2021 Underwriting Guidelines

51+ Employees

A. Employer Eligibility

Eligible employer groups must employ 51 or more employees. Employee count is based on the average number of total employees in the preceding calendar year, including full-time, part-time, and seasonal employees. An employer/employee relationship must be present for all employees.

Employer groups that employ less than 51 employees, using the average number of employee count, do not qualify for large group coverage and must be rated as a small group. For new employers not in existence throughout the preceding calendar year, employer size will be based on the average number of employees reasonably expected in the current calendar year.

Employer group contributions toward the cost of medical coverage will be no less than 50% of the total cost of each rating tier or 50% of the individual premium in each of the tiers. Exceptions will be considered on a case-by-case basis.

Union employees may be carved out. Employees residing outside of the UPMC Health Plan service area may be carved out. All other rating carve-outs are not permitted.

If an employer group that was terminated by UPMC Health Plan for non-payment of premium reapplies for coverage, UPMC Health Plan will require payment of two months of premium in advance of issuance of the policy.

Standard employer group premiums assume that the number of employees residing outside of the UPMC Health Plan service area is limited to a percentage of a group's total workforce. If, for any reason, an existing group's extended network enrollment becomes greater than the guidelines listed, the entire group may be re-rated effective as of the date of such enrollment change.

Extended Network Coverage	
# of Eligible Employees	**Maximum Extended Network % of Total Eligible Employees**
2 – 6	5%
7 – 20	15%
21+	25%

Extended network plans must be equivalent to or of lesser benefit than the in-area plans. Requests for blended rates for in-area and extended network plan offerings will be considered on a case-by-case basis. Blended extended network rates cannot be sold with non-blended in-area rates or vice versa.

B. Employee Eligibility

Eligible employees are legal employees, as defined by the employer, who have met the employer's probationary period and any other eligibility criteria. IRS 1099 contractors who are not employees, directors and trustees of the company, and Medicare-eligible retirees* are not eligible for coverage.

The employer group determines waiting periods, which must be applied consistently to all employees. Employee or dependent eligibility waiting periods cannot be more than 90 days.

Employees will be permitted to enroll during open enrollment. Employees experiencing a qualifying event will be permitted to enroll outside of open enrollment. Generally, enrollment is limited to a 30-day period after the qualifying event. The following are examples of qualifying events:

a. Change in marital status
b. Birth or adoption of a child
c. Loss of other affordable coverage
d. Change in employment status that impacts plan eligibility
e. Change in place of residence (into or out of service area)
f. Court judgments, decrees, or orders that impact coverage for employee or dependents
g. Change in coverage of a spouse or dependent under another employer's plan
h. Loss of Medicaid (Note: Enrollment is limited to 60-day period after loss of Medicaid)

Dependent coverage will be permitted to begin on the effective date of the covered employee's coverage. Enrollment of additional dependents, other than those resulting from a qualifying event, will be permitted at the employer group's benefit plan anniversary date or during open enrollment.

**Medicare eligible retirees may not enroll within the active group. UPMC Health Plan offers group and individual Medicare Advantage plans for such individuals. Please call 1-877-381-3765 (TTY: 711) for more information.*

C. Enrollment Requirements and Plan Options

Quoted premiums assume that a minimum of 75% of eligible employees have coverage in a health benefit plan either through a plan offered by the employer group, a spouse's employer, government programs (Medicare, Medical Assistance, military), a union, the Marketplace, or other comparable coverage. Quoted premiums assume that a minimum of 50% of all eligible employees are enrolled in the employer group plan offered by UPMC Health Plan. Groups who do not meet these criteria must inform UPMC Health Plan and may be re-rated as of the date that any level of enrollment below the minimum threshold is determined to occur. At renewal, UPMC Health Plan reserves the right to non-renew if less than 50% of all eligible employees are enrolled in a plan offered by UPMC Health Plan.

Multiple plan options may be offered to employer groups with 20+ eligible employees:

Multiple Plan Options	
# of Eligible Employees	**Guidelines**
2 – 19	Not permitted.
20 - 99	• Plan options are limited to two plans. • Dual option plans must be a true "buy up" situation and cannot be used to carve out management level employees. • Dual option rates must have a rate differential of no less than 7% and no greater than 35%. • Plan options with no enrollment will be non-renewed. • Plan options cannot be multiple Health Maintenance Organization (HMO) or multiple Point Of Service (POS) plans. • Two HealthyU plans may be offered as a dual option. • HealthyU plans can only be offered alongside a PPO/EPO with a minimum deductible of $500. • Total Advantage plans are intended to be offered as a standalone product, and cannot be offered alongside MyCare Advantage, Inside Advantage, or Premium network plans.
100+	• Plan options are limited to three plans. • Multiple HealthyU plans are permitted. • HealthyU plans can only be offered alongside a PPO/EPO with a minimum deductible of $500. • Total Advantage plans are intended to be offered as a standalone product, and cannot be offered alongside MyCare Advantage, Inside Advantage, or Premium network plans. • Exceptions can be considered for groups with 200+ eligible employees, but must be approved by the Underwriting Department.

Standard quoted premiums assume that UPMC Health Plan will be offered as total replacement coverage. When another carrier(s) group health insurance (medical/pharmacy) is offered alongside a UPMC Health Plan group option, this is known as "optional basis." If an optional basis quote is desired, optional coverage must be indicated on the rate request form to enable proper pricing of the risk. Otherwise all quote requests will be assumed to be on a total replacement basis. Optional basis quotes

are not permitted for groups of 2 to 50 eligible employees. UPMC Health Plan may re-rate or re-quote groups if, after initial quoting or sale, it is determined or disclosed that UPMC Health Plan is not being offered as total replacement coverage. If UPMC Health Plan is offered on an optional basis, the plan design must not discriminate against UPMC Health Plan option in any manner. In the event that a UPMC Health Plan group plan is offered on an optional basis, the following guidelines will apply:

Optional Basis Minimum Participation Guidelines
Fully Insured:

Eligible Employees Within UPMC Health Plan Service Area	Minimum Participation Requirement
500+	20%
51 – 499	35%

ASO:

Eligible Employees Within UPMC Health Plan Service Area	Minimum Participation Requirement
51+	0%

If minimum participation requirements are not met upon enrollment, a minimum 15% load will be applied to rates at the effective date of the quote.

Additional participation requirements may be set at the discretion of the UPMC Health Plan Underwriting Department. Extended network enrollment maximums still apply.

UPMC Health Plan reserves the right to non-renew groups that do not meet the minimum participation requirements.

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. Total COBRA enrolled subscribers cannot exceed 15% of the total number of enrolled subscribers.

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.

D. Rate Determination

UPMC Health Plan uses an adjusted community rating methodology that is adjusted for age, gender, family composition, industry, and geographic area. The adjusted community rate is blended with group-specific experience for groups with more than 51 employees. A census including all eligible employees must be provided to obtain a quote. Submitted census data must include employees waiving coverage and COBRA participants, and must reflect date of birth, gender, residence zip code, tier status, and plan election for each employee. Groups currently without any coverage must submit a census of all eligible employees. In addition to the census, the industry classification or SIC code must be provided. Industry classification should be based on the overall description of

the employer group's business, and not on the individual duties of its employees or locations.

Current carrier(s) claim utilization, if available, must be provided to obtain a quote.

Quoted rates are subject to change pending validation of group demographics, tier status, group SIC, extended network population, optional basis vs. total replacement status, and for legislative/ mandate requirements.

If the number of enrolled contracts of an existing group changes by +/- 50% within the contract period, Underwriting reserves the right to re-underwrite the group and adjust rates accordingly.

Should final enrollment change by +/- 15% either in total or by tier during new group implementation or at annual open enrollment, UPMC Health Plan reserves the right to re-underwrite the group and adjust rates accordingly.

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 this assumption will result in a change in the quoted rates.

All UPMC *HealthyU* products assume that the Health Incentive Accounts (HIA) are funded by UPMC Health Plan. HRA rates assume that employer HRA allocation is 50% of the total plan deductible minus the HIA limit (HRA allocation + HIA limit = 50% of total plan deductible). HRA administration is assumed to be the responsibility of UPMC Health Plan. Employer level of HSA funding will not affect quoted rates. Deviations from these assumptions will not be permitted for employer groups with less than 200 eligible employees.

Prescription drug carve-out will not be permitted for fully insured groups. Prescription drug carve-out for self-funded groups with 200+ eligible employees must be reviewed and approved by Underwriting. Rating loads will be applied for carve-outs.

Self-funded arrangements will not be permitted for employer groups of 2 to 24 eligible employees.

Stop Loss coverage is required for all self-funded groups with 25 – 199 eligible employees, and is recommended for self-funded groups with 200+ eligible employees. Please refer to the Stop Loss Guidelines for more details on quoting.

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

Certain benefits will be available for "flexing" for new business and renewals for employer groups with 100+ eligible employees. Non-standard benefits will be permitted for employer groups with 200+ eligible employees. Flexed and non-standard benefits must be approved by the Underwriting Department.

Hearing Health benefits will be available as an add-on benefit to medical/pharmacy coverage. Hearing must be offered in conjunction with medical and cannot be offered as a stand-alone product. All employees enrolling in medical coverage must enroll in Hearing benefit, and in the same enrollment tier as medical, when Employer elects to add on Hearing Health; Hearing opt-outs will not be permitted. Employers with 2-199 eligible employees may elect one Hearing benefit option. Employers with 200+ eligible employees may elect two Hearing benefit options. Custom plans will be permitted for Employers with 200+ eligible employees.

For groups of **2-199 eligible employees**, firm renewals may be provided no earlier than **90 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

For group with **200- 499 employees,** firm renewals may be provided **120 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

For groups with **500+ employees,** firm renewals may be provided **180 days** prior to the effective date. Exceptions can be made with prior underwriting approval.

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

E. Common Ownership

Employers that have a common ownership interest in multiple legal entities should review our common ownership Limitation of Liability document. If employer signs the document, the separate entities will be combined as a single employer for purposes of group health plan premium rating and administration. All applicable underwriting guidelines must be met as a single employer. Rating carve-outs will not be permitted as outlined in Section A.

If employer group is unwilling or unable to sign Limitation of Liability document, UPMC Health Plan will provide an individualized quote for each business entity consistent with our standard premium rating guidelines.

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

This document 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.