply for coverage during the month prior to the annual renewal date. Enrollment forms must be signed by the last day of open enrollment and must be received by BCBSNE within 31 days.

Temporary Lay-offs, Leaves of Absence, Disability

The Group's documented personnel rules regarding sick leave and leaves of absence will determine continued eligibility. As long as the employer considers the employee to still be eligible for fringe benefits according to documented personnel rules, eligibility will be maintained. Once the employment status is terminated, the employee is eligible for any coverage dictated by federal (COBRA or Family Leave Act) or state law.

In the absence of documented sick leave or leave of absence policy, continued coverage on an active employee basis for a maximum of six months will be allowed.

Reinstatement Policy

Groups terminated for nonpayment may be reinstated once during a 12-month period, but not more often, and only with the approval of the Group Underwriting department. The receipt of two insufficient checks within a 12-month period constitutes nonpayment, and the Group will be terminated. Reinstatement requests should be accompanied by a check for the amount of the arrears. A Group which requests reinstatement after voluntary termination will be subject to full medical underwriting.