

UPMC HEALTH PLAN

EXCERPT FROM

Manufacturer and Business Association

UPMC Health Plan Small Business *Advantage* Insurance Bulletin 2010

This is a summary of the 2010 UPMC Health Plan portfolio of plan options as featured in UPMC Health Plan Manufacturer and Business Association Insurance Bulletin. For the complete publication with the accompanying underwriting guidelines, as well as information about the provider network and the most comprehensive health and wellness programs in the region, go to www.mbausa.org.

Underwriting Guidelines

Employer Eligibility

Eligible employer groups must employ 2 to 99 eligible employees. An employer/employee relationship between **each** individual seeking coverage and the small business entity, regardless of the marital or ownership status of any individual seeking coverage, must be present in order for an individual to be eligible for coverage. Employee eligibility is further defined in the next section.

Employer groups must be in business for a minimum of three months to be eligible for coverage.

Employer group contributions toward cost of medical coverage must be no less than 50 percent of the total cost of each rating tier or 75 percent of the individual premium in each of the tiers.

Union employees may be carved-out. Non-union carve-outs are considered on a case-by-case basis. Executive management level carve-outs are not permitted.

Employer groups terminated by UPMC Health Plan for nonpayment of premium are not eligible to reapply for coverage until 12 months have lapsed after termination date. If the Health Plan grants reapplication, a required payment of two months premium is due before the policy will be issued.

Out-of-area coverage is limited to the following:

Out-of-Area Coverage	
# of Eligible Employees	Maximum Out-of-Area % of Total Eligible Employees
2-6	No coverage available
7-20	15%
21-99	25%

If for any reason, an existing group's out-of-area enrollment becomes greater than the 15% or 25% guidelines listed, the entire group may be non-renewed for failure to meet UPMC Health Plan participation guidelines.

For groups with 2-50 eligible employees, only one out-of-area benefit plan is permitted per group.

Out-of-area benefit plans are applicable only if UPMC Health Plan is offered as the total replacement carrier. Preferred Provider Organization (PPO), Health Reimbursement Arrangement (HRA), and Health Savings Account (HSA) products are the only out-of-area plans offered. If the in-area plan selected is a PPO, HRA, or HSA, the out-of-area plan must be an equivalent or lesser benefit than the in-area plan.

For groups with 51-99 eligible employees UPMC Health Plan will allow blended rates for in-area and out-of-area plan offerings. In no event will a blended out-of-area rate be approved if sold with a non-blended in-area rate or vice versa.

Employee Eligibility

Eligible employees are defined as active, full-time employees working 25 or more hours per week. Part-time employees (those working fewer than 25 hours per week), absentee owners, seasonal workers, IRS 1099 contractors who are not employees, directors and trustees of the company, and Medicare-eligible retirees are not eligible for coverage. UPMC Health Plan offers group and individual Medicare Advantage plans for Medicare-eligible retirees.

An owner must receive full-time compensation from the company to be considered for coverage. If the owner is not reflected on the UC-2A, include the most recent Schedule C and a letter on company letterhead with the owner's name, exact hours worked, and duties performed, and indicate that he or she is a full-time employee of the business enterprise (working 25+ hours per week).

The employer group determines waiting periods, which must be applied consistently to all employees.

All employer groups with 50 or fewer eligible employees must submit a copy of their most recent PA UC-2A/Quarterly Wage and Tax Statement (Unemployment Compensation Tax Form), which must contain names, salaries, and weeks worked for all employees of the employer group.

Employees who have been terminated or work part time must be noted accordingly on the UC-2A. Recently hired employees not listed on the UC-2A must have a W4 or payroll stub submitted with the UC-2A.

There are circumstances when an employee will not be included on a UC-2A form or when the company is not required to file a UC-2A. Refer to following table for alternate types of acceptable documentation.

If a UC-2A is not available, submit one from Category A		... and one from Category B
Category A		Category B
IRS 1040 – Schedule C or F		K-1s or Articles of Incorporation
IRS 1065 – Partnership Income		K-1s or Partnership Agreement
IRS 1120 – Corporate Income		Current Business License
IRS 941 – Not-for-Profit Use Only*		Leases and Other Contracts
IRS 990 – Return of Organization Exempt from Tax*		

* Must submit copy of payroll journal; no Category B information required.

Only new employees and employees experiencing a documented qualifying event will be permitted to enroll outside the open enrollment period during the benefit year. For the purposes of this section, a qualifying event is defined as a (1) marriage, (2) birth/adoption of a child, or (3) a loss of other existing coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or other verifiable reason for loss of coverage eligibility.

Dependent coverage will be permitted to begin on the effective date of the covered employee's coverage. Coverage for additional

dependents (other than those resulting from a documented qualifying event) will be permitted at the employer group's benefit plan anniversary date or during open enrollment.

Employees initially waiving group coverage for any reason other than the employer's waiting period must wait until the next open enrollment period to enroll, unless there is a documented qualifying event.

Group Size and Enrollment Requirements

A minimum of 75 percent of eligible employees must have coverage in a health benefit plan either through the plan offered by the employer group, a spouse's employer, government programs (Medicare, Medical Assistance, military), union, or other comparable coverage.

At least 50 percent of all eligible employees must be enrolled in a plan offered by UPMC Health Plan. A minimum of two employees must be enrolled with UPMC Health Plan.

Medicare-eligible retirees do not qualify as eligible employees.

For groups with 2 to 50 eligible employees, employees covered by another plan must complete the waiver section on the Member Enrollment application and provide their sponsor plan number or a copy of their ID card.

UPMC Health Plan must be offered as total replacement coverage for groups of 2 to 50 eligible employees. **Dual option plans are not permitted for in-area employees in groups with less than 20 eligible employees unless an HSA plan is offered.**

UPMC Health Plan may be offered as a benefit plan along with other competing plans for groups of 51-99 eligible employees. If the plan is offered on an option basis, the employer group must agree to make no attempt, whether through differential premium

contributions or otherwise, to encourage or discourage enrollment in any one plan. At the discretion of UPMC Health Plan Underwriting Department, a minimum participation requirement may be set when offered on an option basis.

Plan options are limited to two plans and cannot be: multiple Health Maintenance Organization (HMO) or multiple Point of Service (POS) plans.

Dual option must be a true "buy up" situation and cannot be used to carve out management level employees offering a richer benefit. UPMC Health Plan requires that there is at least one enrollee in the dual option plan.

Dual option rates must have a rate differential of no less than 5 percent and no greater than 35 percent.

Consolidated Omnibus Budget Reconciliation Act (COBRA) will be offered to eligible individuals who formerly received coverage through employer groups that have active enrollment in UPMC Health Plan and/or to those who UPMC Health Plan is required to offer coverage under state or federal law.

All employer groups must submit their first month's premium no later than the 10th of the month prior to the effective date of the benefit plan.

Rate Determination

The UPMC Health Plan demographic rating applies to groups with eligible 2-99 employees. Employer Standard SIC code or description of industry as well as census data must be provided for all eligible employees.

Industry classification for a particular group is based on overall description of the employer group's business and not on the individual duties of its employees or locations.

Submitted census data must include the names of employees who are waiving coverage as well as COBRA participants and must reflect date of birth, gender, residence zip code, and tier status on each employee.

UPMC Health Plan will apply medical underwriting to new business quotes for groups with 2-50 eligible employees by collecting and reviewing individual medical questionnaires for each enrolling employee, spouse, and dependent.

Medical questionnaires received for underwriting for one quarter can be used to re-rate a 2-50 eligible employees group for only the next consecutive quarter. Thereafter, new questionnaires must be completed.

All questionnaires must be signed by the applicant and spouse, if applicable, to be considered a complete application. The option to submit electronic questionnaires is available via the UPMC Health Plan Web-based portal.

Quoted rates are subject to change pending validation of group demographics, tier status, group SIC, and review of applicable medical questionnaires based on demographic changes.

If enrollment of an existing group changes by more than 50 percent (+/-) within the contract period, Underwriting has the right to re-underwrite the group to determine if rates need to be adjusted accordingly. Medical questionnaires may be requested for new employees in such situations.

Should final enrollment change during new group implementation or at annual open enrollment either in total or by tier, UPMC

Health Plan reserves the right to re-evaluate rates based on the following:

Enrolled Contracts Prior to Change	Where Enrollment Changes by +/-
<10	50%
10-25	25%
26-50	15%

All consumer-directed health plans quoted by UPMC Health Plan assume that the HRA funds will account for no more than 50% of the total plan deductible. The employee must first satisfy his or her portion of the plan deductible before the HRA funds will be available. The HRA administration is assumed to be the responsibility of UPMC Health Plan. Any deviation from these assumptions may result in a change in the quoted rates. Employers choice of HSA funding will not affect quoted rates.

All PPO and EPO plans with deductibles quoted by UPMC Health Plan assume that the employee is paying 100% of the total plan deductible. Any deviation from these assumptions will result in a change in the quoted rates.

Self-funded arrangements will not be permitted for Small Business *Advantage* groups.

Prescription drug carve-out will not be permitted for Small Business *Advantage* groups.

Benefit plan changes/additions/deletions are permitted at renewal of the benefit plan only.

Predetermined nonstandard plan designs are available for "flexing" plan options for new businesses. Any other nonstandard plan designs will not be permitted for Small Business *Advantage* groups.

HMO 5 will be replacing all other HMO plan offerings for Small Business *Advantage* groups.

All rates must be approved by the UPMC Health Plan Underwriting Department.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Manufacturer & Business Association member companies with 20 or more full-time equivalent employees during the prior year are required to offer COBRA coverage. Member firms with fewer than 20 full-time equivalent

employees on the payroll for 50 percent of the previous calendar year are specifically excluded from COBRA coverage. COBRA will be offered only to an employer group that has active enrollment in UPMC Health Plan.

Mini-COBRA

Under the Pennsylvania Mini-COBRA Act, insured group health plans offered by employers with 2–19 employees must provide continuation of coverage to employees and dependents after qualifying events.

- UPMC Health Plan has modified its member material going forward with respect to the availability of Mini-COBRA. Accordingly, it will be the employers' or their designated COBRA administrators' responsibility to notify employees regarding the availability of Mini-COBRA coverage. UPMC Health Plan is not currently a COBRA administrator.

- Two new subgroups have been set up in the UPMC Health Plan administration system:
 - 9C0 – Mini-COBRA Subsidized — Applicants must complete the enrollment form and subsidy form found on the Pennsylvania Insurance Department (PID) website.
 - 9E0 – Mini-COBRA Non-subsidized — Applicants may complete and submit the standard enrollment form.
- Billing statement will show the entire premium, as well as a credit for 65%. No further calculation will be necessary and the client will pay just 35% of the original amount due.

Changes to Programs by Manufacturer & Business Association

Manufacturer & Business Association reserves the right to modify UPMC Health Plan products when Manufacturer & Business Association deems this to be in the best interest of the participating member

companies. Should such a modification become necessary, Manufacturer & Business Association and UPMC Health Plan will make every effort to provide as much advance notice as possible.

Audits

Manufacturer & Business Association and UPMC Health Plan may periodically conduct audits to ensure compliance with underwriting guidelines.

Coverage Transfer Activity

A member company terminated because of nonpayment of premium will be eligible for re-enrollment effective the first day of the 13th month from the date the company notifies Manufacturer & Business Association of its intent to re-enroll. All membership

and underwriting regulations will apply. Two months of premium will be required.

Note: UPMC Health Plan reserves the right to investigate each case to ensure that the basic intent of the underwriting regulations is not being circumvented.

Re-enrollment

Member companies that terminate their participation in one of the Association's health plans must maintain membership in the association for a period of no less than 12 months prior to eligibility for re-enrollment in any Association-sponsored plan.

Common Ownership

If the controlling owner/decision maker owns more than one company, common ownership must be documented and the owner/decision maker must have majority ownership in each company. Shareholders are not considered to be controlling owners/decision makers.

If groups have different SIC codes or tax ID numbers, the groups will be medically underwritten and rated as two separate groups. Requests for blended rates will be permitted following the initial rating.

If groups have only one SIC code, the companies can be rated as one employer group, or at the request of the employer group, UPMC Health Plan will permit separate rate development.

Any deviation from underwriting guidelines must have UPMC Health Plan Underwriting Department approval.

This information is meant to be informative and is not intended to be an all-inclusive statement of UPMC Health Plan underwriting guidelines. Other policies and guidelines may apply.