Medical Commercial Community Rated Underwriting Guidelines

Small Group Level

Policies Effective: January 1, 2023
Last Revised: June 2021

univera HEALTHCARE

16251-22SGU REV 6/22

Introduction

Commercial health insurance coverage is available to employers, trust and association groups, subscribers and dependents that meet the qualifications specified in applicable state and federal requirements and the underwriting guidelines of Univera Healthcare. Throughout this document, Univera Healthcare will be referred to as the "Health Plan." Outlined below are the basic criteria that the Health Plan will follow to qualify employers, trust and association groups, employees and dependents for small group commercial coverage.

Disclaimer

The Health Plan reserves the right to make exceptions to these guidelines for circumstances where the group/subscriber/dependent does not meet all of the criteria in these guidelines and when the exception will not violate any laws/regulations or harm the community pool.

These guidelines are effective **January 1, 2023**, and replace all previous small group guidelines in use.

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I. Group Eligibility

Eligible Groups:

A group, or if the group is a trust or association, a member firm participating in the group, is eligible for commercial group coverage if it meets the following criteria and complies with applicable state and federal requirements:

The Group/Trust/Professional Employer Organization (PEO):

- Is headquartered in the Health Plan's service area or;
    - Has a physical location in the Health Plan's service area or;
    - Is a fully-remote entity filing taxes within the Health Plan's service area or;
    - Has employees that live, work or reside in the Health Plan's service area.
- Is engaged in a legal business or is a government entity with the legal authority to contract.
- Regularly employs persons on an active basis for salaries or wages throughout the year.
- Maintains an employer-employee relationship with its subscribers.
- Files state and federal income taxes as an ongoing commercial enterprise, nonprofit entity, or is validly exempted from filing taxes, or is a government entity.
- A Professional Employer Organization (PEO) is eligible for coverage and may insure co-employees. A PEO may also cover member-employers directly through the Health Plan. A PEO must choose one coverage option and may not offer different coverage arrangements at the same time. A PEO may change this arrangement a maximum of two times.

Association groups:

The Association:

- Must meet criteria listed as "I" above for employer groups/trusts, as well as other criteria specified in applicable state and federal requirements related specifically to associations.
- Member firms must comply with the same underwriting guidelines as groups/trusts enrolled by the Health Plan on a direct basis and must comply with applicable state and federal requirements. This includes requiring a member firm's coverage to be community rated if it has 100 or fewer full time equivalent employees.

Ineligible Groups:

- Groups that do not have common law employees are not eligible groups.
- Groups that consist of only the owner or the owner and his or her spouse are not eligible.

Group Size:

Small groups are defined as groups between one and 100 full-time equivalent employees in the previous year. Large groups are groups with more than 100 full-time equivalent employees. The number of employees in a group is determined by adding the number of full time employees and the number of full-time equivalent employees.

The following general guidelines are applied to determine group size:

- Groups with common ownership/control count as being part of one group.
- Groups with membership inside and outside of the Health Plan service area will be counted together, even if membership within the service area is minimal.

Group size is determined upon renewal. Fluctuations in group size throughout the year do not affect eligibility.

Group Effective Date:

New groups must provide all required enrollment information to the Health Plan 30 days in advance of the effective date. Groups making changes to existing coverage must provide all required enrollment information 15 days in advance of the effective date in order to be effective the first day of the following month.

Guaranteed Availability:

All policies must be guaranteed available to groups year round.

Guaranteed Renewal:

A covered group or, if the group is a trust or association, a member firm, will be renewed unless terminated due to any of the following occurrences:

- Nonpayment of premium.
- Fraud or misrepresentation of material facts.
- Violation of the Health Plan's service area requirements.
- Lapsed membership in the trust or association (including a chamber of commerce) through which the coverage is offered.
- Inability to meet the definition of a permissible group under applicable state and federal requirements.
- The Health Plan discontinues participation in the market or discontinues the class of coverage.

Open Enrollment Period:

The Health Plan's standard policy is one 30-day open enrollment (reopening) period per year, at the time of the group's renewal. The open enrollment period is the time when eligible group members who have previously declined coverage through the group may enroll. Subscribers may select from among the various offerings available through the group during the open enrollment period.

Special Open Enrollment Periods:

A group may request a special open enrollment period when a significant change in business conditions occurs, such as a purchase of a new division or the group expands coverage to a new class of employees.

Classes of Employees:

Classes of employees based on "conditions pertaining to employment" are permitted at the option of the employer; however, all employees, including those in different classes, must be aggregated for purposes of determining group size. Examples of permissible classes of employees are:

- Management
- Non-management
- Salaried
- Hourly
- Full-time
- Part-time
- Professional
- Non-professional
- Geographic location
- Additional classes may be allowable, and will be reviewed on a case by case basis.

II. Subscriber/Dependent Eligibility

Eligible Subscriber:

For coverage through an employer group (including member firms within a trust or association), an eligible subscriber must be:

- A permanent, common law full- or part-time employee working at least 20 hours per week.
- Employed by a company that is headquartered in the Health Plan service area, or reporting to a physical business location in the Health Plan service area.
- Independent contractors (1099 employees) are eligible for coverage if they are an employee as defined by Department of Labor regulations, New York State Insurance Law, and Internal Revenue Code. These employees must be included in FTE reporting for group size.
- An officer, director, owner, or partner that is engaged in the operation of the business and receiving compensation.
- A seasonal worker meeting the employer's eligibility requirements.
- An elected or appointed official if the employer group is a public entity (e.g., city, school district).
- A retiree, covered by the Health Plan immediately prior to retirement and with continuous coverage through the Health Plan.
- An employee disabled or on Family Medical Leave Act.
- A former employee on COBRA/New York state extension of benefits, until the maximum period ends.
- A reservist.

Employer Probationary Periods:

Employers may select probationary periods from zero to ninety days. Insurers may not set waiting periods. Insurers must give newly eligible employees an enrollment period of at least 30 days.

Eligible Dependent:

The eligible dependents are dictated by the subscriber contract/certificate. In general, the eligible dependents are as follows:

- Spouses

  Spouse, including a same-sex spouse, unless the marriage is dissolved through divorce or annulment
- Dependent Children
  a. Children of a subscriber are covered until age 26, regardless of financial dependence, residency, student status, employment, marital status, or eligibility for other coverage.
  b. In addition to the coverage listed in subparagraph (a) above, coverage for the children of a subscriber is available, if elected by the subscriber or eligible young adult, for unmarried adults younger than 30 years of age who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or within the Health Plan's service area and who are not covered under Medicare.
  c. In addition to the coverage listed in subparagraph (a) above, coverage may be available through a "make available" rider, if elected by a group, for the children of a subscriber who are unmarried, younger than 30 years of age, who are not insured or eligible for insurance through their own employer, who live, work or reside in New York state or the Health Plan's service area, and who are not covered by Medicare.
- For purposes of subparagraphs a. b. and c. above, the term "children" includes natural children, stepchildren, legally adopted children and children for whom a court of law has appointed the subscriber or spouse their legal guardian and who are chiefly dependent upon the subscriber for support.

Subscriber/Dependent Initial Enrollment and Retroactivity

The Health Plan will enroll a subscriber and/or dependent for the requested date, provided that:

- The application is received within the retroactive period specified in the subscriber contract/ certificate from the date of the qualifying event.
- If the retroactive period is unspecified, within 30 days.
- If not enrolled when initially eligible, the subscriber/ dependent must wait until the next open enrollment period, unless the subscriber/dependent qualifies for a special enrollment period (see following section).

Special Enrollment Periods:

- Marriage
- Birth
- Adoption
- Placement for adoption
- Termination of the spouse's employment
- Termination of the spouse's other plan or benefit contract
- Death of spouse
- Legal separation, divorce, or annulment
- Reduction in the number of hours worked by the spouse
- Employer ceased its contribution toward the premium for the spouse's plan or benefit contract
- New employee
- Change in business structure or acquisition
- Expansion of coverage to a new class of employees
- Gaining or losing eligibility for Child Health Plus or Medicaid

Special Enrollment Period (60 days)

- Gaining or losing eligibility for Child Health Plus or Medicaid

III. Other Requirements

Eligibility Verification:

New group and subscriber/dependent eligibility and guideline compliance will be verified using information from tax forms, other filings with government agencies and appropriate company records as determined by the Underwriting Department. Recertification of a group will occur annually through a direct request for information from the Health Plan. The annual cycle will repeat as long as the group purchases health insurance coverage from the Health Plan.