Small Group Underwriting & Enrollment Guidelines

The Small Group Underwriting & Enrollment Guidelines (in accordance with the ACA laws and applicable state laws) documents the requirements for new and existing small group employers in New York with effective dates of **January 1, 2024, and later (unless otherwise stated)**.

Revised 10/10/2023

SMALL GROUP UNDERWRITING & ENROLLMENT GUIDELINES

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Underwriting & Enrollment Guidelines

PREFACE

As an insurer, Highmark (herein after referred to as HM) assumes health insurance risk when providing health care coverage (much like a bank or financial institution whom assumes financial risks). Therefore, to assess and confirm a group's eligibility and that of its members for small group coverage, employers are properly required to submit verifiable tax/wage and other documentation. Recognizing that this information is proprietary and extremely sensitive, it is used only for underwriting purposes to verify group and member eligibility and will be kept **STRICTLY CONFIDENTIAL**. HM's confidentiality statement can be found in the New Business Submission Guide.

Applications are to be submitted no earlier than 60 days prior to the effective date. Applications submitted more than 60 days prior to the effective date will need to be revised and resubmitted if expired. Please note, HM will **not** provide (or renew) coverage for groups that refuse to provide employment and ownership tax documents or other requested information needed to validate the eligibility of the group and its members.

In conjunction with the Affordable Care Act (ACA) laws, the goal of these underwriting guidelines is to provide clear, consistent policies and procedures for all **small employers** that apply for or renew HM group health plans, whether that involves purchasing/renewing a post-2014 ACA plan.

HM reserves the right to revise the underwriting guidelines **at any time** and **to make final decisions regarding any situations or issues** that are not specifically addressed within the guidelines.

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HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Defining an Eligible Group

Control Number: UC-101.1

Revision Date: October 10, 2023

Category: Group Eligibility Requirements

An eligible group is defined as a business or other legal entity that is actively engaged in a **full-time** enterprise which has the legal capacity to sponsor a group health plan for the benefit of **one or more** eligible employees (e.g., a corporation, partnership, sole proprietorship, union, religious and nonprofit organizations, municipalities/townships, or other entities formed in accordance with applicable state and federal laws).

To sponsor a small group health plan, an employer and employee relationship must exist among the individuals seeking coverage. In addition, the employer's full-time equivalents over the prior calendar year must be **100 or less**; and there must be **one or more** active (full or part-time) *common-law* employees when coverage commences in accordance with *Affordable Care Act* (ACA). A common-law employee does not include the sole proprietor, a partner of a business or a spouse of the sole proprietor or partner.

Dormant businesses, "side and hobby" businesses, trust arrangements, owner-only and investor/shareholder groups with no common-law employees do NOT qualify for group coverage.

Client firms of a Professional Employer Organization (PEO) will be required to submit the following to show they meet the ACA requirements:

- NYS-45 Proforma
- Or, year-to-date employee tax/payroll register, signed and dated. It must be the regular payroll that shows the taxes withheld. In addition, an attestation letter from the client on company letterhead attesting they are part of the PEO and are either being carved out or not being offered coverage through the PEO group plan.

For the purpose of the Employer Shared Responsibility provisions of the Affordable Care Act, the number of full-time employees and full-time equivalents (FTEs) over the prior calendar year determines whether the employer is large or small for the next renewal period. Exact calculations are reached by calculating the number of full-time equivalent employees over the prior calendar year. To determine the number of full-time equivalent employees over the prior calendar year, complete the following steps:

1. Hours worked by part-time employees over the prior calendar year:
    a. Multiply the total weekly hours by the number of weeks each part-time employee had worked over the prior calendar year.
    b. Add the results for each part-time employee together. This will be the total hours worked by part-time employees.

2. Hours worked by full-time employees:
    a. Multiply the number of full-time employees by the number of hours full-time employees worked per week over the prior calendar year.
    b. Multiply the result by the number of weeks full-time employees work per year. This will be the total hours worked by full-time employees.

3. Combine the hours worked by part-time and full-time employees. This is the total number of hours worked by all employees.

4. Divide the total hours worked by all employees by the number of full-time hours. This will determine the FTEs over the prior calendar year.

This would include all full-time, part-time, seasonal/intermittent, in and out-of-area ***employees***, union employees as well as owners and working family members who were issued a W-2.

Stockholders, board members, professional associates, trustees, legal counsel, 1099 consultants/contractors, and elected officials who do not meet the employee eligibility requirements are **not** eligible for group coverage.

An excerpt published by the IRS, defines a *common-law* employee as follows: *Employee (Common-Law Employee) Under common-law rules, anyone who performs services for you is your employee if you can control what will be done and how it will be done. This is so even when you give the employee freedom to action. What matters is that you have the right to control the details of how the services are performed.*

The IRS rules also indicate that the following individuals are NOT considered to be *common-law* employees and therefore, employers are to **EXCLUDE** these individuals when calculating their full-time employees and full-time equivalents over the prior calendar year: independent contractors (including sole proprietors); partners in a partnership; shareholders owning more than two percent of an S corporation; owners of more than five percent of other businesses; family members of the owners and partners, including a child (or descendant of a child), a sibling or step-sibling, a parent (or ancestor of a parent), a step-parent, a niece or nephew, an aunt or uncle, or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or a sister-in-law. A spouse is also considered a family member for this purpose, as is a member of the household who is not a family member but qualifies as a dependent on the individual income tax return of an excluded individual.

Groups with no common law employees that are typically family run businesses may still qualify for small group coverage under the ACA by providing supporting documentation that explains the business acts in an employer/employee capacity, except where the only enrollees are the sole owner of a business or the owner and his or her spouse. Supporting documentation would include ownership tax documents, unemployment compensation quarterly tax filings, federal tax Form 941, as well as a written letter from the employer describing how the relationship exists.

Note: Employers that have multiple related businesses that are part of a controlled group which are to be treated as a **"single employer"** under the Internal Revenue Code *Section 414* rules must provide an aggregated full-time employee and full-time equivalents count over the prior calendar year **for all related entities** for group/market size purposes - regardless of whether some or all the companies are seeking coverage through HM. (Refer to UC-101.4 and 104.1 for more information.)

In addition to the above ACA requirements, groups must provide current Unemployment Compensation tax (or payroll report if the entity is not required to pay Unemployment Compensation tax) and ownership tax documents as outlined in UC-103.2 and in the New Business Submission Guide and satisfy all applicable underwriting requirements.

New "start-up" businesses may apply for coverage contingent upon receipt of ALL of the following documents at time of application:

- Employer must provide the number of employees that are **"reasonably expected"** to be employed at the time of enrollment on the Small Group Business Application.
- If the UC report is not yet available, then a payroll report (identifying all employees and hours worked per pay period) that is annotated according to employee eligibility, signed, and dated **by the employer**.
- New Employee Affidavit can be submitted only for any new employees that do not yet appear on the UC report or payroll report.
- New Start up Business Affidavit can be submitted only if the UC report or payroll report is not yet available.
- SS-4 letter received from the IRS showing the EIN assignment.
- Upon request, Underwriting may require additional information to support group eligibility (e.g., declaration pages from the employer's workers' compensation and/or liability policies, business license, sales invoices/materials, etc.).

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Group Location/Residency Requirements

Control Number: UC-101.2

Revision Date: October 10, 2023

Category: Group Eligibility Requirements

To qualify for coverage, the **physical site** (street address) of a company or corporate headquarters must be located in HM's licensed service area or they are an employer in New York state and have eligible employees that live, work, or reside in the service area. Separate mailing and post office box addresses may only be used for billing, correspondence and/or administrative purposes.

If at least 50% of a group's enrolled employees (including owners and COBRA continuants) live, work, or reside within Highmark's service area, we will cover the entire group; if less than 50%, we will only cover those employees who live, work, or reside within Highmark's service area and/or the state of New York.

Private residences do not qualify as a branch office and post office boxes cannot be used as physical locations.

Requirements for groups with multiple locations are as follows:

- If a company has headquarter and branch locations within HM's service areas, the headquarter location will govern which Plan will write the combined locations (e.g., if headquarters are in western NY, the combined locations will be written by the western plan).

- If a company is headquartered outside of HM's licensed service area and it has a **branch location within the service area**, HM may write the branch location based on the following provisions. However, the size of the entire group would be taken into account for purposes of determining appropriate market segment (Large Group/ Small Group) including the headquartered location.

    - The headquarters must provide written authority to HM to negotiate coverage with the branch location(s).
    - The group must have an authorized decision maker (contract signor as noted on the Small Group Business Application) at the insured location.
    - HM will issue a notification to the BCBSA licensee located in the other state or region.

- If a company's headquarter location is within HM's service area and its branch location(s) are out-of-area, the branch location(s) should NOT be quoted (or added to existing groups) **without PRIOR written approval by Underwriting.**

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Carve-Out Groups/Employee Classes

Control Number: UC-101.3

Revision Date: March 8, 2022

Category: Group Eligibility Requirements

Carve-Out Groups:

Union/Non-Union:

Employers that have union employees who are provided health coverage through a separate union organization may choose to only cover non-union employees. To validate that the union employees have "creditable" waivers, the group **must provide evidence of current union coverage** (e.g., a copy of a union bargaining agreement and/or a health carrier invoice that identifies all covered union employees). In addition, the employer must also provide a copy of its current unemployment compensation (UC) report which must be annotated according to eligibility and union/non-union status.

Employee Classes:

Groups may offer differing levels of coverage and contributions and apply different hourly and new hire waiting period requirements to various employee classes (e.g., hourly/salary, union/non-union, etc.) based on the following conditions:

- The employee classes must be verifiable and directly related to employment divisions and the segmentations must exist for purposes other than insurance coverage.
- Employee classifications must **not** violate any state or federal antidiscrimination laws.
- Group must have written human resources policies outlining the classifications and a year-to-date payroll register that identifies the employee classes.
- Separate group numbers may be established for accounting/cost allocations and to identify applicable waiting period requirements if they vary by employee class.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: "Single Employer" Groups Involving Multiple Businesses

Control Number: UC-101.4

Revision Date: March 8, 2022

Category: Group Eligibility Requirements

Multiple businesses may be quoted and written as a **"single employer"** under one small group health plan provided all the following requirements are met:

- The group's authorized representative must provide a *Certification of Eligibility to Combine and Employer Group* Size form that cites all related entity names **as evidence of "single employer" status** (i.e., (a) controlled group of corporations, (b) partnership, proprietorship, etc.).

  Notes: The *IRC Section 414* rules are not applicable to public and religious entities. Therefore, when seeking coverage for multiple entities of this nature, please contact Underwriting **PRIOR to quoting such groups**.

  Highmark will not underwrite Affiliated Service Groups as defined in 26 U.S.C. Section 414(m).

- The employer must provide a full-time employee and full-time equivalents employee count over the prior calendar year **for all related entities** (regardless of whether all entities are seeking coverage through HM) and the below must apply. (Refer to UC-101.1 for employee count information.)
  - Client size is determined based on full-time employees and full-time equivalents over the prior calendar year, collectively for all related entities. The total full-time employees and full-time equivalents over the prior calendar year must be **100 or less**.

- The group must have a common decision maker (contract signor) within HM's licensed service area that is legally authorized to make benefit/human resource decisions and contract on behalf of the related entities.

- **Each business must be located within HM's licensed service area unless they meet the requirements of the Inter-Plan (IPP) programs, policies and provisions (refer to exceptions below).**

- The combined enrollment for all the businesses must satisfy the minimum participation requirement as outlined in UC-102.1.

Note: Multiple businesses written as a "single employer" group do **not** have the option of breaking apart later unless they no longer meet the IRC section 414 aggregation rule.

If approved by Underwriting, separate group numbers will be assigned to each business to identify the respective EIN, SIC code, physical location, and enrollment information for audit/legal purposes.

Likewise, if an existing group is found to have multiple businesses enrolled/embedded under one group number, they will be separated and assigned separate group numbers provided a *Certification of Eligibility to Combine and Employer Group Size* form confirms "single employer" status, and all underwriting requirements are met. If they do not qualify as a "single employer", the businesses must be quoted and underwritten as separate groups at the end of the contract period (via the new business process).

In addition, "single employer" groups that experience ownership changes (e.g., businesses are sold or acquired) must report such changes to HM (in writing) **within 30 days from date of the change**. Enrollment of newly acquired businesses is contingent upon the above requirements and **written approval by Underwriting**.

(Refer to UC-105.2 and 105.3 for more information regarding ownership and group size changes.)

Exceptions

Parent-Subsidiary:

- If ***both*** the parent and the subsidiary are headquartered in the same Highmark service area, then Highmark can issue a policy of insurance to the parent that covers ***both*** the parent and the subsidiary.
    - If ***only*** the parent or ***only*** the subsidiary is to be covered, then Highmark can issue a policy to either.
- If the parent is headquartered in a Highmark service area and the subsidiary is headquartered in another state, then Highmark can issue the policy to the parent that would cover both; ***if*** (i) the subsidiary is wholly owned (100%) by the parent; and (ii) the parent makes all benefits decisions for the subsidiary. In this case, no cede is required from the Local Licensee where the subsidiary is headquartered; however, Highmark is required to issue a consolidation of companies notification to the Local Licensee.
- If the parent is headquartered in Highmark's service area and the subsidiary is headquartered in another state, and ***both*** (i) and (ii) of the immediately above paragraph cannot be satisfied, then Highmark can issue the policy to the parent that would cover both; ***provided*** that (i) the subsidiary is a National Account; and (ii) Highmark obtains a cede from the Local Licensee where the partially owned subsidiary is headquartered.
- If the parent is headquartered in a state outside of Highmark's service area and the subsidiary is headquartered in a Highmark service area, then Highmark can only issue a policy of insurance to the subsidiary.

Brother-Sister Corporations (Common Ownership but no Parent-Subsidiary Relationship):

- Highmark can issue a policy of insurance to one or the other or under a single policy **if both** are headquartered in the same state as Highmark's service area.

- If **only** one brother-sister corporation is headquartered in the same state as Highmark's service area, then Highmark can only issue a policy to the corporation headquartered in Highmark's service area **unless the following criteria have been met**:

    - The out of state brother-sister corporation is a National Account;
    - A cede is obtained from the Local Licensee;
    - Both entities are within the same controlled group of corporations – as that term is defined in Section 414 of the Internal Revenue Code;
    - The brother-sister corporation located within the Highmark service area makes benefit decisions on behalf of the brother-sister entity located outside of the state where the Highmark service area is located; and
    - An officer capable of binding both brother-sister corporations is located in the state where the Highmark service area is located.

Note: Under BCBSA Inter-Plan Programs Policies and Provisions (IPP), only "National Accounts" can be ceded by a Local Licensee. For purposes of the IPP, a National Account is an entity having employee(s) that reside in more than one BCBSA licensee service area.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Employer (Group) Responsibilities

Control Number: UC-101.5

Revision Date: March 8, 2022

Category: Group Eligibility Requirements

As the sponsor and contract holder of a group health plan, employers must:

- Administer coverage by uniformly offering enrollment opportunities to **ALL** individuals that meet the employee and dependent eligibility requirements as noted on the Small Group Business Application and as outlined in guidelines in Section UC-103. Please note, eligibility changes **must be reported to HM in writing and may only be made at renewal**.

  Note: The employer's policies should not violate state or federal laws that prohibit unfair discrimination regarding eligibility standards for participation in employee benefits plans.

- Collect HM approved enrollment/waiver forms from ALL eligible employees that elect to enroll or waive coverage **for themselves and/or their dependents** (for all products offered at initial enrollment and annual open enrollment periods for renewal).

- Submit all enrollment terminations to HM in a timely fashion to remove members on the dates that they cease to be eligible for coverage. The effective date of cancellation should be no earlier than the date the member ceases to be eligible and, in no event should it be earlier than the first day of the month preceding the month from which HM receives the termination notice.

- Report accurate employee counts at initial enrollment and annually for renewal purposes for ACA group/market size, Medicare Secondary Payer, and applicable COBRA law purposes. Groups are encouraged to seek advice from their legal counsel as state and federal mandates carry different definitions for counting employees.

- Notify their Sales contact of any **major enrollment changes** involving employee layoffs and/or ownership changes (e.g., business acquisitions/mergers or "sell-offs") and/or **business status and/or location changes within 30 days of the change**. (Refer to UC-105.2 for more information.)

- **Provide a 30-day written cancellation notice** should the group decide to cancel any current coverage(s) as stated in the small group contract.

  Note: When a termination request is received the client is cancelled first of the next month. All termination requests at the client level are to be submitted prior to the effective date of termination.

HM reserves the right to terminate group coverage at any time if the group performs an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact. In the event of cancellation, **it is the employer's responsibility to notify its subscribers of the termination of group coverage**. Conversion notices for individual coverage will be offered as options for replacing group **medical** coverage.

Exceptions

New groups applying for December 1st effective dates AND new groups applying from November 15-December 15 for January 1st effective dates are not subject to the minimum participation requirements. **However, enrollment is contingent upon receipt of all submission materials in the timeframe noted below and all other underwriting requirements being met**.

Note: Applications are to be submitted no earlier than 90 days prior to the effective date. Applications submitted more than 90 days prior to the effective date will need to be revised and resubmitted if expired.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Medical/Dental Participation Minimums

Control Number: UC-102.1

Revision Date: March 8, 2022

Category: Group Participation/Product Requirements

Definitions:

Groups must have a minimum of 75% participation in medical/drug when offered through an employer sponsored group health plan (unless stated otherwise). See chart on UC-102.2.

The total number of eligible employees is tabulated by counting all active, eligible employees and owners that qualify for coverage and those waiving for no coverage (as outlined in UC-103.1 and 103.2). Eligible employees who waive for "creditable coverage" (as described below) should be EXCLUDED from the tabulation.

Note: While COBRA continuants are considered eligible for group coverage, they **cannot** be used to satisfy the minimum participation requirements.

"Creditable coverage" is defined as: other group coverage through a spouse, parent, or other employer; individual coverage; Medicare (Part A or Parts A and B); Medicaid; Medicare replacement plan; coverage through the Indian Health Service or a tribal organization; or a state, federal or Peace Corps health benefits plan. To receive credit, such individuals must submit a waiver form and upon request, may be required to provide a copy of their subscriber identification card as proof of other coverage.

Note: Short Term or Limited Benefit plans are not considered "creditable coverage". Waivers for Short Term/Limited Benefits plans or "no coverage" are not considered valid waivers and will not be carved out.

Please note, that if an eligible employee (age 26 or younger) waives for parental coverage and the parent is also an eligible employee under the same employer, they are counted as two eligible employees and two enrollees for participation purposes (regardless of the fact that they are enrolled under one contract). The same premise applies for husband-and-wife employees that work for the same employer and enroll under one contract.

All eligible employees and owners must complete Enrollment/Waiver forms indicating their intentions to enroll and/or waive available coverage(s) for themselves **and/or** their dependents.

Exceptions

New groups applying for December 1st effective dates AND new groups applying from November 15-December 15 for January 1st effective dates are not subject to the minimum participation requirements. **However, enrollment is contingent upon receipt of all submission materials in the timeframe noted below and all other underwriting requirements being met**.

Note: Applications are to be submitted no earlier than 60 days prior to the effective date. Applications submitted more than 60 days prior to the effective date will need to be revised and resubmitted if expired.

Dental:

Blue Edge Dental (BED) calculates participation as follows:

- Dental DOES provide waivers based on Underwriting guidelines below:
  - This mirrors how medical participation is calculated
  - The total number of eligible employees is tabulated by counting all active, eligible employees and owners that qualify for coverage and those waiving for no coverage (as outlined in UC-103.1 and 103.2). Eligible employees who waive for "creditable coverage" should be EXCLUDED from the tabulation.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Medical Participation Chart

Control Number: UC-102.2

Revision Date: March 8, 2022

Category: Group Participation/Product Requirements

The following participation requirements apply to medical/drug coverage offered through employer sponsored group health plans.

Active Eligible Employees	Minimum Enrolled	Active Eligible Employees	Minimum Enrolled	Active Eligible Employees	Minimum Enrolled	Active Eligible Employees	Minimum Enrolled
1	1	26	20	51	39	76	57
2	2	27	21	52	39	77	58
3	3	28	21	53	40	78	59
4	3	29	22	54	41	79	60
5	4	30	23	55	42	80	60
6	5	31	24	56	42	81	61
7	6	32	24	57	43	82	62
8	6	33	25	58	44	83	63
9	7	34	26	59	45	84	63
10	8	35	27	60	45	85	64
11	9	36	27	61	46	86	65
12	9	37	28	62	47	87	66
13	10	38	29	63	48	88	66
14	11	39	30	64	48	89	67
15	12	40	30	65	49	90	68
16	12	41	31	66	50	91	69
17	13	42	32	67	51	92	69
18	14	43	33	68	51	93	70
19	15	44	33	69	52	94	71
20	15	45	34	70	53	95	72
21	16	46	35	71	54	96	72
22	17	47	36	72	54	97	73
23	18	48	36	73	55	98	74
24	18	49	37	74	56	99	75
25	19	50	38	75	57	100	75

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Eligible Employees

Control Number: UC-103.1

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

An "eligible employee" is defined as: "an employee who works on a full-time basis and has a normal work week. The term includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. An employee that is not a part-time, temporary or substitute employee, but, for various reasons, might work fewer than 9 months could still be considered an eligible employee if the employee is employed full-time. However, a client can set a minimum of 20 hours per week. As such, employers must clearly identify their weekly hour requirements on the Small Group Business Application.

In accordance with New York law, an employer's new hire waiting period requirements **cannot exceed 90 calendar days** from the hire date.

Note: Stockholders, board members, professional associates, trustees, legal counsel, 1099 consultants/contractors who are not common law employees, and elected officials who do not meet the employee eligibility requirements are **not** eligible for group coverage.

In addition to the weekly hourly requirement, employees must also meet all the following requirements:

- Receives a regular hourly wage (or salary) as shown on the employer's most recent unemployment compensation (UC) tax report (and/or year-to-date payroll report). These documents should **not** be altered, the wages/credit weeks omitted and must be annotated according to employee eligibility, **signed, and dated by the employer.**

- Satisfies the new hire waiting period requirement (as noted on the employer's group application).

  Note: The group has the option to waive the new hire waiting period requirement for all employees at the time of initial enrollment, the group should indicate this on the SGBA, or via a client letter or email.

Additional waiting period requirements include the following:

- **Ineligible Employees Moving to Eligible Employment** – The employee must satisfy the new hire waiting period from the date they begin working the required number of hours to be eligible for coverage set forth per the group application.

- **Recalled Employees** – Per Highmark's business decision, employees returning to work from a laid-off status of one year or LESS are eligible for coverage on the date they return to work. If laid off for MORE than one year, the employees must re-satisfy the new hire waiting period requirement.

- **Rehired Employees** – Per Highmark's business decision, returning employees who were enrolled in coverage prior to a "loss of employee relationship" who are rehired **within 13 weeks from their termination date** are eligible to enroll on their rehire date or no later than first of the month following the rehire date.

Employers may apply different hourly and/or new hire waiting period requirements for multiple employee classes (e.g., hourly/salary, union/non-union, etc.) provided the classes are directly related to employment divisions and the segmentations exist for purposes other than insurance coverage. In addition, employee classifications must be clearly defined in the employer's written human resources policies and **cannot** be in violation of any state or federal antidiscrimination laws.

Changes to hourly and new hire waiting period requirements may only be made **at renewal and must be reported to HM in writing**.

Exceptions
Union employees covered through a separate union group health plan may be excluded as ineligible **contingent upon proof of coverage** (e.g., a copy of a union bargaining agreement or its health carrier invoice that lists all covered union employees).

In addition, eligible employees waiving for religious beliefs may also be excluded as ineligible provided they submit a copy of an Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits (Form 4029) which has been filed with the government.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Eligible Owners

Control Number: UC-103.2

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

Business owners may only enroll in group coverage provided they are eligible to sponsor a "small employer" group health plan under the ACA and they work at least 20 hours per week. Specifically, the employer must have full-time employees and full-time equivalent employees over the prior calendar year of **100 or less** **AND** have **at least one** (full or part-time) active *common-law* employee enrolled when coverage commences. (Refer to UC-101.1 and 104.1 for common law employee definition and for more information regarding employee counts and group/market size determinations.)

For example: If an owner had three full-time employees over the prior calendar year, the owner would be eligible to enroll in the group health plan provided the owner works at least 20 hours per week and at least one of the three full-time employees is enrolled.

To validate that a business exists and to objectively identify the total number of eligible owners/partners, the following tax documents are required:

- **Sole Proprietors** (for non-incorporated businesses) - Schedule C (Sole Proprietorship – Profit or Loss from Business), Schedule F (Profit or Loss from Farming), Schedule E (Form 1040 for rental businesses), or Schedule H (Form 1040 for Household Employers).

- **S Corporations or Partnerships (e.g., LLC, LLP, etc.)** – First page of Form 1120S (U.S. Income Tax Return for an S Corporation) **AND** Schedule K-1s (Partner's Share of Income, Deductions, Credits etc.) identifying **ALL partners** – OR - 1065 Form (U.S. Return of Partnership Income) **AND** Schedule K-1s (Partner's Share of Income, Deductions, Credits etc.) identifying **ALL partners**.

  Note: Limited liability companies/partnerships (those that file the Form 1065 and Schedule K-1's) have the option to not offer coverage to Limited, Domestic, or Foreign partners (who are not involved in the day-to-day business operations). In this case, **only general partners are considered eligible for coverage**. Should any Limited, Domestic, or Foreign partners elect coverage, then they are all considered eligible. Limited, Domestic, or Foreign partner exclusions must be submitted **in writing** (via the comments section on the group application or a signed letter from the group on company letterhead). However, partners of an S-Corporation (1120S and Schedule K-1s) do not have the option of carving out their partners.

- **C Corporations** - 1120 Form (U.S. Corporation Income Tax Return) first two pages only. Corporate officers/shareholders of C corporations will only be considered eligible for coverage provided **they appear as paid employees** on the group's current UC tax report (or year-to-date payroll register) and wage/salary

information must support the weekly hour requirement as stated on the Small Group Business Application.

Note that the following document can be reviewed for eligibility for those Officers that are not showing up on the UC report:

- Form 1125-E, Compensation of Officers, can verify for those entities with total receipts of $500,000 or more (gross sales of the company) the full-time wage compensation paid to officers.

- Underwriting reserves the right to request additional legal/tax documentation when deemed necessary as further validation of owners and/or business/group eligibility.

  All owners not enrolling in coverage must complete waiver forms and subsequently, do not have the option to enroll in coverage prior to the next open enrollment/contract period unless an event occurs that allows for special enrollment rights as defined under HIPAA and the ACA.

  In accordance with the ACA, owners/partners having multiple businesses may only combine them under one group health plan provided they are part of a controlled group of entities that are to be treated as a **"single employer"** under the Internal Revenue Code *Section 414* (aggregation) rules. (Refer to UC-101.4 for more information.)

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Employees with Disabilities

Control Number: UC-103.3

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

Employees with disabilities do not have to qualify for Social Security benefits and may continue under the active benefit program. Group coverage may be offered to employees with disabilities if **ALL** the following requirements are met:

- The employee with disabilities was actively employed **and** covered under the employer's group health coverage **at the time the disability occurred,** and an active employer-employee relationship currently exists.

- The employer must provide a copy of the unemployment compensation (UC) tax report (or payroll register) which identifies the employee with disabilities **as being actively employed at the time the disability occurred** (e.g., if the employee became disabled in October 2021, a fourth quarter 2021 unemployment compensation report is required).

- The employer must have an established written human resources (HR) policy that uniformly offers **ALL** employees with disabilities the privilege of continuing on the group health plan.

- The employer must submit a Disability Verification Form for **each** employee with disabilities enrolling. Disability Verification form is available on the Producer Portal.

Upon request, additional information may be requested relative to the eligibility of employees with disabilities.

Exceptions

The above definition does **not** include an individual with qualified disabilities who is entitled to protection from discrimination by the Americans with Disabilities Act ("ADA"). The ADA defines such an individual as "someone who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires". Individuals protected under the ADA are considered working employees and therefore, the employer is not required to complete the Disability Verification Form.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Dependent Spouse

Control Number: UC-103.4

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

Eligible dependents include an employee's spouse under a legally valid existing marriage between persons of the opposite or same sex. Upon request, HM may request copies of marriage certificates or a letter from the employer certifying the marriage exists, validating the eligibility of spouses.

Note: Regardless of court decrees, ex-spouses are **not** eligible for group coverage unless they qualify as COBRA beneficiaries as defined by applicable state or federal law or due to state continuation of benefits. If enrolling as a COBRA beneficiary, the group must provide a copy of the COBRA election notice.

Spouses of **legally recognized** *common-law* marriage arrangements between persons of the opposite sex may also be considered eligible.

To establish the validity of a *common-law* spouse, a notarized Affidavit of Common-Law Marriage form must be completed **and** at least three supporting financial documents must be attached (e.g., joint titles to property or automobiles, joint bank/credit account information, etc.). Affidavit of Common-Law Marriage form is available on the Producer Portal.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Dependent Children

Control Number: UC-103.5

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

Employers who elect to offer dependent coverage are required to insure a dependent child for group coverage until they reach age 26, regardless of marital or student status or financial dependency. Upon request, HM may request copies of birth certificates, adoption/ court ordered legal custodial documents or other information to validate dependent eligibility.

Eligible children include the following:

- Natural children (including newborns)
- Stepchildren
- Children legally placed for adoption
- Adopted children of the employee or the employee's spouse
- Children awarded coverage pursuant to an order of a court
- Children of a valid domestic partnership (if such coverage was elected by the employer)
- Children of a legal guardian who has assumed financial responsibility for the children

Note: Grandchildren are not considered eligible dependents (unless the contract holder has been awarded custody and can provide a copy of the legal custodial papers/court order to support eligibility).

Please note, health coverage for foster children is the responsibility of the appropriate social services agency.

Make Available Option:
Employers may extend medical coverage only for adult children through age 29 provided the election is made when they **initially enroll or upon renewal** (on the group application). To be eligible to be covered through age 29 under the Make Available Option, an adult child must:

- Be unmarried
- Not have coverage under or be eligible for other group health coverage.
- Be a New York resident or if not a resident, be enrolled as a full-time student at an institution of higher education.

Young Adult Option:
Adult children under age 30 of a member enrolled through a small group may be issued individual coverage under the group contract and will be charged the individual rate. The employer may collect this premium. To be eligible for this coverage, the adult child must:

- Be unmarried;
- Not be insured by or eligible for coverage through the young adult's own employer-sponsored group policy or contract, whether insured or self-funded;
- Live, work or reside in New York State and
- Not be covered under Medicare
- Recertified on yearly basis
- Be unmarried;

Exceptions

Eligibility may continue beyond age of 25 (without the make available or young adult coverage) for unmarried children who reach age 26 who are medically certified by a physician to be incapable of self-support due to mental retardation, physical disability, mental illness or developmental disability **that started before age 26**. A disability form **must** be completed and submitted with the new submission paperwork to HM for review and approval.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: COBRA Continuants

Control Number: UC-103.6

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

Federal COBRA:

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), which applies only to an employer with 20 or more employees ("large employer"), an employee may continue his or her current employer-sponsored group health insurance coverage upon loss of eligibility for group coverage. Under federal COBRA, the employee's dependent who loses eligibility for group coverage also may continue coverage. In order to determine whether federal COBRA applies, employers must calculate their full-time and full-time equivalent employees for the preceding calendar year (referring to the COBRA definition for counting employees and if applicable, the Internal Revenue Code Section 414 (aggregation) rules for multiple businesses that are to be treated as a "single employer"). Employers are encouraged to seek legal counsel in making their determinations.

Mini-COBRA:

New York State continuation coverage, known as "mini-COBRA," which applies to employers with fewer than 20 employees and all other groups not subject to federal COBRA, permits a person who is an employee or member of a group to continue group health insurance coverage for up to 36 months, regardless of the reason that the person lost eligibility for coverage. Mini-COBRA also "wraps around" federal COBRA and extends the continuation period for an employee or dependent receiving federal COBRA coverage by permitting the employee or dependent to receive mini-COBRA coverage upon termination of federal COBRA coverage. Mini-COBRA provides rights similar to federal COBRA to a member of such a group and the member's dependents. Mini-COBRA applies to insured, comprehensive coverage and may end sooner than 36 months if timely premium payment is not made; the employer ceases to maintain any group health plan; the employee or member is covered under any other group health plan that is not maintained by the employer, even if that other coverage is less comprehensive than COBRA or continuation coverage; or the qualified beneficiary becomes entitled to Medicare benefits.

Notes:

Although the law does not extend to ancillary coverage, qualified continuants that were enrolled in ancillary coverage at the time of the qualifying event may also continue that coverage.

COBRA continuants **cannot** be used to satisfy the minimum participation requirements.

When quoting new business, **ALL** qualified COBRA continuants enrolling in medical coverage must be included in the census. In addition, **the employer must submit copies of the COBRA election notices to validate eligibility**. Upon request, additional information may also be required to support eligibility.

Separate group numbers will be assigned for COBRA continuants for identification and audit purposes.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name:	Domestic Partners
Control Number:	UC-103.7
Revision Date:	March 8, 2022
Category:	Subscriber/Member Eligibility

Domestic Partner coverage is only available at the employer's discretion and the election must be made known at the time of **initial enrollment or at renewal**. Employers choosing to cover domestic partners must note the election on their group application (or submit the request in writing at renewal).

A Domestic Partner is defined as a member of a Domestic Partnership consisting of two partners (of the same or opposite sex). To qualify for group health coverage, the following requirements must be met:

- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other party by adoption or blood;
- Is the sole Domestic Partner of the other partner and has been a member of the Domestic Partnership for at least six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships which are currently enacted, or which may be enacted in the future.

In addition to the above requirements, evidence of a Domestic Partnership must exist. Employees enrolling a domestic partner must complete a Domestic Partner Affidavit and submit verification of one of the following three items along with their enrollment application. Domestic Partner Affidavit is available on the Producer Portal.

- Employee and Domestic Partner registered with a Domestic Partner Registry in effect in the municipality or government entity within which the Domestic Partner currently resides.

- Employee and Domestic Partner currently meet the definition of a Domestic Partner as defined by the state or local government in which you and your Domestic Partner reside.

- Attach two (2) or more of the following documents to the Affidavit:
  - A joint mortgage or lease on the primary residence
  - A designation of one of the partners as beneficiary in the other partner's will
  - A durable property and/or health care power of attorney
  - A joint title to an automobile
  - A joint banking account
  - A joint credit account

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: New Entrants

Control Number: UC-103.8

Revision Date: March 8, 2022

Category: Subscriber/Member Eligibility

HM reserves the right to verify the eligibility of new entrants (as described below) **at any time during the contract period**. Upon request, groups are required to supply information that establishes employee and dependent eligibility in accordance with the special enrollment rights and the employer's eligibility requirements. Supporting documents may include employee tax/payroll information, marriage/birth certificates, adoption/legal custody papers, etc.

New Entrants include the following:

- Newly hired/rehired employees (and eligible dependents) who meet the eligibility requirements as outlined in UC-103.1.

  Note: New enrollment received within 30 calendar days of the eligibility effective date will receive the eligibility effective date as their enrollment effective date. Any enrollments received after 30 calendar days from the eligibility effective date must wait until open enrollment or a qualifying life event.

- Employees and dependents who waived HM coverage at initial or open enrollment that have special enrollment rights based on the occurrence of certain qualifying life event or changes (loss of other coverage, marriage, birth, adoption, placement for adoption or employer contribution has stopped).

  Note: Enrollment received within 30 calendar days (or 60 calendar days for newborns) of the qualifying event will receive the qualifying event effective date. If the date of the notification is greater than 30 calendar days (or 60 calendar days for newborns) will have to wait until open enrollment or a qualifying life event.

- Employees and eligible dependents that meet eligibility requirements per UC-103.1 at the group's open enrollment.

  Note: Enrollment received within 30 calendar days of open enrollment (renewal) will receive the renewal effective date. Any enrollment applications received after 30 calendar days of the renewal date will be required to wait until the next renewal or qualifying life event.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Retired Employees

Control Number: UC-103.9

Revision Date: October 16, 2023

Category: Subscriber/Member Eligibility

Definitions

The group must have a bona fide IRS approved retirement program in process before retired employees can be enrolled in coverage (e.g., a pension or 401k plan, etc.). The group must also submit a copy of its written human resources retirement policy to HM and retired employees must meet the following requirements:

- Length of service (with the group) plus age must equal **60 or more years**;
- Must have worked **20 or more** hours per week prior to retirement;
- Employee must have been continuously employed **and** be enrolled in the group health plan for at least 5 consecutive years prior to retirement; and
- Must have maintained continuous coverage under the group health plan from date of retirement to present.

The group must contribute a minimum of 25% of the Retiree's premium.

Note: If a group's retiree requirements are different from those above, HM reserves the right to review and approve requested retiree coverage on a case-by-case basis.

Violations

Exceptions

If an owner of a company "retires" by selling the company, then HM will permit the former owner to remain on the group health plan as a Retiree if the former owner meets the 5 conditions listed above and if the company offers health coverage to all other Retirees on an equal basis.

A former owner may also be eligible to remain on the group coverage as a qualified COBRA beneficiary contingent upon receipt of a COBRA election notice.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Group/Market Size and Rating Methodologies

Control Number: UC-104.1

Revision Date: March 8, 2022

Category: Rating Requirements

Group/Market Size:
In accordance with the ACA, employers must report accurate employee counts for applicable group/market size determinations. To qualify for small group coverage, at initial submission, employers must have 100 or less full-time employees and full-time equivalents over the prior calendar year **AND** have at least **one or more** *common-law* employees enrolled (may be full-time or part-time) when coverage commences.

For more information regarding how employers are to calculate their full-time employees and full-time equivalents, refer to UC-101.1.

Notes:

If an employer has one or more related businesses that are to be treated as a "single employer" under the IRC *Section 414* aggregation rules, the employer must count all eligible employees (as defined above) for all related entities for group/market purposes (refer to UC-101.4 for more information).

Multiple businesses written as part of a "single employer" group under the IRC Section 414 aggregation rules do not have the option of breaking apart later unless they no longer meet the IRC section 414 aggregation rule.

Rating Methodologies:

Based on the above group/market size requirements, the following examples illustrate small and large group/market size determinations and applicable rating methodologies:

- If a group's full-time employee and full-time equivalents count over the prior calendar year was **100 or less**, it will be rated as a **small group**.
- If group's full-time employee and full-time equivalents count over the prior calendar year was **100.01 or greater**, it will be rated as a **large group**.

Employers of new "start-up" businesses (that were not in existence in the prior calendar year) should report the number of individuals **"reasonably expected"** to be employed at the time of enrollment.

Note: Under the ACA, the number of enrolled contracts has no bearing on group/market size determinations, nor does it allow for flexibility to groups that experience enrollment changes from one year to the next. As such, groups may be determined small group one year and large group the next year **depending on the full-time employee and full-time equivalents reported over the prior calendar year**. Therefore, it is important that employers report accurate full-time employee and full-time equivalent counts as outlined in UC-104.1.

Exceptions

Multiple businesses written as a "single employer" that experience ownership changes (that no longer qualify as such) must provide a *Certification of Eligibility to Combine and Employer Group Size* form from an authorized group representative confirming that "single employer" status no longer exists. Subsequently, each business must re-apply for separate group health plans via the new business process. The same premise applies for non-aggregated businesses that are discovered during an underwriting audit. (Refer to UC-105.2 and 105.3 for more information.)

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Communication of Approved Rates/Premiums

Control Number: UC-104.2

Revision Date: March 8, 2022

Category: Rating Requirements

For newly approved groups, Underwriting will issue a written approval notice (which includes the product/rate information and effective date of coverage) to the applicable sales representative. The notice must be presented to the group.

Should a group (or any of its members) not meet the Underwriting & Enrollment Guidelines, Underwriting will reach out to Sales to work with the group to get into compliance.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Adding/Changing Products

Control Number: UC-105.1

Revision Date: March 8, 2022

Category: Existing Business Re-Underwriting Requirements

The following rules apply to existing groups that wish to add or change products:

- Existing groups with supplemental coverage may add medical **at any time** by submitting all necessary paperwork (same as new business) **for review and approval by Underwriting**.

- The group must submit a signed Small Group Business Application (SGBA) reflecting chosen product(s) and the group's renewal date and business reason(s) for the change should be noted in the comments section.

  The SGBA must be received by HM in a timely fashion to ensure that the group receives its "Summary of Benefits and Coverage" (SBC) 60 days prior to the effective date so that it can provide proper notice to its employees as required by the ACA.

HM reserves the right to request tax documentation to verify that the group is in compliance with the underwriting and enrollment guidelines at any time. If requested, the tax documentation requirements are identical to those for new group submissions. Refer to the New Business Submission Guide for the additional information.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Ownership Changes/Business Restructures

Control Number: UC-105.2

Revision Date: March 8, 2022

Category: Existing Business Re-Underwriting Requirements

Existing groups are required to report ownership and/or other changes that affect their group health plan **within 30 days from the change** to their producer or HM Sales contact as such changes must be reviewed and approved by Underwriting for compliance purposes. Such changes include but are **not** limited to the following scenarios:

- **Ownership Change** - Group is sold and new owner wishes to assume the role of policyholder for the current group health plan.
- **Business Restructure** - e.g., a non-incorporated business incorporates whereby, a new Employer Identification Number (EIN) is assigned.
- **Acquisition or Merger** - Group acquires a new business or merges with another business.
- **Adding Other Related Entities** – Group wishes to add other related entities (not currently insured by HM) that are to be treated as a "single employer" under the IRC *Section 414* aggregation rules. Note that newly purchased or newly started "single employer" entities can be added during the current policy period. Existing entities that the group wishes to add can only be added at renewal.
- **Asset Purchases** - Group acquires the assets/employees of another business and wishes to cover the new employees.
- **Spin-off Groups** - Group experiences ownership or business structure changes whereby, new companies are formed (or businesses are sold off) that do not qualify as a "single employer" and must be written separately.

Note: Existing groups involving ownership changes should not be quoted as new business or added to a current group health plan without approval from Underwriting.

Depending on the type of change, groups may be required to submit some (or all) of the following documents as deemed necessary by Underwriting for review and approval:

- **Group Application** – Fully completed and signed by an authorized group representative.

- **Letter of Explanation** – Written by group's policymaker citing all details of change (e.g., ownership/business structure and name changes, date sale/acquisition was finalized, enrollment increases/decreases, etc.).

- **Certification of Eligibility to Combine and Employer Group Size form** – Required for additional entities being added to a current group health plan.

(or to separate multiple entities written under one group health plan that no longer qualify as such). The *Certification of Eligibility to Combine and Employer Group Size* form must be submitted by an authorized representative of the group citing all related entity names (or an explanation as to why multiple entities written as a "single employer" no longer qualify as such). (Refer to UC-101.4 for more information).

- **Tax/Legal Documentation** – e.g., copy of the group's SS-4 application and the Employer Identification Number assignment form, operating/purchase agreement **and/or** other current tax and/or payroll documents as applicable.

- **Enrollment/Waiver Forms** – For all new employees being added because of ownership changes.

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Renewal Information and Changes

Control Number: UC-105.3

Revision Date: March 8, 2022

Category: Existing Business Re-Underwriting Requirements

Based on the HIPAA laws and the ACA, groups are guaranteed renewable unless they are in violation of the following conditions:

- The group fails to pay its monthly premiums in a timely fashion and falls into a delinquent or nonpayment status.
- Fraud or misrepresentation of the policyholder, contract holder or employer with respect to coverage of individual insured or their representatives.
- Group fails to meet the applicable underwriting requirements.
- Market exits (products withdrawn from marketplace).
- Service area limitations (e.g., group moved and is no longer located in the designated service area or provider network is not available in the area that the group is located).

Groups may request a renewal date change **contingent upon legitimate business reasons**. All requests must be submitted in writing (via a signed letter on company letterhead or email) from the group and cite the business reason(s) for the change. Supporting documentation must also be included (e.g., change is being requested because of a new union bargaining agreement).

Note: Requests for renewal date changes for the purpose of aligning medical products with other carriers' supplemental products, health savings accounts, etc. will not be honored.

All requests are subject to **review and approval by Underwriting**. If approved, the current contract period can be no greater than 12 months (e.g., if group renewed on 7/1/2022 and wants to move to a 1/1/2023 renewal date, then the current coverage will end on 12/31/2022).

HM Small Group Underwriting & Enrollment Guidelines

Guideline Name: Existing Business Audits

Control Number: UC-105.4

Revision Date: March 8, 2022

Category: Existing Business Re-Underwriting Requirements

HM reserves the right to audit existing groups **at any time** to confirm compliance with the underwriting guidelines and eligibility of members. Selection criteria may be random, routine, by referral or based on enrollment variances, market segment changes, etc.

If Highmark determines that a group does not meet the underwriting guidelines or that it does not qualify as a small group employer, coverage will be cancelled at the end of the current contract period or be moved to the large group market.

Ineligible members will be canceled first of the month after **30-days.** A written notice to the employer and all cancelled members who are entitled for a conversion will receive conversion information for individual (direct pay) coverage. Subsequently, the **members will have the opportunity to enroll in group coverage via the employer's next open enrollment/contract period** provided they qualify as eligible employees or dependents at that time. It is the employer's responsibility to notify all members of the cancellation of coverage.

Note: Those contracts that were never eligible to be added (erroneous or fraudulent adds) will **not** be eligible to be offered conversion information.

Employers should be reminded that they are to adhere to the employer/member eligibility requirements (participation, hours and as stated on their group applications (or other written communications to HM) for the duration of their contract periods as eligibility changes may only be made upon renewal.

Misrepresentations/omissions on applications may result in cancellation (as described on the previous page) and/or retroactive premium adjustments. In addition, certain cases may be referred to HM's Special Investigations Unit.

Audit letters and underwriting questionnaires will be mailed to each group's policymaker. The policymaker is asked to complete the questionnaire and return it along with current tax documentation to Underwriting. HM Sales and producers will be notified of any groups that fail to respond and will have the opportunity to contact the groups to encourage a response.

Upon receipt of the response, Underwriting will review the groups for compliance and will contact groups **directly** to obtain and/or to clarify any additional information **as the audit is between the insurer and the group**.

Groups that do not respond or fail to meet the underwriting requirements will receive a written cancel notice (via certified mail) **and coverage will be canceled upon renewal** (or earlier for fraud). HM Sales contacts will be notified by Underwriting of all group cancellations and will have the opportunity to assist groups in achieving underwriting compliance **prior** to cancellation (when applicable).

If a group is audited, and it does not meet the minimum participation requirement, additional employees (who previously waived coverage) can be added prior to the group's open enrollment/contract period to satisfy the minimum participation requirements. Renewability of coverage is contingent upon employers meeting the participation requirements for the next contract period.

Subsequently, if they are able to meet the participation requirement once all employees have made their enrollment elections for the next contract period, employers must submit that enrollment information along with their most recent tax/payroll documents to HM Underwriting at least 30 days prior to the cancel date for the current contract period. If found to be compliant, Underwriting will rescind the cancellation and group coverage will be renewed.

In the event of cancellation, Highmark will issue a minimum 60 day written notice to the group via certified mail. Subsequently, **it is the employer's responsibility to notify its subscribers of the termination of group coverage**. Conversion notices for individual coverage will be offered as options for replacing group **medical** coverage.

Note: Certain violations that have the appearance of fraud or misrepresentation will be referred to HM's Special Investigation Unit and may result in immediate cancellation.

Highmark reserves the right to terminate group coverage at any time should a group perform an act or practice that constitutes fraud, intentional misrepresentation of a material fact.