

## TO: CAREFIRST DISTRIBUTORS

This Small Employer Group Eligibility Manual was developed to educate and assist you in selling all CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice (BlueChoice) products sold in the State of Maryland including PPN, MPOS, and BluePreferred.

Many of you who have participated in previous training sessions may be familiar with this document; for some of you, this may be your first exposure to CAREFIRST's Small Employer Group Eligibility Manual. Regardless of which category you fall into, this reference manual should be utilized by you on an ongoing basis to assist you in both new business and renewal sales. Additionally, changes and additions have been shaded to assist you.

This manual was originally released in September-October 1996 and has now been revised to include many new sections and to incorporate the guidelines associated with all of our Maryland small group products. We hope that the additional information will be of value to you and will help facilitate more efficient writing of both new business and renewal sales.

Since the inception of Maryland Small Group Market Reform in July, 1994, many additional pieces of legislation have been implemented that have modified the original legislation. In addition, CAREFIRST has implemented several internal changes regarding our small group product portfolio and rating practices. To further assist you in your new business and renewal sales, we have added a section of Small Group Reform Highlights, listing those legislative and internal CAREFIRST changes impacting small employer groups in Maryland. We are sure that you will find this section very informative in helping you to better serve your clients.

Every effort has been made to ensure that the information is complete and accurate. The information provided in this manual is based on the CAREFIRST interpretation of Maryland legislation in addition to CAREFIRST Sales and Underwriting policies and guidelines. The manual's "Highlights of Maryland Small Group Reform" section will be updated annually in the 4<sup>th</sup> quarter of the year. However, in an effort to be of more support to our brokers, we will be updating the body of the manual when changes are made to ensure that the online copy is the most current documentation of our policies and procedures. These updates will normally be preceded by a SalesFlash alerting you of change to our policy.

We believe that the information here will provide you with the basics to successfully prospect and sell any small group account in Maryland and to then retain and renew that business. Please review all sections carefully, as our guidelines will vary at times, based on the product sold.

*As our appointed and contracted Distributors, your continued support and adherence to our policies and guidelines is appreciated.* Any questions regarding the information contained within this manual should be directed to your assigned **General/Full Service Producer** or your CAREFIRST Broker Representative.

# TABLE OF CONTENTS

If you are viewing this file online (PDF format), **BOOKMARKS** have been added which link to the page being referenced.

- Click on the **BOOKMARKS** tab in the left-hand navigator pane to view.
- Click the plus sign (+) to expand sub-categories.
- Click the topic to be linked to the page referenced.

	<b>PAGE(S)</b>
<b>Highlights of Maryland Small Group Reform</b>	<b>3-13</b>
<b>CareFirst Product Offerings</b>	<b>14</b>
<b>State Defined Geographic Regions</b>	<b>14</b>
<b>Calendar Year vs. Contract Year Benefit Periods</b>	<b>15</b>
<b>Deductible Carryover</b>	<b>15</b>
<b>Employee Eligibility for Determination of Group Size</b>	<b>15-16</b>
<b>HB8 Elections: Retirees, Part-time Employees &amp; Full-time with other Coverage</b>	<b>16</b>
<b>Movement between Products</b>	<b>17</b>
<b>Enrolling Eligible Employees and Dependents</b>	<b>18-20</b>
<b>Account Eligibility</b>	<b>20-21</b>
<b>House Bill 857 &amp; House Bill 988</b>	<b>22</b>
<b>Multiple Option Offerings &amp; Account Segment Eligibility</b>	<b>23-24</b>
<b>Affiliated Companies</b>	<b>25</b>
<b>Account Eligibility Verification</b>	<b>26</b>
<b>Tax Documentation</b>	<b>27</b>
<b>Husband/Wife Businesses</b>	<b>28</b>
<b>Special Product Offerings</b>	<b>29</b>
<b>MD Parity</b>	<b>30-32</b>
<b>Limited Benefit Plan</b>	<b>33</b>
<b>Maryland Small Group Subsidy Program</b>	<b>33</b>
<b>Small Group Rating</b>	<b>34-35</b>
<b>New Business Rating</b>	<b>36</b>
<b>Renewal Business Rating</b>	<b>37-39</b>
<b>Matrix: Eligibility, Rating &amp; Participation</b>	<b>40</b>
<b>Medicare Matrix: Eligibility, Rating &amp; Participation</b>	<b>41-42</b>
<b>Rating: Medicare Eligibles BlueChoice/BluePreferred</b>	<b>43</b>
<b>Regional Dental Benefits</b>	<b>44-49</b>
<b>Regional Vision Benefits</b>	<b>50</b>
<b>Self-Employed Individuals</b>	<b>51-52</b>
<b>MSGR Product Portfolio</b>	<b>52</b>

## **HIGHLIGHTS OF MD SMALL GROUP REFORM**

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
January 1, 1997	BlueCard Program added to Comprehensive products	CAREFIRST introduces the BlueCard program as a core benefit to small employer group Comprehensive contracts for PAR providers.
June 1, 1997	Md. House Bill 211/Senate Bill 69	Expands the tax documents required for self-employed individuals to include corporations and those filing other than Schedule C or F.
July 1, 1997	Federal Health Insurance Portability and Accountability Act (HIPAA)	Federal legislation ensures portability of coverage for employees when changing employers or health carriers and limits pre-ex and eliminates medical underwriting in the group market.
July 1997	Regulatory changes to the Indemnity and HMO products.	Services were added to cover Diabetes treatment, equipment, and supplies and to extend coverage for insulin using beneficiaries; also for reconstructive breast surgery.
August 1, 1997	Preferred Health Network (PHN)	CAREFIRST begins marketing Preferred Health Network (PHN) products to new and existing accounts.
October 1, 1997 New or Existing Business upon Renewal	Md. House Bill 368	Allows prescription fills of a 90-day supply of maintenance medication for one copay.
October 1, 1997	Md. House Bill 988	Expands small group reform definition of an eligible small group to include a small employer group who has since downsized to only one remaining eligible employee.

## **HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)**

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
January 1, 1998	Federal Health Insurance Portability and Accountability Act (HIPAA)	CAREFIRST begins offering HIPAA products through the Individual Market Division to those applicants meeting HIPAA criteria, as well as others.
January 1, 1998 New or Existing Business upon Renewal	CAREFIRST BlueCard PPO	CAREFIRST introduces the BlueCard PPO program as a core benefit to small employer group Preferred Provider Network contracts.
January 1, 1998 New or Existing Business upon Renewal	CAREFIRST Indemnity Pharmacy	CAREFIRST introduces new pharmacy benefits to indemnity small employer groups, offering generic/ brand copes.
February 1998	Offered SEGO HMO Vision Endorsement	CAREFIRST removes the eye exam as core and creates an endorsement to cover the exam and hardware.
February 1, 1998 New or Existing Business upon Renewal	CAREFIRST HMO Pharmacy	CAREFIRST introduces new pharmacy benefits to HMO small employer groups, offering generic/brand copays.
April 1, 1998	Preferred Health Network (PHN) New Endorsements	PHN introduces Triple Option endorsements: Waive Option 2 Deductible, Waive Option 2 Co-Insurance.
April 1, 1998 New or Existing Business upon Renewal	CAREFIRST HMO Consolidation	Internal change by CAREFIRST: Consolidates CareFirst and Columbia Medical Plan into FreeState HMO.
July 1, 1998 New or Existing Business upon Renewal	Legislative Benefit Changes	HCACC* introduces changes to the CSHBP**: Adds new standard Comprehensive and PPN products; Increases lifetime maximum on standard Comprehensive, PPN and MPOS; Changes maintenance drug copay from one copay to two copays for a 90 days supply; Eliminates chiropractic tiers in lieu of flat coinsurance/copay; Adds additional preventive benefits such as osteoporosis and prostate cancer screenings; Requires carriers to provide same benefits in and out-of-network for HMO opt-out products.
July 1, 1998 New or Existing Business upon Renewal	CAREFIRST Streamlining of HMO Opt-Out	Internal change by CAREFIRST: Eliminates FreeState HMO Opt-Out II (Willse Health Elect network) due to lack of market interest.

## **HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)**

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
September 1998	PHN Co-branding of SEGO Triple Option	PHN introduces the SEGO CareFirst Provider Network endorsement for Triple Option product. Allows the member to use the CareFirst of Maryland, Inc. participating provider network for option 3 services and avoid balance billing.
September 1, 1998 New or Existing Business upon Renewal	CAREFIRST HMO Participation Requirements	Internal change by CAREFIRST: Institutes a minimum participation requirement of 75% of all eligible employees for HMO only business.
October 1998	HB 1064: Indemnity and HMO Regulation Change for Account Notification	Changes account renewal notification from 30 to 45 days prior to the renewal effective date
October 1998	PHN Introduces Upgrade Endorsement for Option 3 under Triple Option Plan	PHN introduces endorsement to reduce the deductible in option 3.
January 1999	HB3 Internal Grievance Process	Mandate applies to indemnity and HMO. Requires carriers to establish a formal internal grievance process with specific guidelines. Establishes the Health Care Regulatory Fund.
July 1999	Elimination of the SEGO Comp	Effective with all new groups and existing groups upon renewal, CareFirst ceased to offer the Comprehensive Major Medical SEGO product due to minimal market interest and the availability of the BlueCard PPO program.
June 1999	HCACC* revised the floor/ceiling offered to the CSHBP**	Floor and ceiling was expanded to allow for wider rate differentials.
June 1999	HB1086: Limits Stop Loss Policy Attachment Points	Prohibits any carrier from issuing stop loss insurance policies with aggregate attachment points of less than 115% of expected claims or specific attachment points of less than \$10,000.

## HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)

Effective Date of Change	Title	Description
July 1999	Introduction of Medicare Complementary	CareFirst ceases to market the Standard Group Over 65 product in the SEGO market. Instead, the SEGO approved Medicare complementary rate is offered to Medicare primary members.
July 1999	SEGO benefits available to retirees for CareFirst products	HCACC* allows SEGO benefits to be extended to retirees and domestic partners at the employer's discretion. CareFirst files to adopt the retiree portion of the legislation. Employers elect at renewal to offer Medicare Complementary rates to retirees or active rate if retiree is not Medicare eligible. Neither CareFirst nor PHN will cover domestic partners.
July 1999	Legislative Benefit Changes	HCACC* introduces changes to the CSHBP**; increased inpatient mental and nervous and substance abuse days from 25 to 60; removed tiers on outpatient mental and nervous benefits in the standard product; removed the tiers in mental and nervous and substance abuse product upgrades; added audiology screening for newborns; clarified well child ages for indemnity; added coverage for contraceptive devices; made co-insurance for out-of-network emergency services the same as in-network; added coverage for breast prostheses; added general anesthesia benefits for some children's dental care.

## **HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)**

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
October 1999	PHN Implements Legislated Changes	PHN implements the legislated changes introduced by HCACC* to the CSHBP** implemented by CareFirst effective 7/1/98
October 1999	Senate Bill 350	Coverage Determinations: All accounts will be required to pay applicable subscription charges for a covered member until the later of the termination date defined in the contract or the date CareFirst receives notice from the account that indicates that the member is no longer eligible for coverage. Bill was repealed shortly after implementation.
October 1999	House Bill 182	Patients' Bill of Rights Act of 1999: referral to a specialist outside the provider network
October 1999	Senate Bill 67	Extension of Benefits: provides coverage for existing conditions for medical, dental & vision after the member's termination date
October 1999	House Bill 91	Personal Injury Claims Subrogation – Reduction: applies to the amount CareFirst can recover
November 1999	MIA Bulletin	Services provided for Home Health Care visits following a mastectomy or removal of a testicle
January 2000	MIA Bulletin	Offer of Standard Plan separately from any additional benefits.
June 2000	House Bill 649	Eligibility Requirements: changed the definition of self-employed individual and the definition of a small employer. Also, changed the minimum participation requirements
July 2000	Legislative Benefit Changes	Changes to CSHBP** Added a benefit for Chlamydia screening. Changed the prescription drug copayment to a three tiered benefit. Increased the PPN deductible and out-of-pocket limits. Added a provision for referrals to specialists.
October 2000	HMO Dental	Changed dental vendor to The Dental Network (TDN) new and renewing accounts.

## HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)

Effective Date of Change	Title	Description
January 2001	HMO Dental	Changed dental vendor to The Dental Network (TDN) all accounts.
January 2001	House Bill 405	Member Grievance and Appeals: amends single notice as opposed to two notices.
June 1, 2001	MPOS	Enhancing the Point-of-Service Product by eliminating the need for a referral for certain services.
July 1, 2001	MIA Bulletin – Legislative Benefit Changes	CSHBP**
July 1, 2001	HMO Changes	Modified Preventative Services, added colorectal screening. Direct Access to OB/GYN Care. Changed Primary Care Services copay to \$20; Specialty Care Services copay to \$30. Added a \$250 per admission copay. Changed the RX Deductible to \$250. Added Dental implants to exclusion #28.
July 1, 2001	Indemnity Changes	Modified Preventative Services, added colorectal screening. Direct Access to OB/GYN Care (MPOS). PPN – changed deductibles; \$1,000/\$2,000 MPOS – changed deductibles to \$400/\$800 Changed the RX deductible to \$250. Added dental implants to exclusion #28.
October 1, 2001	Senate Bill 856	Grievance and Appeal Procedures: Amends the time limit for filing a complaint to the MIA.
January 1, 2002	BCBS Association Requirement	Revised the BlueCard Program language according to the Association's required language.
January 1, 2002	ERISA Disclosure	Disclaimer added to Group contracts. Employer is responsible for SPD.
January 1, 2002	FreeState Health Plan Market Exit	Effective upon account renewal, FreeState accounts were notified that FreeState was no longer available in the market
January 1, 2002	Delmarva Health Plan Market Exit (Maryland)	Effective upon account renewal, DHP (MD) accounts were notified that DHP was no longer available in the market.
April 1, 2002	Delmarva Health Plan Market Exit (Delaware)	Effective upon account renewal, DHP (DEL) accounts were notified that DHP was no longer available in the market.
July 1, 2002	MIA Bulletin	Revised the definition of Experimental Services. Added a benefit for hearing aids for minor children ages 0-18.
October 1, 2002	Mandated Changes	Preauthorization for Durable Medical Equipment removed. Defined Medical Child Support Orders and Qualified Medical Support Orders. (QMSO)

## HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)

Effective Date of Change	Title	Description
October 1, 2002	House Bill 1427	Changes the Open Enrollment Period for Self-Employed Individuals to December 1 <sup>st</sup> each year and lasts for 30 consecutive days.
October 1, 2002	House Bill 1158	Continuation of Coverage revised the definition of “change in status” to include voluntary termination of employment.
July 1, 2003	MIA Bulletin – Legislated Changes	<p>Added definitions for “congenital or genetic birth defect”</p> <p>Added definition for “residential crisis services”</p> <p>“Residential crisis” services were added to inpatient Mental Health and Substance Abuse services</p> <p>Changes made to Exclusions for operations on or for the treatment of or to the teeth or supporting tissue</p>
July 1, 2003	CareFirst contract change	Medically necessary Private Duty Nursing deleted from managed care provisions in SEGO contracts.
March 1, 2004	CareFirst contract change	Waives a referral from Member’s PCP when services are provided directly related to a cancer diagnosis. Applies to SEGO MPOS and MSGR BlueChoice
July 1, 2004	SEGO/MSGR Regulatory Changes	<p>Core PPN/MPOS/SPPP: Deductibles and out-of-pockets increased; some copays changed from \$20 to \$40; ER copay changed from \$35 to \$100.</p> <p>Core BlueChoice: PCP copay \$30; specialist copay \$40; ER copay changed from \$35 to \$100; some copays increased to \$40.</p> <p>Core Rx: Tier 2 \$20 to \$25; Tier 3 \$30 to \$50; maintenance Tier 2 is \$50 and Tier 3 is \$100.</p>
September 1, 2004	Domestic Partner Coverage	Offers employer’s choice of adding Domestic Partner coverage for MSGR, D.C. small group, and Individual markets in D.C. & MD. Domestic Partner coverage is not available in VA.
November 1, 2004	Waiver of New Hire Waiting Period	CareFirst will no longer accept any request for waiver of contractual waiting period by the employer. A new CareFirst contract must be executed.
December 1, 2004	Deductible Carryover Option	New upgrade available to BlueChoice and BluePreferred medical and RX with in-network deductible and calendar year benefits

## HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
January 1, 2005	PT/OT/ST/CHIRO Authorization Removed	No plan authorization required for all MD, VA, and D.C.1-50 and 51+ groups with the exception of core MSGR/SEGO, VA Essential and Standard; PCP referral still required
January 1, 2005	PT/OT/ST/CHIRO 1-50 Copay Change	\$15 copay for these services under BlueChoice, BluePreferred, PPN and MPOS
March 1, 2005	PT/OT/ST/CHIRO 51+Copay Change	\$15 copay for these services under BlueChoice, BluePreferred, PPN and MPOS
April 1, 2005	New RX Vendor	ARGUS replaced CareMark
May 1, 2005	Dual Waiting Periods Allowed	When a group contractually defines 2 specific classes of employees, multiple new hire waiting periods will be allowed
July 1, 2005	Open Access Feature Launched for BlueChoice HMO and Opt Out Plus	All Opt Out Plus groups are renewed with the Open Access feature; HMO and HMO Open Access are offered
July 1, 2005	MSGR Limited Benefit Plan Launch	BluePreferred Option offered in the MSGR portfolio to make available limited benefits to those groups not currently offering benefits and average wages less than 75% of the MD average annual wage
August 1, 2005	Individual/Children Coverage Tier Launched	Affects new groups and existing groups upon renewal ( <i>and off-renewal benefit change</i> ) for all BlueChoice, BluePreferred and Regional Dental plans
October 1, 2005	SB1014 Health Insurance Small Group Market: Self-Employed	Changes the definition of "small employer group" to remove self-employed and removes the open enrollment period for self-employed new sales. Allows grandfathering of current self-employed as long as they remain in their current group plan
January, 2006	MSGR BluePreferred HSA/HRA Launch	The Consumer Driven Health Plans were launched with the BluePreferred product to the MSGR market. Both BlueFund and Compatible plans were offered
January, 2006	Integration of all Dental Products	Regional Traditional and Preferred (PPO) dental products are offered with DHMO products and the total enrollment is calculated in the 75% participation requirement
June 1, 2006	FreeStanding Regional Dental Products	Sold down to 2 eligibles; 1enrolled
July 1, 2006	HRA/HSA Available in a POE	Systems are modified to allow the quoting and sale of both HRA and HSA products in a POE
July 1, 2006	MD Self Employed Renewal Change	All remaining self-employed renewals will be offered a proposal upon renewal representing the group's current benefits. No benefit change of any kind will be accepted; benefits will be defaulted

\*HCACC – Health Care Access and Cost Commission \*\*CSHBP – Comprehensive Standard Health Benefit Plan

## **HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)**

<b>Effective Date of Change</b>	<b>Title</b>	<b>Description</b>
July 1, 2006	Average Annual MD Wage Change	The average annual wage in MD is now \$44,356; therefore for purposes of the MSGR Limited Benefit Plan, the average annual wage of employees in the group cannot exceed \$33,267 (75% of \$44,356)
July 1, 2006	SEGO/MSGR Regulatory Changes	Core RX Change: \$2,500/\$5,000 deductible followed by 75% member coinsurance MPOS Core Change: \$2,500/\$5,000 deductible; \$4,900/\$9.800 out-of-pocket BlueChoice Core Change: Inpatient hospital copay increased to \$1,000 per admission BluePreferred Core HSA Change: \$2,700/\$5,450 deductible; \$5,250/\$10,500 out-of-pocket The term "deductible" was expanded to include any medical and RX deductible amounts for purposes of accumulating the medical out-of-pocket maximum.
September 1, 2006	BlueChoice HSA	BlueChoice and BlueChoice Opt Out Plus HSA Open Access products launched
October 1, 2006	\$0 Generic Drug Copay Options	Options made available with no copay for the generic tier; \$0/\$25/\$45 with and without a \$100 deductible; includes a 4 <sup>th</sup> tier for self-administered injectables. New option replaced \$5/\$25/\$45 copay option under the integrated HMO HSA plans
January 2007	FlexAmerica merger with PayFlex Systems USA, Inc	Allows FlexAmerica and CareFirst to provide more robust product solutions, better technology and improved service levels to employers, brokers and members
January 2007	Tax relief and Health Care Act of 2006	Enhanced many of the benefits already available through Health Savings Accounts
April 1, 2007	Insulin Pump Benefit	Added to contract as a covered service for all products and all options except for the Core options
April 1, 2007	HRA participant fees waived	Ended the billing of fees associated with the set-up or monthly enrollment of employees for both existing and new groups; includes the per month participant fee and the minimum fee per group
June 2007	Print-On-Demand (POD) launched	Moved to the "POD" system of literature release to eliminate the need to stock literature and to avoid dating on the shelves
July 2007	BlueVision Core benefit available to all MSGR products	All non-Core MSGR products now include the Core BlueVision benefit and the Core medical products are offered with or without the benefit. Effective with new sale or upon renewal.

## HIGHLIGHTS OF MD SMALL GROUP REFORM (cont'd)

July 2007	SB952	Allows a self-employed to change to another product within the MSGR product portfolio upon renewal
August 1, 2007	HSA member fees waived	Eliminated the member set-up fee and the monthly account fee for BlueFund HSAs through Mellon Bank
August 2007	DHMO standalone product sales discontinued	New sales of The Dental Network (TDN) Dental HMO standalone products temporarily discontinued due to a technical issue involving the internal restructuring of TDN
October 1, 2007	HSA Option 4 retired: new sales	Due to non-compliance with MSGR regs, no new sales accepted beginning October 1
October 1, 2007	Enhanced BluePreferred referrals	A referral to a Specialist or Non-physician Specialist who is not a Preferred Provider may be requested if the member is diagnosed with a condition or disease that requires specialized health care services or medical care under certain conditions
January 1, 2008	HSA Option 4 retired: upon renewal	Due to non-compliance with MSGR regs, existing groups will not be issued a renewal for HSA Option 4
July 1, 2008	MSGR BluePreferred Limited Benefit Plan Eliminated	Decision was made to eliminate the offering due to there being no enrollment in the product
October 1, 2008	MD Small Group Subsidy Program and Wellness Rider	Senate Bill 6 resulted in the implementation of the MD Small Group Subsidy Program which exists to subsidize small employers of 2-9 employees not currently offering health insurance. To support this program's requirements, a Wellness Rider was filed and added to the Group Contract and Enrollee Certificate

October 1, 2008	BlueFund HRA Debit Card	Debit cards made available to HRA BlueFund groups, both new and renewing
October 1, 2008	Required Fraud Statement Added to Enrollment Forms	HB 404 required that a Fraud Disclosure Statement appear on all claim and enrollment forms informing consumers that it is a crime to commit insurance fraud
January 1, 2009	National Dental Network	All new and renewing dental groups with either Regional Traditional or Preferred coverage have access to national dental network through Dental Network of America, Inc.
January 1, 2009	FSA Administration no longer through BCBS of Delaware	Upon renewal, all groups enrolled in a FSA administered by BCBS Delaware must transition to a new administrator. HFS Benefits is the suggested administrator; however, any administrator can be used.
January 1, 2009	New Minimum Requirements for Errors and Omissions Insurance	CareFirst increasing the minimum required amount of E&O insurance to \$1M per occurrence and \$2M aggregate
January 1, 2009	New Terms: Full Service Producer and General Producer	Effective with the 2009 Agreements, the term "Wholesaler" was changed to "General Producer" and "Delegated Billing Entity (DBE)" was changed to "Full Service Producer"

\*HCACC – Health Care Access and Cost Commission \*\*CSHBP – Comprehensive Standard Health Benefit Plan

## CAREFIRST PRODUCT OFFERINGS

CareFirst, Inc. is made-up of several subsidiaries that are licensed separately and as such are viewed as separate carriers by the Insurance Divisions. However, for new sales bonus and Broker of Record transfer requirement purposes, any business in these subsidiaries is considered “existing CareFirst business.” Various products are offered through each CareFirst carrier as shown in the chart below:

CareFirst of MD, Inc. (CFMI)	Group Hospitalization and Medical Services, Inc. (GHMSI)	CareFirst <b>BlueChoice, Inc.</b>
PPN	BluePreferred PPO	BlueChoice HMO
MPOS	BluePreferred Limited Benefit Plan	BlueChoice HMO <i>Open Access</i>
	Select Preferred Provider Plan (SPPP)	BlueChoice HMO Opt-Out <i>Open Access</i>
		BlueChoice Opt-Out <i>Plus Open Access</i>
		FreeStanding DHMO “Provider Choice” products
		Regional DHMO Ridered Dental
		DHMO Ridered Dental
Regional Traditional Dental*	Regional Traditional Dental	Regional Traditional Dental
Regional Preferred Dental*	Regional Preferred Dental	Regional Preferred Dental
BlueVision Plus	BlueVision Plus	BlueVision Plus

Please note product combination guidelines discussed throughout this manual, as some products cannot be offered in combination with others. \*Installed on FACETS

## STATE DEFINED GEOGRAPHIC REGIONS:

The State has divided Maryland into defined regions for purposes of rating:

Baltimore Metro	DC Metro	Western MD	Eastern & Southern MD
Anne Arundel County	Montgomery County	Allegany County	Calvert County
Baltimore City	Prince George’s Co	Carroll County	Caroline County
Baltimore County		Frederick County	Cecil County
Harford County		Garrett County	Charles County
Howard County		Washington County	Dorchester County
			Kent County
			Queen Anne’s County
			Somerset County
			St Mary’s County
			Talbot County
			Wicomico County
			Worcester County

Note that these defined geographic regions do not affect non-MSGR (MD Parity) rate calculations.

## CALENDAR VS CONTRACT YEAR BENEFIT PERIODS

- ⇒ All PPN/MPOS groups have contract year benefit periods with deductibles/maximums beginning/renewing on the effective date
- ⇒ BluePreferred/BlueChoice sold for first of the month effective dates follows contract year benefit periods with deductible/maximum beginning/renewing on the effective date
- ⇒ BluePreferred /BlueChoice groups sold on a 15<sup>th</sup> of the month effective date follow a calendar year benefit period. **System constraints do not permit us to alter the benefit period once the group is set-up.** Under the calendar year benefit period, the deductible and maximums reset each year on January 1 even if the group changes its benefits upon renewal during the year

## DEDUCTIBLE CARRYOVER

Deductible carryover is available as a benefit enhancement to all medical options other than the core and SPPP plans as well as all RX options that have an in-network deductible and a calendar year benefit period.

## EMPLOYEE ELIGIBILITY FOR DETERMINATION OF GROUP SIZE

CAREFIRST definition of eligible employee: “A **full-time employee** of a company who works on a full-time basis and has a **“normal” work week of 30 or more hours**, even though the employee may not be actively at work during the open enrollment. **State law requires that the health benefits be offered to all employees who work at least 30 hours per week.** An eligible employee must be a person who is **compensated by the company** for work/services performed in accordance with applicable Federal and State wage and hour laws, which compensation is reported to the Internal Revenue Service by Form W-2 and the State of Maryland Department of Labor, Licensing and Regulation by form DLLR/OUI 15/16.

### **Effective 6/1/00 – For New Business:**

<b>SMALL GROUP REFORM ELIGIBLE</b>	<b>SMALL GROUP REFORM INELIGIBLE</b>
All F/T employees (including those in probationary period). However, employee must complete their contractual probationary period prior to enrolling in the plan even if the Open Enrollment occurs during the probationary period.	Part-time employee (less than 30 hrs)
F/T independent contractor – 1099 employees (discretion of employer)	Seasonal employee
	COBRA ex-employee or dependent
	Retiree or dependent
<p><b>TEFRA vs. Non-TEFRA:</b> TEFRA only applies to a group health plan sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. Segments of employees (i.e.: union members) not eligible for plan benefits are not included in the calculation to determine TEFRA/Non-TEFRA designation. Groups should also note that there is a period of time that a group must maintain the required number of employees to actually be moved from one TEFRA/Non-TEFRA designation to another. CMS has put this in place to avoid groups moving between designations repeatedly. Groups are responsible for determining their designation and should enlist assistance from their accountant if there is confusion.</p>	

**Board Members:** Board members of accounts are not considered eligible for coverage under an employer group plan because they are not employees.

**Full-time Independent Contractors:** Independent contractors (e.g. 1099 employees) working 30 or more hours per week may be considered eligible at the discretion of the employer. If the employer has elected to cover part-time employees, 1099’s meeting the definition for part-time; that is, working less than 30 hours per week, may enroll. If the employer elects to extend coverage to this segment of employees, coverage must be offered to all 1099 employees. In addition to providing the 1099, a notarized letter must be provided listing all full-time 1099 employees, the number of hours worked per week, and their eligibility status.

## **EMPLOYEE ELIGIBILITY FOR DETERMINATION OF GROUP SIZE**

### **(cont'd)**

#### **Full-time Independent Contractors (cont'd):**

A group of only 1099 contracted employees is NOT an eligible group and there needs to be at least 1 full time employee enrolling. **Independent (1099) contractors are not eligible for coverage under non-MSGR (MD Parity) contracts.**

**Terminated Employees in COBRA Election Period:** If the employee is in his 60 day COBRA election period, they should not be included in the group census. If the employee then elects coverage, they will be provided coverage retroactive to their termination date.

### **HB8 Elections: Retirees, Part-Time Employees and Full-Time Employees with Other Coverage:**

- ⇒ Retirees, part-time employees, and employees with other coverage including Medicare (A or A&B) and Medicaid are able to enroll at the option of the employer, through HB8 elections.
- ⇒ Part-time employees must have a normal work week of at least 17 ½ hours per week and have been employed at least 4 consecutive months before the employer may extend coverage. The employer may choose to impose an additional waiting period for part-time employees that run consecutively with or subsequent to the 4 consecutive months required by the legislation.
- ⇒ Part-time employees may not be enrolled on an employer's small group policy if they are eligible to be enrolled as a dependent child on another group policy.
- ⇒ In non-TEFRA accounts, an employer must elect to cover those with other coverage in order to cover employees with Medicare (A or A&B).
- ⇒ In non-TEFRA accounts, an employer wishing to cover retirees who are eligible for Medicare (A or A&B), must elect to cover both retirees and those with other coverage.
- ⇒ In TEFRA accounts, since Medicare is secondary, the employer does not have to elect "yes" to "other coverage" to cover active Medicare employees. In TEFRA groups, an election of "yes" to "other coverage" applies to offering benefits to employees with other coverage besides Medicare
- ⇒ In TEFRA accounts, since Medicare is secondary, an employer wishing to cover retirees who are eligible for Medicare (A or A&B) must only elect to cover retirees.
- ⇒ "Other coverage" includes Medicare (for non-TEFRA), Medicaid/Medical Assistance, and competitors' group products. Tricare, the successor to Champus is no longer considered "other coverage" so employees with this coverage can enroll without the employer having to cover people with other insurance; however, it is considered a legitimate waiver and does not count against participation requirements.
- ⇒ HB8 elections can be changed only at renewal and may not be altered during the contract year unless the change is in conjunction with an off-renewal benefit change
- ⇒ HB8 elections are applicable only to the employee and are not applicable to dependents; for example, if the HB8 election is "no" to "other coverage", the employee has coverage only through the employer, the spouse has coverage through their employer, the spouse is still offered coverage and the employee can enroll as "Ind/Adult".

#### **Medicare Eligibles and Retirees:**

Effective July 1, 1999 carriers were allowed to file to offer benefits to retirees (both under and over age 65) at the employer's election. CFMI filed for this change and added the election to offer coverage to retirees to the HB8 elections on the rating proposal. CareFirst offers small group Medicare secondary rates to active employees with Medicare parts A & B, in non-TEFRA accounts. If the employer elects to extend benefits to retirees, only the MPOS and PPN products provide coverage. CareFirst BlueChoice and GHMSI have not filed to offer benefits to retirees. Please refer to other sections in this manual regarding rating of Medicare eligibles and retirees as well as eligibility, rating and participation.

## **Movement between Products:**

CareFirst is made-up of several companies from which our various products originate. These include CFMI (PPN and MPOS, Regional Dental on FACETS and BlueVision Plus); GHMSI (BluePreferred, Regional Preferred and Traditional Dental and BlueVision Plus); and BlueChoice (BlueChoice products, Regional DHMO, Preferred and Traditional Dental and BlueVision Plus). Although these products are all offered through CareFirst and are all included in our Administrative Manual for Broker of Record transfers and compensation, there are some legislated requirements that come into play when moving between our products. Legislatively, this product movement constitutes movement between carriers because of the way CareFirst is structured. These include, look-back periods for eligibility and paperwork/tax document requirements which would then apply when moving between our various companies. Note that although movement between these products/companies may require new sales paperwork/tax documentation, for purposes of broker compensation, movement between our family of products is considered migrated (existing) business and is therefore not applicable under our new sales bonus.

## **Employer Contribution:**

There is no minimum employer contribution requirement for MSGR groups; although groups are encouraged to contribute a minimum of 50% of the Individual rate.

## **ENROLLING ELIGIBLE EMPLOYEES**

Eligible employees may enroll:

- ⇒ As a new hire, after satisfying any employer waiting period
- ⇒ During small employer's annual open enrollment
- ⇒ Part-time employees may not be enrolled on an employer's small group policy if they are eligible to be enrolled as a dependent child on another group policy.
- ⇒ Proof of employment and hours worked via a current DLLR/OUI 15/16, and the most recent 2 payroll statements or a notarized letter indicating the number of hours the employee works must be provided when eligible part-time employees are enrolled under the age of 19.
- ⇒ Within 31 days of lifestyle change as defined by the Health Insurance Portability & Accountability (HIPAA) special enrollment period; this applies to those who initially declined coverage
- ⇒ Within 31 days of loss of spouse's employment (voluntary or involuntary) that results in loss of insurance (except gross misconduct)
- ⇒ Within 31 days of significant change in employment status (i.e. reduction in hours)
- ⇒ Within 31 days of the expiration of COBRA coverage
- ⇒ Proof of employment and hours worked via a current DLLR/OUI 15/16, and the most recent 2 payroll statements or a notarized letter indicating the number of hours the employee works must be provided when full-time employees are enrolled under the age of 19.

## **ENROLLING ELIGIBLE DEPENDENTS**

Eligible dependents may include a lawful spouse, a same sex or opposite sex domestic partner, biological child, stepchild, legal dependent child of a domestic partner dependent, foster child or grandchild if legal custody has been appointed to the subscriber. Eligible dependents may enroll:

- ⇒ Along with newly hired employee
- ⇒ During small employer's annual open enrollment
- ⇒ Within 31 days of marriage, birth, adoption, obtaining legal custody or guardianship\*
- ⇒ Within 31 days of lifestyle change as defined by the Health Insurance Portability & Accountability (HIPAA) special enrollment period; this applies to those who initially declined coverage.
- ⇒ Within 31 days of loss of employment (voluntary or involuntary) that results in loss of insurance (except gross misconduct)
- ⇒ Within 31 days of the expiration of COBRA coverage
- ⇒ Proof of employment and hours worked via a current DLLR/OUI 15/16 must be provided when full-time employees are enrolled under the age of 19. If a DLLR/OUI 15/16 is not available, a payroll statement or notarized letter indicating the number of hours the employee works must be submitted.

Enrolling a newborn always requires an enrollment application, *even if* the subscriber already has Family coverage.

An elderly parent does not meet the contractual definition of a dependent; therefore he/she may NOT be enrolled on the employee's membership.

*\*Guardianship as contractually defined according to HIPAA*

### **Full-Time Students:**

- ⇒ Eligibility may *continue* past age 19 for unmarried dependents who are full-time students.
- ⇒ Eligibility will continue until the earlier of, the end of the month in which full-time student status ends, or the end of the month in which the dependent reaches the age limit of 23.
- ⇒ A full-time student is defined as a child who attends a:
  - ⇒ public or private high school;
  - ⇒ college or university;
  - ⇒ graduate school; or
  - ⇒ Trade school.
- ⇒ Attendance must meet the requirements of the institution for full-time status.
- ⇒ If an enrolled, over-age student disenrolls from the subscriber's coverage for a period of time and wishes to re-enroll, they may be reinstated onto the subscriber's policy, providing they still meet the eligibility requirements of a full-time student dependent and are within the age limit.
- ⇒ CAREFIRST requires proof of full-time student status at time of enrollment. Forms are available on the CareFirst.com Broker website.
- ⇒ Over-age dependent may maintain a full-time job and be eligible if they meet other requirements.

## **ENROLLING ELIGIBLE DEPENDENTS (cont'd)**

### **Handicapped Dependents:**

- ⇒ Eligibility may *continue* past age 19 for unmarried dependents who are mentally or physically incapacitated while covered under the health benefit plan and became disabled prior to reaching the limiting age, or the person was covered as a disabled dependent immediately prior to applying for coverage.
- ⇒ Certification of eligibility is required through the submission and acceptance of a Disability Qualification Questionnaire.
- ⇒ Once reviewed and accepted by CAREFIRST, the dependent will be coded as a “disabled dependent” on the subscriber’s policy.
- ⇒ If found ineligible to remain enrolled as a disabled dependent, the child may select a policy through the Individual Market Division.
- ⇒ CAREFIRST may request proof of mental or physical incapacity at any time.

### **Domestic Partner Dependents:**

- ⇒ Available only to D.C. and MD small group and Individual markets. Coverage is available to VA groups but not to VA individuals.
- ⇒ Available as of 9/1/04 renewals and new business at the employer’s discretion. Coverage may also be added off-cycle with no rate or renewal date impact.
- ⇒ Suggested that the Subscriber consult with a tax advisor regarding the cost of coverage for a person who is not a spouse or a child through marriage, as payments made by the employer may be taxable income to them.
- ⇒ Requirements for eligibility are monitored by the employer and may be subject to audit by CareFirst subsequent to the initial enrollment.

Requirements for eligibility are as follows:

- ⇒ If the couple resides in a jurisdiction that requires or permits registration with that jurisdiction’s government as a domestic partnership, the couple has registered in accordance with the law of that jurisdiction.
- ⇒ The Subscriber and the Domestic Partner are the same sex or the opposite sex and both are at least eighteen years of age and have the legal capacity to enter into a contract.
- ⇒ The Subscriber and Domestic Partner are not parties to a legally recognized marriage, either to each other or to anyone else.
- ⇒ The Subscriber and Domestic Partner share no blood or familial relationship that would bar marriage under the laws of the jurisdiction in which the couple resides, and neither the Subscriber nor the Domestic Partner are a member of another Domestic Partnership or substantially similar relationship.
- ⇒ The Subscriber and Domestic Partner share a close, committed and exclusive personal relationship that is meant to be of lasting duration.
- ⇒ The Subscriber and Domestic Partner have a shared common legal residence continuously for at least six months and have submitted documentary evidence of such cohabitation that is satisfactory to the Group.
- ⇒ The Subscriber and/or the Domestic Partner have not been a member of another Domestic Partnership or substantially similar relationship within the past six months.
- ⇒ The Subscriber and Domestic Partner are Financially Interdependent, as defined below and submit documentary evidence of such interdependence that is satisfactory to the Group; have both signed the appropriate affidavit, enrollment form, or other document(s) required by the Group, confirming their Domestic Partnership and agree to notify the Group, in writing, within thirty (30) days of the date of the Domestic Partnership.

## **ENROLLING ELIGIBLE DEPENDENTS (cont'd)**

### **Termination:**

- ⇒ Changes for dependents can only be made during the open enrollment period or within 31 days of a lifestyle change.
- ⇒ Employees will not be permitted to disenroll a dependent anytime other than as stated in the health benefit plan.
- ⇒ Employees whose employment is terminated for any reason but are then reinstated, must satisfy a new waiting period and complete a new enrollment application unless the employer chooses to waive the waiting period based on the nature of the reinstatement and applies that decision to all similar reinstatements.

## **Account Eligibility**

According to Maryland legislation, any eligible employer must have the majority of its eligible employees employed in Maryland to purchase Maryland Small Group health coverage. An account must be headquartered or have a physical location in the State of Maryland to be covered under a small group product. If an employer is split 50-50 between Maryland and another state, the employer is NOT eligible for Maryland Small Group health coverage.

**Note:** Employees working in the District of Columbia are NOT considered employed in the state of Maryland for purposes of determining whether the employer is eligible for Maryland Small Group health coverage.

If the employee is a DC resident and commutes to a MD employer, a notarized letter to that effect must be submitted noting same as well as the mileage to and from the MD location.

**Effective 6/1/00, HB649/SB801 determined the criteria for determining new account eligibility: Account must have 2-50 eligible employees on at least 50% of its working days during the calendar quarter prior to sale.** Existing small group accounts which were enrolled under the old guidelines (prior calendar year rather than prior quarter) are able to remain under the prior rules or request a 51+ quote at renewal if, under the new guidelines they are not eligible for small group. 51+ quote requests require a wage and tax and the risk screening questionnaire, and should be coordinated with your 51+ Sales Executive at least 45 days prior to the AI deadline.

As a general rule, renewing groups are reviewed 120 days prior to the renewal date. At that time, the most recent 6 months of enrollment data is pulled. "Under 50" groups that average greater than 50 enrolled contracts are designated to be moved to the 51-199 market segment. "Over 50" groups that average less than 50 enrolled contracts are designated to be moved to the small group segment.

### **Exclusivity:**

CareFirst requires exclusivity from all accounts, meaning no product offered by a carrier other than CareFirst may be offered to employees. Union accounts are the only exception to this rule.

### **Minimum Participation Requirements:**

All CareFirst products require 75% participation. If multiple products are offered, there must be 75% total participation. To calculate participation, all legitimate waivers should be removed from the employee total and then the 75% calculated off of the remaining eligibles. Example: 10 total employees; 3 spousal waivers; 75% of 7 eligibles requires 5 participants.

### **Sole Proprietorships, Partnerships or Corporations:**

A company insured with CAREFIRST must be an active entity with a Federal Tax I.D., engaged in a trade or business, consisting of at least 2 eligible employees (unless HB 857 or HB988).

## **Account Eligibility (cont'd)**

### **Non-Profit Organizations:**

As of June 1995, a non-profit organization with only 1 eligible employee working 20 hours or more per week on a regular basis may purchase CAREFIRST small group coverage. The group must provide CAREFIRST with the "Letter of Determination" also known as Form 501(c)(3), provided by the Internal Revenue Service, which denotes their non-profit status. In lieu of this form we will accept the charter documents of the organization along with an affidavit of a CPA certifying the status of the organization pursuant to IRC 501 (c) (3).

### **Enrollment BlueChoice Products:**

All enrolling members must reside in the BlueChoice enrollment service area in order to be enrolled in any of the BlueChoice products.

All members must choose a primary care provider no matter what product they are choosing including HMO, HMO *Open Access*, Opt-Out *Open Access* and Opt-Out *Plus Open Access*.

### **Waiting Period for New Employees:**

- ⇒ Account must define a specific waiting period(s) for employees
- ⇒ Waiting period can be any length of time
- ⇒ Waiting period may not be discriminatory or involve health related matters
- ⇒ Once defined in Group Application or Group Contract, a new Group Application/Contract must be submitted to change the waiting period
- ⇒ If the group elects to change their new hire waiting period current employees who have not completed their waiting period will be affected as follows:
  - ⇒ If the new waiting period is longer than the prior one, the new waiting period is applied to the employee's original hire date
  - ⇒ If the new waiting period is shorter than the prior one, the employee is effective on the effective date of the waiting period change
- ⇒ Waiting periods using the word "month" will be calculated on the number of days in the month applying to the specific new hire (28,30, 31)
- ⇒ Day 1 of a waiting period begins the day after the date of hire
- ⇒ If the waiting period includes verbiage referencing the first of the month after a specific time period (i.e. 30 days) and the end of the time frame falls on the first day of the month, the effective date would be the first day of the following month, not the last day of the time period
- ⇒ Reinstated employees must fulfill a new waiting period and complete a new enrollment application unless the employer chooses to waive the waiting period based on the nature of the reinstatement and applies that decision to all similar reinstatements.
- ⇒ New Employees must fulfill their waiting period prior to enrolling even if the group's annual open enrollment occurs during the waiting period; the group's annual open enrollment does not override the waiting period.

## **HOUSE BILL 857**

Effective October 1, 1996, House Bill 857 enables the one, remaining eligible employee in a company of two or more full-time employees to obtain small group coverage.

If a group consists of 2 full-time employees, 1 under 65 without Medicare or other group sponsored coverage, and 1 over or under 65 with Medicare A&B, the group qualifies under HB857 as long as the employee with Medicare waives coverage and the under 65 enrolls.

**House Bill 857 does NOT allow for the 1 remaining employee that is enrolling to be any of the following:**

- ⇒ Companies, sole proprietors, corporations or partnerships with only one (1) eligible employee because all remaining employees are part-time.
- ⇒ Self-employed individuals including corporations, where the owner is the ONLY person in the company.
- ⇒ A 1099 employee.
- ⇒ A Medicare eligible employee (A or A&B).

## **HOUSE BILL 988**

Effective October 1, 1997, House Bill 988 allows for the expansion of the definition of “small employer” to include small employers who downsize to only one (1) remaining full-time eligible employee. Therefore, when the number of eligible employees employed and enrolled in a small employer group falls to one (1), the group should not be canceled or converted to “self-employed” status as was done in the past unless they make a benefit change. The group will continue to be defined as a “small employer” and will be issued a small employer group contract as long as they remain in the same product.

This CAREFIRST decision is based on the expectation that enrollment in the group will grow. If we required movement between the “self-employed” and “small group” guidelines, the migration could be administratively confusing for the employer and CAREFIRST.

## **MUTIPLE OPTION OFFERINGS**

Up to 3 product options may be offered to the entire employee population. The options offered must be either DC-based products (FACETS) or MD-based products (CARE). The only exception that allows for small group mixed platform offerings resulted from the accommodations made for the PHN migration project which ended March 2005.

- ⇒ New/Renewal rates will be calculated based on the guidelines in the Small Group Rating portion of this manual
- ⇒ Participation requirements will be assessed on the total enrollment in the account and not on each option.
- ⇒ Employer may apply multiple waiting periods to defined segments of employees within the same account. (See “waiting period for new employees” section above).
- ⇒ All employee segments must be offered all product options; classing out of employees is not permitted.
- ⇒ The options offered must be differentiated by the medical benefits offered, and may not be limited to an “Open Access” or prescription drug benefit differentiation.
- ⇒ If offering a MD-based (CARE) product combination only two (2) products may be offered, one (1) MPOS option and one (1) PPN option. Two (2) PPN or two (2) MPOS options may not be offered.
- ⇒ Regional Dental: If two (2) or three (3) medical plans are offered, two (2) dental plans may be offered as long as the offering includes no more than one (1) option from a product type (Regional Traditional, Regional Preferred PPO or DHMO)  
If one (1) medical option is offered, a Regional Traditional or Regional Preferred PPO plan may be offered.
- ⇒ Two (2) RX options can be offered if two (2) medical options are offered; three (3) RX options can be offered if there are three (3) medical options offered.
- ⇒ “Open Access” cannot be used as the only differentiation between the same option number under the same product.

**MATRIX: ACCOUNT SEGMENT ELIGIBILITY**

Headquarters	>50% Working in MD	>50% Working Outside MD	50% Working in MD; 50% Working Outside MD	Segment	Coverage
MD	Yes	No	No	MSGR	All Employees
MD	No	Yes	No	Non-MSGR	All Employees
MD	No	No	Yes	Non-MSGR	All Employees
Out-of-State	No	Yes	No	Non-MSGR	HMO product only for those employees working in the service area
Out-of-State	Yes	No	No	MSGR	HMO product only if branch office is not a separate purchasing entity HMO/Indemnity if branch office is separate division or subsidiary. Must have a letter from headquarters defining the corporate organization.
Out-of-State	No	No	Yes	Non-MSGR	HMO product only for those employees working in the service area

## **AFFILIATED COMPANIES**

According to Small Group Reform legislation, “in determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a consolidated federal income tax return shall be considered one employer.” *The key phrase here is “eligible to file”*; the type of affiliation between the parent company and the others will determine whether or not they are eligible to file a consolidated tax return or separate returns. In other words:

<b>“PARENT COMPANY”</b>	<b>TAX FILING METHOD</b>	<b>LEGISLATIVE INTERPRETATION</b>
<b>Corporations</b>	If corporation has <b>80% Ownership or more in the Other businesses</b> , they have a choice of filing separate returns OR a consolidated tax return.	Either way they choose, they are eligible to file consolidated returns. Therefore, <b>SEGO law considers them one employer.</b>
	If corporation has <b>less than 80% ownership</b> in the other businesses, they must file separate tax returns.	Since they are not eligible to file consolidated tax returns, <b>SEGO law considers them separate employers.</b>
<b>Sole Proprietors</b>	Must file separate tax returns	Since they are not eligible to file consolidated tax returns, <b>SEGO law considers them separate employers.</b>
<b>Partnerships</b>	Must file separate tax returns	Since they are not eligible to file consolidated tax returns, <b>SEGO law considers them separate employers.</b>

- ⇒ **Just because two companies have different names and different employer tax ID numbers does not necessarily mean that they are Small Group eligible as two separate employers!**
- ⇒ **YOU NEED TO CHECK ON THE AMOUNT OF OWNERSHIP BETWEEN THE COMPANIES AND HOW THE COMPANIES INTERACT WITH EACH OTHER!**

## **ACCOUNT ELIGIBILITY VERIFICATION**

As a requirement for all new business and upon request at renewal, an account must provide a copy of their most recent quarterly Wage and Tax Statement (DLLR/OUI 15/16). This quarterly document, filed with the State of Maryland, lists all compensated employees for unemployment tax purposes. It is via this document that CAREFIRST will be able to determine the total number of eligible employees. When the DLLR/OUI 15/16 is submitted, the account should note eligibility status next to each employee. For example:

Mary Peters	no insurance
John Smith	group spousal waiver
Steve Meyers	part-time
Susan Jones	probationary/waiting period

Note that the most current Wage and Tax (DLLR/OUI 15/16) statement filed with the State of Maryland is required on all new accounts including those transferring from one company within CareFirst to another (CFMI, GHMSI, BlueChoice). CareFirst requires a duplicate copy of the DLLR/OUI 15/16 sent to the state. W-4's are required for those employees not appearing on the Wage and Tax, unless they are an owner. Owner's name and social security number should be written on the bottom of the Wage and Tax and identified as such with the number of hours worked per week and eligibility status.

### **Payroll Registers in Lieu of a DLLR/OUI 15/16:**

Payroll registers will be accepted in lieu of the Maryland Wage and Tax when the payroll register is filed as an amendment. This option should only be exercised on an exception basis when the Maryland Wage & Tax Statement (DLLR/OUI 15/16) is not available. If a payroll register is provided, it must be generated by a payroll service (EasyPay, ADP, etc.) and must not be generated by software via desktop computers.

### **Newly Formed Companies:**

When a newly formed company does not have a DLLR/OUI 15/16, they should submit a notarized letter on company letterhead listing their employees, the number of hours per week and their eligibility status. W-4's must be submitted for each employee as well as the business formation documents. The application for the DLLR/OUI 15/16 should be submitted as well, if available.

### **Segment Migrations from 50+:**

Between 90 and 120 days prior the group's renewal, underwriting produces a listing of groups that are being moved between size segments. For those groups that have had less than 50 enrolled for a consistent 6 month period, brokers are required to obtain an identified wage and tax at least 60 days prior to the renewal date so that it can be determined whether the group should be rated as MSGR or non-MSGR/MD Parity. Because rating and documentation for the non-MSGR/MD Parity segment can be time consuming, brokers are strongly encouraged to secure the identified wage and tax as soon as possible after segment migration notification is made.

### **Groups with New Federal Tax ID Numbers:**

A new Fed tax ID number is generally consistent with a change of entity for the group (i.e.: sole proprietorship shifting to a partnership or new ownership) and requires that the original group be termed and the new entity written as a new group. This may be of concern for existing groups currently offering a high deductible plan.

## Tax Documentation

The following information was either provided by State legislation (as in the case of a self-employed individual), or by the Maryland Office of Unemployment Insurance to determine which tax documents are available to verify eligibility of an employer group and its employees:

<b>TYPE OF BUSINESS</b>	<b>DLLR/OUI 15/16 REQUIRED IF EMPLOYEES ARE</b>	<b>DLLR/OUI 15/16 NOT REQUIRED IF EMPLOYEES ARE</b>	<b>IF NO DLLR/OUI 15/16 REQUIRED, SUBMIT INSTEAD</b>
<b>Self-Employed Individuals</b>  <b>Self-Employed “Licensed Professionals”</b> such as <i>Attorneys, physicians (LLP “Limited Liability Partnership” excluded)</i>			<b>Signed Form 1040 or 1040EZ and any one of the following: Schedule C, C-EZ, F, SE, Form 1120, 1120-S or Form 1065 with K-1, Form 7004, and Form 4868.</b>  <b>Articles of (Professional) Incorporation and “Letter of Good Standing”</b> from licensing group
<b>Effective 10/1/05 self-employed are no longer considered “small employer groups.” No open enrollment periods will be offered.</b>			
<b>Corporation</b> <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>			<b>Form 1120, Form 1120-S or Articles of Incorporation</b> showing owners of business
<i>Note: In most cases, corporations will have a formal Wage &amp; Tax (DLLR/OUI 15/16)**</i>			
<b>Sole Proprietorship</b> <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>	Owner’s children (over age 21) Other employees	Owner Spouse Owner’s children (under age 21) Owner’s parents	<b>Signed Schedule C/ F</b> Showing <i>at least</i> Husband and wife as Owners**
<b>Partnership</b> <i>(HB 857, HB 988 or HB 1359: 2+ eligibles)</i>	Spouse Owner’s children Other employees	Partners	<b>Form 1065 and signed K-1 forms for each Partner**</b>
<b>Non-Profit Organization</b> <i>(1 sole eligible employee working 20 hrs/wk)</i>		Any employee(s)	<b>IRS Form 501(c)(3)</b> a.k.a. “Letter of Determination” w/ <b>notarized letter</b> on company letter-head, listing employees, hours per week/eligibility status*

Note that a current Wage and Tax Statement (DLLR/OUI 15/16) is required on all accounts including those migrating between CareFirst companies. Stock certificates are not accepted as proof of ownership.

\*In lieu of Form 501 C 3, will accept the Charter Documents of the organization along with an Affidavit of a CPA certifying the status of the organization pursuant to IRC 501 C 3.

\*\*If the owners are the only employees, in addition to the tax documents they must also submit a notarized letter on company letterhead listing the name of each, the number of hours per week each works, and their eligibility status.

## Husband/Wife Businesses

To be considered an eligible employee a spouse must appear on the wage and tax, appear as an owner on the tax document, or produce a W-2. In addition to the required tax documentation, the group must provide a *written* statement that they are *both* working 30+ hours per week. Refer to the following matrix for help in determining whether your small employer group should be written as a 2+ Husband/Wife under a group contract or is defined as “self-employed” and not eligible for coverage under MSGR.

		Receiving Salary?	Listed on Tax Doc/ Schedule	Owner?	Type of Small Group
<b>A</b>	Spouse 1	yes	yes	Yes	Self-employed owner w/ dependent.
	Spouse 2	no	no	No	
<b>B</b>	Spouse 1	no	yes	Yes	Self-employed owner w/ dependent.
	Spouse 2	no	no	No	
<b>C</b>	Spouse 1	no	yes	Yes	2+ Small Group. May enroll as either 1 contract or 2 contracts.
	Spouse 2	no	yes	Yes	
<b>D</b>	Spouse 1	yes	yes	Yes	2+ Small Group. May enroll as either 1 contract or 2 contracts.
	Spouse 2	yes	yes	Yes	
<b>E</b>	Spouse 1	yes	yes	Yes	2+ Small Group. May enroll as either 1 contract or 2 contracts.
	Spouse 2	yes	yes	No	

The above assumes Maryland Small Group Reform eligibility is being met. In other words, both spouses are 30+ hours per week and have no other health insurance coverage.

In the event that an existing account no longer meets the minimum eligibility requirements for a 2+ Husband/Wife group, the account may remain active under HB 988.

Newly formed Husband and Wife Only groups must produce a notarized letter listing all full-time employees, the number of hours worked per week and their eligibility status **AND** the actual business formation documents that list both the husband and wife as owners. It must also be understood that, in the event of a future renewal audit, the proper tax documentation must be provided.

# Special Product Offerings

## Consumer Driven Health Products (CDH):

In the Fall of 2006 CareFirst launched the first of the line of products categorized as Consumer Driven Health Products to the MSGR market. The first were BluePreferred Options that combined with a Health Savings Account (HSA) fund or with a Health Reimbursement Account (HRA) fund administered by our vendor Flex America. These were launched under the banner of “BlueFund”. At the same time, products were also made available that employers could offer either with no fund or through another administrator referred to as “Compatible”.

Then, in July 2006, HSA products were launched to the MSGR market for September 2006 effective dates based off of the BlueChoice Open Access HMO and the BlueChoice Opt Out *Plus Open Access* products.

Although quite popular and very cost competitive, these products require much understanding of IRS regulations and CareFirst business rules on the part of the broker. The CareFirst sales representative and the **General/Full Service Producers** provide ongoing training on these products and are able to provide additional training upon request as needed

When selling CDH products, please keep the following in mind:

- ⇒ Additional lead time is required with these products to ensure that employers and employees understand how the product works and to get the most out of the funding, if applicable.
- ⇒ Paperwork and tax documentation must be provided within the stated timeframes to **General/Full Service Producers** and to CareFirst.
- ⇒ Special care should be taken to ensure that average age adjustments, county code adjustments and any other adjustments to the renewal rating is done prior to the stated timeframes by **General/Full Service Producers** and CareFirst to allow for the adjustment to be finalized prior to the applicable cut-off.
- ⇒ Retroactivity on these plans is not allowed
- ⇒ It is strongly recommended that CDH plans not be sold exclusively, but instead along with a second alternative or if “BlueFund” is sold with the corresponding “Compatible” plan. By doing so, those ineligible for funding either as new hires or during the year will have an alternative option to accommodate them.

Please refer to our HSA and HRA Reference Guides located at [www.carefirst.com](http://www.carefirst.com) for basic business rules for this line of CDH products to be used as a quick reference to brokers selling these products.

## **Special Product Offerings (cont'd)**

### **Non-MSGR (MD Parity):**

Accounts fall in this market segment for one of three reasons.

- 1) The account has more than 50 full-time eligible employees, with less than 50 full-time employee enrolling
- 2) The account's headquarters are located outside of the state of Maryland, and therefore, do not qualify for Maryland Small Group reform (MSGR). In this scenario, if the Account's headquarters are not located within the CareFirst territory, the Non-MSGR plans marketed must be BlueChoice.
- 3) The majority of the enrollment works outside of MD (headquarters is in MD).

### **Required Documentation for both medical and freestanding dental or vision:**

Less than 25 enrolling:

- Medically underwritten application for each enrolling individual
- Census
- Identified\* Wage and Tax
- Rates (existing or renewal) from prior carrier
- Plan design from current carrier
- Number of years with current carrier
- Employer contribution

25-50 enrolling:

- Group Risk Questionnaire
- Census
- Identified\* Wage and Tax
- Rates from prior carrier
- Plan design from current carrier
- Number of years with current carrier
- Employer contribution

**Identified Wage and Tax:** Identification of the most recent Quarterly Wage and Tax report is required in order for the Broker Representative and Underwriting to be able to determine the correct number of eligible employees and that the group is meeting CareFirst's minimum participation level of 75%. The identifications should include (but are not limited to) terminations, part-time, new hires, spousal waivers, enrolling, etc. Please make sure to cross-reference the census to the Wage and Tax to identify **all** employees. In addition to meeting the 75% participation requirement, a minimum of 50% of the eligible employees must be enrolling in the plan.

### **New Business:**

- ⇒ Rates for both categories are adjusted using loads to a maximum of 65%. These include SIC code and POE adjustments
- ⇒ Although a base rate can be determined using the rating systems, the HIPAA point load and an underwriter's judgment will affect the base rate. Brokers should never quote the initial rate to a potential group *as underwriting may load the base rate or decline to quote.*
- ⇒ Requests from a group or broker for an existing CareFirst group to be reviewed to move market segments to Parity are handled just like New Business coming from another carrier and require the same information as outlined above. *Underwriting reserves the right to decline to quote MD Parity to existing group.*
- ⇒ Determine which sales office should handle the quote based on the physical address of the group.
- ⇒ MD Parity benefits cannot be extended to 1099 employees.
- ⇒ Required employer contribution is 50% of the Individual rate
- ⇒ Groups requesting quotes for the MD PPN or BluePreferred products must have a minimum of 25% of the total eligibles living and working in the service area
- ⇒ A discount is applied for groups choosing a single option rather than a POE

## **Special Product Offerings (cont'd)**

### **Non-MSGR (MD Parity) (cont'd):**

#### **Renewing Business:**

- ⇒ Average Age adjustments for MD Parity rates are handled in the same manner as MSGR adjustments **either through the General/Full Service Producer or Broker Sales**
- ⇒ Requests from the MD Underwriting Department for groups to move to the 2-50 market segment, based on the average enrollment for a 6 month period falling under 51 contracts; requires an Identified wage and tax to be provided to determine the correct Market segment (MSGR or MD Parity).
- ⇒ Any renewal alternative quotes must be quoted by the CareFirst Sales Representative or the **General/Full Service Producer.**
- ⇒ Renewal increases are capped at 35% as of this writing and are subject to change
- ⇒ Underwriting approval must be granted for off-cycle benefit change requests with the average age used for rating reflective of the current enrollment system.

#### **General Guidelines:**

- ⇒ When providing the Underwriting requirements with the prospect request, include the benefits you wish quoted, the broker selling the case, the desired effective date and turnaround expectations.
- ⇒ Enrolling substantially more or less enrollees than projected can change the rates (if the average age changes) and/or market segment (Underwriting may require a 51+ rating to occur if the participation is well over 51 ).
- ⇒ It is preferred for you to request which BlueChoice or Blue Preferred plans and Rx benefits you would like quoted. If not, we will quote what most closely matches the benefits from the previous carrier.
- ⇒ Broker commission is built into the 1-50 rates *and follows the commission schedule for 1-50 new and renewing business in all jurisdictions (commissions cannot be altered)*. Non-MSGR benefits typically follow 51+ benefits, with the exception of the new Regional Dental plans, which follow MSGR plan designs.
- ⇒ Accounts in Non-MSGR segment typically have Calendar year benefits; with the exception of those accounts already on Facets that were once Contract year MSGR. **Facets keeps history and those accounts must keep contract year benefits unless a benefit change is initiated to change the benefit period. Likewise, if a group currently on a Calendar year benefit period wishes to move to a Contract year benefit period, a benefit change must be initiated.**
- ⇒ Domestic Partnership follows under 50 guidelines, rather than 51+.
- ⇒ Promotional materials with a turnaround requirement of less than 5 business days will need to come through the CareFirst Sales office handling the group. We are unable to guarantee materials requested in less than 5 business days without Literature Resource's approval. Existing groups should be made aware of these timeframes in advance and encouraged to adhere.
- ⇒ **The MSGR defined geographic regions do not affect the rate calculation for Non-MSGR (MD Parity) groups.**
- ⇒ **There must be at least 1 contract in the service area and the group must be headquartered and physically located in MD (a P.O. Box is not sufficient)**

**Special Product Offerings (cont'd)**  
**Non-MSGP (MD Parity) (cont'd):**

Applicable Group Applications by Product(s):

PRODUCTS	GROUP APPLICATION REQUIRED			
	GHMSI	BlueChoice	GHMSI/BlueChoice Opt Out Plus	GHMSI/BlueChoice Point of Enrollment
BlueChoice HMO		X		
BlueChoice Open Access		X		
BlueChoice Opt Out Open Access		X		
BlueChoice Opt Out Plus Open Access			X	
BluePreferred	X			
POE w/ BluePreferred & BlueChoice				X
POE w/BluePreferred & BlueChoice w/dental and/or vision Parallel				X
POE w/BluePreferred & BlueChoice w/dental and/or vision Non Parallel				X
POE w/multiple BlueChoice (except Opt Out Plus Open Access) w/dental and/or vision Parallel		X		
POE w/multiple BlueChoice (except Opt Out Plus Open Access) w/dental and/or vision Non-Parallel	X	X		
POE w/multiple BlueChoice (including Opt Out Plus Open Access) w/dental and/or vision Parallel		X	X	
POE w/multiple BlueChoice (including Opt Out Plus Open Access) w/dental and/or vision Non-Parallel	X	X	X	

## Special Product Offerings (cont'd)

### **Limited Benefit Plan (LBP):**

Effective 7/1/2005, CareFirst began offering the Capped Benefit Plan version of the LBP which complies with Maryland Senate Bill 570. The product was eliminated July 1, 2008 due to no enrollment.

### **Maryland Small Group Subsidy Program:**

Effective 10/1/2008 the Working Families and Small Business Health Coverage Act (SB6), established the Health Insurance Partnership (a Maryland Small Group Subsidy Program) for small employers not currently offering health insurance to their employees. The goal was to reduce the number of uninsured residents in Maryland by providing a subsidy of up to 50% of premium to groups and their employees if the MHCC requirements are met.

In order for a group to qualify for the subsidy program, they must be enrolled in a Wellness Benefit Program that

- ⇒ Offers a Health Risk Assessment (HRA) that includes personalized feedback from the HRA
- ⇒ Offers a Financial Incentive to promote Preventive Care

This program has specific eligibility and administrative requirements. Details have been provided in Sales Flashes and through training provided by the Broker Sales Representatives and through the MHCC as well as the General Producers.

Below is a list of some fundamental requirements of the program:

- ⇒ Business must have been in operation for at least 12 months and must not have offered health insurance (MSGP product) to its employees for at least 12 months
- ⇒ Business must employ at least 2 but not more than 9 eligible employees
- ⇒ Business must have an average wage based on full-time employees of less than \$50K; with owners' wages capped at \$60K
- ⇒ Requires that the group be enrolled in a health plan that provides a Wellness Benefit Program
- ⇒ No 15<sup>th</sup> of month effective dates
- ⇒ All billing is done by CareFirst, Inc; product can only be sold through General Producers and Brokers
- ⇒ POE may include up to 3 HSA products but MUST include at least 1 HSA Compatible product
- ⇒ No product, benefit or average age changes will be allowed until renewal
- ⇒ No short plan year dental and/or vision products
- ⇒ Subsidy groups will not be set-up on CareFirst Connect and all initial and subsequent enrollment will be handled via paper
- ⇒ The following products are the only ones available to subsidy groups and can be offered as "BlueFund" or "Compatible" and all include an integrated RX benefit of \$0/\$25/\$45
  - BlueChoice HMO HSA Option #1 (\$1200 Ded)
  - BlueChoice HMO Opt-Out Plus HSA Option #1 (\$1200 Ded)
  - BluePreferred PPO HSA Option #1 (\$1200 Ded, 90/70%)
- ⇒ All Account Installation deadlines are strictly adhered to with these products and Direct Brokers are required to provide their initial paperwork to Broker Sales by the 8<sup>th</sup> day of the month prior to the requested effective date

# **SMALL GROUP RATING**

*MPOS and PPN are calculated using a weighted composite factor. BluePreferred and BlueChoice use average age rating.*

## **MEDICARE ELIGIBLES/DEPENDENTS AND RETIREES**

Anyone enrolling in any of CareFirst's Medicare Secondary products must have parts A & B of Medicare.

### **TEFRA vs. NON-TEFRA:**

TEFRA only applies to a group health plan sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. Segments of employees (i.e.: union members) not eligible for plan benefits are not included in the calculation to determine TEFRA/Non-TEFRA designation. Groups should also note that there is a period of time that a group must maintain the required number of employees to actually be moved from one TEFRA/Non-TEFRA designation to another. CMS has put this in place to avoid groups moving between designations repeatedly. Groups are responsible for determining their designation and should enlist assistance from their accountant if there is confusion.

### **MPOS and PPN:**

- ⇒ TEFRA: At the employer's election, retirees and their dependents can be offered health benefits by opting "yes" to the "retiree" HB8 question on the rating proposal
- ⇒ TEFRA: Active Medicare-eligibles are included in the under 65 census at their actual age, billed the under 65 rate, and are considered "group primary".
- ⇒ Non-TEFRA group, "yes" to the "other insurance" HB8 questions on the rating proposal
- ⇒ Retirees and dependents are never included in the under 65 census.
- ⇒ Non-TEFRA: Active Medicare-eligibles must be included in the under 65 census at their actual age, and are considered "Medicare primary" unless they are enrolled in the grand-fathered Standard Group Over 65 product.
- ⇒ Medicare Complementary is available as the Medicare Supplemental option. Or Standard Group Over 65 for those accounts grandfathered since 1999 (see below).

### **Standard Group Over 65 (PPN and MPOS):**

- ⇒ Accounts that had a non-SEGO Standard Group over 65 product in place prior to July 1, 1999 with active enrollment will be allowed to continue to offer that product to their Medicare-eligibles and retirees.
- ⇒ If enrollment in this product drops to 0, the Standard Group Over 65 product will be terminated and will not be reinstated.
- ⇒ This product must be terminated should the group choose BlueChoice/BluePreferred medical coverage for their non-Medicare employees

## **SMALL GROUP RATING (cont'd)**

### **MEDICARE ELIGIBLES/DEPENDENTS AND RETIREES (cont'd)**

#### **BlueChoice and BluePreferred: *see chart on page 35***

- ⇒ These products do not offer coverage to retirees
- ⇒ Non-TEFRA: Employer can offer coverage to their active Medicare-eligible employees by opting “yes” to the “other insurance” HB8 question on the Group Application
- ⇒ Non-TEFRA: Active Medicare-eligibles must be included in the under 65 census along with their spouses.
- ⇒ TEFRA: active Medicare eligibles are always offered benefits and the HB8 election of “yes” to “other insurance” will not apply to them.
- ⇒ TEFRA: Active Medicare-eligibles are included in the under 65 census at their actual age and billed the under 65 rate.
- ⇒ Non-TEFRA: The Medicare-eligible’s age is currently capped at age 48 and the spouse’s age is currently capped at 48 if they have Parts A & B, and actual age if they have Part A only or are not Medicare-eligible.

#### **Applicable to all products:**

If the active employee is under age 65 and the spouse is over 65 with Parts A & B of Medicare:

- ⇒ The spouse should not be included in the under 65 census
- ⇒ The employee should be included in the under 65 census at their actual age.
- ⇒ They should be enrolled as “Husband/Wife” or “Family,” if appropriate.

#### **Medicare Only Enrollment:**

- ⇒ New groups whose enrollment is based solely on enrollees with Medicare A & B will not be accepted.
- ⇒ New sales of Medicare Complementary will be contingent on the enrollment of at least 1 active non-Medicare employee in the under 65 product.
- ⇒ Groups with under 65 enrollment of “0” and at least 1 active Medicare Complementary enrollee cannot be termed.
- ⇒ Groups should be terminated if the under 65 enrollment drops to “0” and the enrollment in Medicare Complementary consists only of retirees.
- ⇒ Grandfathered Standard Group Over 65 products will remain in-force as long as enrollment remains in the product.

## **SMALL GROUP RATING (cont'd)**

### **NEW BUSINESS**

#### **Physical Address:**

All new accounts must provide their physical address on the account page, group page, and route sheet of the installation paperwork. The physical address allows us to verify the account eligibility and provides us with an address for priority deliveries including contracts. Likewise, the physical address of all subscribers is required on all enrollment applications.

#### **15<sup>th</sup> of Month Effective Dates:**

This initial effective date is available under BlueChoice and BluePreferred products only. The account will then renew 12 and ½ months later. Groups migrating from another one of our CareFirst products may take an initial 15<sup>th</sup> of the month effective date; however, they will be responsible for the premium for both products during the time that coverage overlaps. CareFirst strongly recommends this option not be used; as 15<sup>th</sup> of the month effective dates necessitate a calendar year benefit period which is not preferred under MSGR.

#### **Initial Premium Requirement:**

For all non-Administrator business, the first month's premium is required in order for the new account to be processed. For accounts effective on the 15<sup>th</sup> of the month, premium will be prorated with the first 43-47 days required based on the number of days in the month. Fax/copies of checks will not be accepted. This includes migrating business between CareFirst companies.

#### **Pre and Post Sale Census:**

Guidelines for all CareFirst products require that the applications received match the census used to rate the account. If the applications received after the enrollment do not match the census used to determine the rate, the new census must be used to run a revised proposal. The new proposal must then be signed by the account decision maker and provided along with the applications and other paperwork/documentation.

#### **Point of Enrollment – Blue Selections:**

Although up to three benefit selections may be offered, two of the same plan option may not be offered if the only variance is in the Rx options offered. Likewise, the "Open Access" feature may not be the only variation between 2 options of the same plan.

#### **Single Product Offering for All Products:**

⇒ The census on the rate proposal must match the number of applications submitted. Be sure that the correct ages of applicants have been rated using the age on the effective date of the contract.

Note: If a husband and wife are enrolling as one H/W contract, rate as one in census.

If a husband and wife are enrolling as two Individual contracts, rate as two.

#### **BlueChoice/BluePreferred Product Combinations:**

⇒ The census on the rate proposal must include all applications, even applications for part-timers and those full-time employees with other coverage who are enrolling. In other words, we are including these employees in the rate because they will be using our benefits; however, since they are ineligible, we will not be counting them towards meeting the 75% participation requirement.

⇒ When POE's are sold, each proposal must be rated on the actual total enrollment of all products offered.

#### **MPOS / PPN Product Combinations:**

⇒ When dual product options are sold, each proposal may be rated using the combined total enrollment or the actual enrollment in each product option.

⇒ The same tier structure must be used for medical and any ancillary product.

⇒ If new Rate First proposal is more than one page, the variation number and the date and time of the proposal run must match on all pages.

## **SMALL GROUP RATING (cont'd)**

### **RENEWAL BUSINESS:**

**All CareFirst renewals are rated based on the actual enrollment in the product(s).**

- ⇒ MPOS, PPN: renewals rated on each product offered based on the actual enrollment in each option.
- ⇒ BlueChoice, BluePreferred: renewals based on the total combined enrollment in all options offered.
- ⇒ If renewing MPOS, PPN proposal is more than one page, the variation number and the date and time of the proposal run must match on all pages.
- ⇒ New enrollment applications are required when a change to another product is made.

### **Migrating Business:**

- ⇒ All Groups migrating from one CareFirst company to another are considered NEW BUSINESS to the new company. As such, a current Wage and Tax statement (DLLR/OUI 15/16), new group paperwork, new group rating, and a first month's premium check (if moving CFMI to BlueChoice or GHMSI) is required.
- ⇒ Broker of Record Transfer letters are required when the non-incumbent broker migrates any CareFirst account from one CareFirst company to another.
- ⇒ Business migrating from one CareFirst company to another is considered "existing" business even though new group paperwork is required and as such is not considered "new" business for purposes of CareFirst's new business bonus schedule
- ⇒ Business migrating from one CareFirst product to another is considered "existing" business even though new group paperwork is required and as such follows the renewal paperwork deadlines.

### **Census Change Only:**

- ⇒ PPN, MPOS: If there have been any enrollment changes since the original renewal was prepared, and still prior to the submission deadline, the renewing account can be re-rated by the broker using RateFirst to reflect the current enrollment. Proof must be provided to substantiate the enrollment change (e.g. new applications or termination forms).
- ⇒ BlueChoice, BluePreferred: Requests for census changes must be submitted directly to CareFirst Broker Sales or through the **General/Full Service Producer** using the "Request for Average Age Adjustment" form. Census change only requests for these products can be made through the end of the month prior to renewal
- ⇒ BlueChoice, BluePreferred: Census change requests submitted for groups that are also planning to make a benefit change must be received no later than 3 days prior to the submission deadline to allow adequate time for the census change to be processed, the revised proposal run, and the benefit change to be submitted by the deadline. If this timeframe cannot be met, the broker should submit a signed proposal reflective of the original average age at deadline. The benefit change will then be processed and the rates will be automatically revised in the system once the average age adjustment is completed. Benefit change paperwork should not be held pending an average age adjustment request.
- ⇒ Benefit change requests received prior to the submission deadline will be held and processed once the average age adjustment is completed.
- ⇒ Changing from a H/W or Family Contract to 2 Individual Contracts:
  - ⇒ If a husband and wife (working for the same employer) wish to change their membership category from Husband/Wife to two Individuals, they may submit two applications and alter their membership during the annual open enrollment. The renewal is then re-rated based on this membership change.
  - ⇒ If benefit change: The membership change may be made AND the account may be re-rated to reflect the census and benefit change at renewal from one contract to two.

## **SMALL GROUP RATING (cont'd)**

### **RENEWAL BUSINESS:**

#### **Census Change Only (cont'd):**

- ⇒ Changing Subscriber to Younger Age:
  - ⇒ If a husband and wife (working for the same employer) wish to switch the main policyholder to the younger of the two, they may submit an application and alter the membership during the annual open enrollment. The renewal is then re-rated based on this membership change.
  - ⇒ If benefit change: The membership change may be made AND the account may be re-rated to reflect the change in age

***Remember, requests for census changes to BlueChoice/BluePreferred renewals must be submitted directly to CareFirst Small Group Underwriting or through the **General/Full Service Producer** and are limited to one request per group per renewal.***

#### **County Code Changes:**

- ⇒ The address and county code must be updated in FACETS either through Broker Sales or through the General/Full Service Producer prior to a request for a recalculation of rates being submitted; this may only be done in conjunction with the group's renewal, and must be done at least 3 days in advance of the A/I cut-off so as to allow time for the renewal rate recalculation and the approval by the group.

#### **Benefit Changes During Contract Year (for contract year accounts):**

- ⇒ Mid-contract year benefit changes are defined as any change initiated by the account to alter medical coinsurance, copay, deductible, endorsement, product or complete line of business. CAREFIRST-initiated "product streamlining", census changes, the addition of/change to dental and vision, any RX changes, or tier structure changes will not be accepted as reason for a mid-contract benefit change and the re-rating of a group.
- ⇒ Census change requests do not constitute a benefit change. An account cannot try to change their effective date and renew mid-contract year for the sole reason of adding enrollment or deleting enrollment. They must be making a legitimate change in their benefit portfolio to warrant a new effective date with applicable rates.
- ⇒ Requests for Benefit changes to existing products or movement between products offered by the same CareFirst entity (i.e.: CFMI's PPN and MPOS) will not be approved 90 days prior to the account's current renewal date.
- ⇒ Accounts wishing to make off-renewal benefit changes may do so on the first of the month after their renewal or new sale.
- ⇒ BlueChoice or BluePreferred existing accounts electing to make a benefit change within their current product will be rated based on their total enrollment as follows:

Months 1-6	Prior renewal enrollment
Months 7-9	Rated by Underwriting based on current enrollment
Months 10-12	No changes
- ⇒ MPOS, PPN existing accounts wishing to make benefit changes within their existing product during the first 9 months of the contract will be rated using the current enrollment.
- ⇒ The effective date of the medical benefit change will become the new renewal date.
- ⇒ Under a contract year benefit period, DHMO or Regional dental /vision products can be added to the group mid-contract year without affecting the medical renewal date.
- ⇒ Changes only to tier structure are not accepted; must make a benefit change as well
- ⇒ Refer to the Dental/Vision sections of this manual for more details.
- ⇒ When changing/adding benefits/products during the contract year, a new proposal must be run and for the BluePreferred and BlueChoice products, closing documents (if required) and the new group/benefit change worksheet completed and signed.
- ⇒ Termination of medical or ancillary products must be done as a benefit change and not a termination to avoid termination of both products.

## **SMALL GROUP RATING (cont'd)**

### **RENEWAL BUSINESS:**

#### **Benefit Changes at Renewal:**

##### **BlueChoice/BluePreferred:**

- ⇒ Single or POE combinations are rated based on the total combined enrollment for the product configuration purchased at renewal.
- ⇒ Termination of medical or ancillary products must be done as a benefit change and not a termination to avoid termination of both products.

##### **PPN / MPOS:**

- ⇒ If coinsurance, copay, deductible, endorsement, product or complete line of business changes are being made to an account with only a single line of business, the proposal must be rated to reflect the new benefits with either the original renewal enrollment or the most current enrollment.
- ⇒ If adding an additional line of business to the current plan, each proposal may be rated to reflect the new benefits using the original renewal enrollment, the most current total enrollment or rating each product based on the actual enrollment.
- ⇒ If coinsurance, copay, deductible, or endorsement changes are being made within existing dual lines of business, each proposal must be rated to reflect the new benefits, using the original renewal enrollment or the most current enrollment in each.
- ⇒ If deleting a line of business within existing dual option, rate the remaining product based on the final enrollment in the remaining product.
- ⇒ All benefit changes must be received prior to the renewal.

#### **Benefit Changes with a Census Jurisdiction Change at Renewal:**

##### **BlueChoice/BluePreferred:**

- ⇒ Benefit Changes must be received prior to deadline, census change requests prior to end of month prior to renewal.
- ⇒ If the benefit change is received and the census change is received in sufficient time prior to cut-off for Sales or **General/Full Service Producer** to run a new proposal for the requested benefit change once the census change is made; the broker will be asked to have the new proposal signed and returned by cut-off
- ⇒ If the census change is processed after cut-off, Sales or the **General/Full Service Producer** will forward the signed proposal with the renewal census to A/I for benefit processing and the census change will be automatically made in the system

##### **PPN/MPOS:**

- ⇒ All census changes should be run by the broker or MD Administrator prior to deadline with the benefit change included.
- ⇒ The revised, signed renewal should be received by sales/AI by deadline.

## MATRIX: ELIGIBILITY, RATING & PARTICIPATION

Employee Categories	Eligible Employee (Include In group count)	Include in <65 Census?	Emp Required in Participation Calculation?
F/T emp enrolling w/ CareFirst/no other insurance product	YES	YES	YES
F/T emp w/ no ins coverage, not enrolling	YES	NO	YES
F/T emp w/ other health plan offered by their employer ***	N/A CareFirst	N/A Requires	N/A Exclusivity
P/T emp, not enrolling	NO	NO	NO
P/T emp (17 ½ hrs, 4 consec months), enrolling for coverage*	NO	YES	NO
Seasonal emp	NO	NO	NO
F/T emp w/ other group sponsored coverage not enrolling	YES	NO	NO
FT emp w/ other group sponsored coverage enrolling for coverage*	YES	YES	NO
F/T emp w/ IMD coverage, not enrolling	YES	NO	YES
F/T emp w/ IMD coverage, enrolling for coverage*	YES	YES	YES
F/T new hire in probationary period (not yet enrolling)	YES	NO	NO
COBRA w/ current grp (no longer emp, enrolling for coverage) includes divorced dep or qualified beneficiary	NO	YES	NO
F/T emp. w/COBRA from previous employer (keeping previous group sponsored coverage, not enrolling)	YES	NO	NO
F/T Independent Contractor (1099 emp)**	YES	YES	YES
F/T emp w/MSA enrolling	YES	YES	YES
F/T emp w/Medicare Parts A&B, enrolling for coverage	YES	YES	NO

\*At the option of the employer, part-time employees meeting the criteria, full-time employees with other group sponsored coverage and retirees (only filed for MPOS and PPN) may be offered small group coverage. “Group sponsored” coverage includes Medicare and Medicaid, and all other competitors’ group products.

\*\*At the option of the employer, full-time independent (1099) contractors may be offered the small group coverage. If so, all must be offered coverage and will be considered eligible. If enrolling, will be rated and applied towards the 75% participation requirement. **Independent (1099) contractors are not eligible for coverage under non-MSG (MD Parity) contracts.**

\*\*\*Since CareFirst does not allow other carriers to be offered along with a CareFirst product, “F/T employee with other employer coverage” is not applicable.

Note: Reference to COBRA above also refers to MD Continuation

## MEDICARE MATRIX: ELIGIBILITY, RATING & PARTICIPATION

Employee Categories	Product	Eligible Group Count	Include in <65 Census?	Emp Required in Participation Calculation?
<b>TEFRA GROUP</b>				
F/T active emp with Medicare secondary	Group	YES	YES	YES
<ul style="list-style-type: none"> <li>• Dependent with Medicare (secondary)</li> <li>• Dependent without Medicare</li> </ul>	Group		NO	
	Group		NO	
<65 F/T active emp without Medicare	Group	YES	YES	YES
<ul style="list-style-type: none"> <li>• Dependent with Medicare (secondary)</li> <li>• Dependent without Medicare</li> </ul>	Group		NO	
	Group		NO	
<b>NON-TEFRA GROUP</b>				
F/T active emp with Medicare (Medicare primary)	Medicare	NO	YES	NO
<ul style="list-style-type: none"> <li>• Dependent with Medicare (primary)</li> <li>• Dependent without Medicare</li> </ul>	Medicare		NO (PPN/MPOS) YES, age 48, (BC/BP)	
	Group		NO (PPN/MPOS) YES, actual age (BC/ BP)	
<65 F/T active emp without Medicare	Group	YES	YES	YES
<ul style="list-style-type: none"> <li>• Dependent with Medicare (primary)</li> <li>• Dependent without Medicare</li> </ul>	Medicare		NO	
	Group		NO	
<b>RETIREEES PPN/MPOS ONLY</b>				
Retiree with Medicare as primary	PPN/ MPOS Medicare	NO	NO	NO
<ul style="list-style-type: none"> <li>• Dependent with Medicare (primary)</li> <li>• Dependent without Medicare</li> </ul>	PPN/MPOS Medicare		NO	
	PPN/MPOS Group		NO	
Retiree without Medicare	PPN/MPOS Group	NO	NO	NO
<ul style="list-style-type: none"> <li>• Dependent with Medicare (primary)</li> <li>• Dependent without Medicare</li> </ul>	PPN/MPOS Medicare		NO	
	PPN/MPOS Group		NO	

## **MEDICARE MATRIX: (cont'd)**

- At the option of the employer, retirees (only filed for MPOS and PPN) and full-time 65+ employees with other group-sponsored coverage including Medicare may be offered the small group coverage.
- The 65+ employee in a TEFRA group can opt for group benefits as primary. If the employee does not select the group rates as primary, the Medicare Secondary rate may not be offered. Exception would be retirees in a MPOS or PPN group.
- 65+ employees with Medicare and/or retirees (MPOS and PPN) are not included in the group eligible count nor counted toward participation.
- The Medicare Secondary rate has only the individual coverage level.
- Medicare eligible active employees with Parts A & B of Medicare in a non-TEFRA account should be included in the group census for rating purposes when the account has elected to extend benefits to employees with other coverage.
- Retirees (MPOS and PPN) are never included in the group census.
- Dependents of Medicare-eligible subscribers are never included in the group census for PPN and MPOS.
- Spouses of Medicare-eligible subscribers in a non-TEFRA group for BlueChoice and BluePreferred are included in the group census with their age currently capped at 48 if they have Medicare Parts A&B, or at their actual age if they have Medicare Parts A only or are not Medicare-eligible.
- If the active employee is under age 65 and the spouse is over 65 with Parts A & B of Medicare, the spouse should not be included in the under 65 census and the employee should be included in the under 65 census at their actual age. They should be enrolled as “Husband/Wife” or “Family,” if appropriate.
- Groups with Medicare-eligible enrollment only will not be accepted.
- Active employees with Medicare A&B in a TEFRA group have the group coverage as primary and are not included in the employer’s HB8 election for “other coverage.”
- Active employees and their dependents in a non-TEFRA account with Medicare A or A&B may only be covered if the employer elects to offer *coverage* to those employees with “other coverage” under their HB8 elections.

# Rating: Medicare Eligibles BlueChoice/BluePreferred

How to Rate Medicare Eligibles in PC Rate Quote as of 8/1/05

	Rate EE	Rate SP	Rate CH
1	EE is Medicare	N/A	N/A
2	EE is Medicare + SP	Rate spouse as Individual using their real age if Non-TEFRA, and enroll as Individual; If TEFRA, spouse is not rated separately.	N/A
3	EE + SP is Medicare	N/A	N/A
4	EE is Medicare + SP is Medicare	Rate spouse as Medicare if Non-TEFRA, and enroll as Medicare; If TEFRA, spouse is not rated separately.	N/A
5	EE is Medicare + CH	N/A	Rate Child as Individual if Non-TEFRA, and enroll as Individual; If Child is <16, rate at age 16 as this is minimum age allowed for rating; If TEFRA, Child is not rated separately.
6	EE + CH is Medicare	N/A	N/A
7	EE is Medicare + CH is Medicare	N/A	Rate Child as Medicare if Non-TEFRA, and enroll as Individual; If TEFRA, Child is not rated separately.
8	EE is Medicare + SP + CH	N/A	N/A
9	EE + SP is Medicare + CH	N/A	N/A
10	EE is Medicare + SP is Medicare + CH	N/A	N/A
11	EE + SP + CH is Medicare	N/A	N/A
12	EE is Medicare + Two or more CH	N/A	N/A
13	EE is Medicare + SP + CH is Medicare	N/A	N/A
14	EE + SP is Medicare + CH is Medicare	N/A	N/A
15	EE is Medicare + SP is Medicare + CH is Medicare	N/A	N/A

**EE = Employee**

**SP = Spouse**

**CH = Child**

Note: Numbers 8 through 15 above: You will always rate on EE's actual age and enroll as Family, as there are three (3) or more members on contract.

## **REGIONAL DENTAL BENEFITS**

CareFirst offers a varied line of dental products including Traditional, Preferred (PPO), and DHMO, both ridered and freestanding; as well as a Discount Dental fee schedule for BlueChoice members. Each of these utilizes different networks of providers and all can be accessed via the CareFirst.com website.

### **REGIONAL DENTAL PORTFOLIO:**

- ⇒ Regional provider network across Maryland, D.C. and Virginia
- ⇒ Members outside of CareFirst's service area in Regional Traditional and Preferred products have access to a national network of participating dentists through Dental Network of America, Inc.
- ⇒ Unified portfolio of Traditional, Preferred(PPO) and DHMO dental products
- ⇒ Ability to sell dental products with medical coverage, freestanding or as part of a POE/Blue Selections combination
- ⇒ Consistent underwriting methodology and business rules
- ⇒ Ability to offer accounts parallel and non-parallel group enrollment
- ⇒ Comprehensive benefits – emphasis on preventive care
- ⇒ No balance billing for members when using in-network services
- ⇒ No claim forms for members to file when using in-network services
- ⇒ Ability to add orthodontics coverage (up to age 19) to Traditional and Preferred (PPO) plans. Orthodontia is included in the DHMO products
- ⇒ All dental products (Traditional, Preferred, and DHMO) combine for participation requirements

### **REGIONAL BUSINESS RULES:**

- ⇒ Groups offering one medical plan can offer a DHMO plan combined with either a Traditional or Preferred plan
- ⇒ Groups offering two or three medical plans can offer up to two dental plans.
  - Note: If group is offering two dental plans, the two dental offerings must be selected from different product types.
  - The three product types are:
    - Regional Traditional
    - Regional Preferred (PPO)
    - DHMO (HMO or Opt-out)
  - Example: Group offering two dental plans could choose one Traditional plan and one Preferred dental plan.
- ⇒ New and renewing groups must have 75% of eligible employees enrolling in the dental plans offered (Traditional, Preferred, and DHMO).
- ⇒ For all 1-50 groups (regardless of medical product), the dental tier rate structure must match the medical tier rate structure.
- ⇒ Example:
  - Four (4) tier MPOS – must take four (4) tier dental
  - Two (2) tier BluePreferred/ BlueChoice – must take two (2) tier dental
  - Four (4) tier BluePreferred/BlueChoice – must take four (4) tier dental

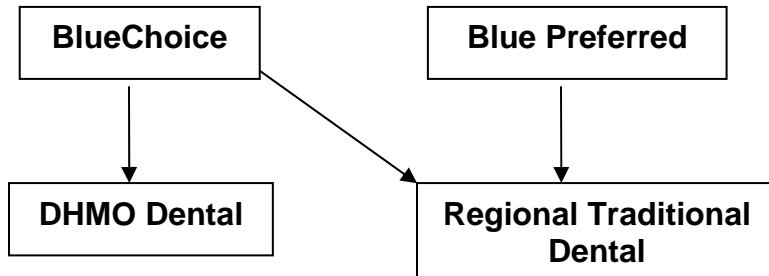
### **Parallel Group Enrollment:**

- For groups that offer both medical and dental benefits, parallel group enrollment means that all eligible employees may choose either:
  - Medical & Dental OR
  - No coverage
- All employees must enroll in medical and dental under the same coverage level. (Example: Family Medical, Family Dental)

## **REGIONAL DENTAL BENEFITS (cont'd)**

### **Non-Parallel Group Enrollment:**

- For groups that offer both medical and dental benefits, non-parallel group enrollment means that all eligible employees may choose either:
  - Medical & Dental
  - Medical Only
  - Dental Only, Traditional and Preferred; DHMO is only available with BlueChoice
  - No coverage
- Employees may enroll differently in medical and dental. (Example: Family Medical, H/W Dental)
- **Exception:** Even though the employer has selected non-parallel group enrollment, anytime Ridered DHMO dental is offered and selected by someone enrolling in BlueChoice medical, the member must enroll in Ridered DHMO dental at the same coverage level that they selected for medical. For example, if a member chooses BlueChoice family medical coverage, they must choose family Ridered DHMO coverage.
- **POE Example:** POE existing of BlueChoice and BluePreferred. Group is offering both Regional Traditional and DHMO dental. Non-Parallel Group Enrollment selected



**Important Note:** BlueChoice members can select Ridered DHMO or Regional Traditional. If Ridered DHMO is selected, the member must enroll in the dental at the same coverage level selected for the medical. If member elects the Regional Traditional they may enroll differently in the medical & dental as the employer has selected Non-Parallel group enrollment. BluePreferred members can only select Regional Traditional, but may enroll differently in medical and dental.

### **PARALLEL / NON-PARALLEL MOVEMENT GUIDELINES**

- ⇒ Groups can change their parallel / non-parallel group enrollment status upon renewal
- ⇒ The only time a group can change between parallel and non-parallel enrollment off-cycle is:
  - If the group is changing their medical benefits; or
  - If the group is adding Regional dental

### **Ridered DHMO Enrollment**

- ⇒ Ridered DHMO enrollment will always be parallel to the medical enrollment even if the employer has chosen non-parallel group enrollment (i.e. BlueChoice family medical / Ridered DHMO family dental)
- ⇒ In a POE/Blue Selections combination, BlueChoice members do not have to choose Ridered DHMO coverage if multiple dental products are offered. If they do choose Ridered DHMO, they must have parallel enrollment.
- ⇒ Members enrolling in BluePreferred medical products cannot enroll in Ridered DHMO dental.

## **REGIONAL DENTAL BENEFITS (cont'd)**

### **Short Plan Year Dental**

- ⇒ Regional Dental products or orthodontia benefits can be added to existing medical plans for a short plan year without affecting the medical renewal month.
- ⇒ No changes can be made 90 days prior to the renewal date. You may not change, remove or add dental during this timeframe.

### **Freestanding DHMO**

- ⇒ Definition: DHMO underwritten by The Dental Network that can be offered alongside CareFirst Regional Traditional and Preferred Dental products and/or medical products or without other CareFirst medical or dental products
- ⇒ TDNs “Provider Choice” products
- ⇒ Enrollment in these products is combined with Regional Traditional and Preferred product enrollment to meet total participation requirement of 75%
- ⇒ There is no participation requirement for the Freestanding DHMO if offered with no other CareFirst dental product
- ⇒ Available to groups with 2 eligibles; 1 enrolling
- ⇒ Can be offered non-parallel

### **Freestanding Dental Business Rules**

- ⇒ Definition: An account with CareFirst dental coverage and medical coverage with another carrier.
- ⇒ Regional Traditional and Preferred products as well as the Freestanding DHMO products can be sold as freestanding.
- ⇒ 75% participation of eligible employees on the Regional Traditional and Preferred products
- ⇒ No participation requirement on the Freestanding DHMO products
- ⇒ Group must prove medical coverage with another carrier by submitting current health carrier invoice
- ⇒ Freestanding dental groups may only offer one dental plan
- ⇒ FreeStanding Dental may only be sold with first of the month effective dates. Freestanding Dental may not be sold 15th of the month.
- ⇒ New and renewing groups with Freestanding Regional and Preferred dental will receive a 15% rate load
- ⇒ Freestanding dental group will be sold under a CFMI contract if the group is located in any Maryland county, except PG and Montgomery counties; it will be sold under a GHMSI contract if located in PG/Montgomery counties.
  - CFMI - Small Group Regional Dental Information Form (CFMI) PPN/MPOS/ Dental employee application
  - GHMSI – BluePreferred Group Application, BluePreferred member application

### **BlueChoice Discount Dental**

- ⇒ The BlueChoice Discount Dental is core to all BlueChoice medical products and not available to any other CareFirst products
- ⇒ A fee schedule of discount fees rather than a percentage of discounts is used
- ⇒ The Discount Dental fee schedule is an added feature to the BlueChoice product line and is not a contractual benefit; nor can it be carved out of the benefit/rate package

## **REGIONAL DENTAL BENEFITS (cont'd)**

### **NEW SALES**

#### **Regional Dental – MSGR Group / MSGR Member Applications**

##### **Parallel Group Enrollment**

BlueChoice Plan(s) with Regional Traditional, Preferred or DHMO Dental	BlueChoice Group Application BlueChoice Member Application
BluePreferred Plan(s) with Regional Traditional or Preferred Dental	BluePreferred Group Application BluePreferred Member Application
POE BlueChoice/Blue Preferred With Regional Traditional, Preferred Dental or DHMO dental	BlueChoice Group Application BluePreferred Group Application  <b>BlueChoice Member Application (Used to enroll in medical <u>and</u> Traditional, Preferred or DHMO dental)</b>  <b>BluePreferred Member Application (Used to enroll in medical and Traditional or Preferred dental).</b>
PPN/MPOS Plan(s) with Regional Traditional or Preferred Dental	CFMI Information Sheet PPN/MPOS/Dental SEGO Application
Freestanding Dental – CFMI	CFMI Information Sheet PPN/MPOS/Dental SEGO Application
Freestanding Dental – GHMSI	BluePreferred Group Application BluePreferred Member Application

##### **Non-Parallel Group Enrollment**

BlueChoice Plan(s) with Regional Traditional, Preferred or DHMO Dental	BlueChoice Group Application BluePreferred Group Application  <b>BlueChoice Member Application is used to enroll in medical and DHMO dental if applicable. Member must also complete the BluePreferred application to enroll in Traditional or Preferred dental. Also use the BluePreferred application for employee enrolling in dental only.</b>
BluePreferred Plan(s) with Regional Traditional or Preferred Dental	BluePreferred Group Application BluePreferred Member Application
POE BlueChoice/Blue Preferred with Regional Traditional, Preferred Dental or DHMO dental	BlueChoice Group Application BluePreferred Group Application  <b>BlueChoice member enrollment form is used by the employee to enroll in medical and DHMO dental. A BluePreferred member enrollment form is completed to enroll in Traditional or Preferred dental.</b>  <b>BluePreferred member enrollment form is used to enroll in medical <u>and</u> Traditional or Preferred dental. Also use this application for employee enrolling in dental only.</b>
PPN/MPOS Plan(s) with Regional Traditional or Preferred Dental	CFMI Information Sheet PPN/MPOS/Dental SEGO Application
Freestanding Dental – CFMI	CFMI Information Sheet PPN/MPOS/Dental SEGO Application
Freestanding Dental – GHMSI	BluePreferred Group Application BluePreferred Member Application

## REGIONAL DENTAL BENEFITS (cont'd)

### MSGR Paperwork Requirements/Guidelines By Product(s) Sold

#### New PPN and or MPOS Group(s)

##### Sold With

#### Regional Traditional or Preferred Dental Non-Parallel or Parallel Group Enrollment CareFirst Maryland Inc. (CFMI)

New PPN and or MPOS groups sold with Regional Traditional or Preferred dental, or existing PPN/MPOS groups adding Regional Traditional or Preferred dental for a short plan year will be issued under CFMI contracts.

The CFMI contract allows for an employer to elect coverage for retirees, in addition to coverage for part-time employees and employees with other group sponsored coverage. **Reminder: The BlueChoice and BluePreferred (GHMSI) contracts do not.**

**CFMI business does not require a group application; however, the group must complete the Small Group Regional Dental Information Form (CFMI).** PPN and MPOS medical enrollees use the same application to enroll in dental.

**Note:** If the group chooses **Parallel** group enrollment, the group contract and employee benefit guides will include both the medical and dental in one booklet.

If **Non-Parallel** group enrollment is chosen, the group will receive separate medical and dental contracts and employee benefit guides. Therefore, employees will only be given benefit guides for the benefits that they elected.

#### New BluePreferred Group(s)

##### Sold With

#### Regional Traditional or Preferred Dental Non-Parallel or Parallel Group Enrollment Selected Group Hospitalization Medical Services, Inc. (GHMSI)

New BluePreferred group(s) sold with Regional Traditional and or Preferred Dental. Since the dental will follow the medical entity, the Regional Traditional or Preferred dental will be issued along with the BluePreferred medical under a GHMSI contract.

The medical and dental benefits will be covered by the same BluePreferred PPO Group Application.

The BluePreferred employee application will be used to enroll in both the medical and dental.

**Note:** If the group chooses **Parallel** group enrollment, the group contract and employee benefit guides will include both the medical and dental in one booklet.

If **Non-Parallel** group enrollment is chosen, the group will receive separate medical and dental contracts and employee benefit guides. Therefore, employees will only be given benefit guides for the benefits that they elected.

#### New BlueChoice Group(s)

##### Sold With

#### Regional Traditional, Preferred or any DHMO Dental Parallel Group Enrollment Selected

New BlueChoice group(s) that choose **Parallel** group enrollment and offer any of the following dental plans, only have to complete the BlueChoice medical employee application to enroll in both the medical and dental.

***DHMO, Regional DHMO, Regional Traditional, and or Regional Preferred***

**This is allowed as all CareFirst dental products have been filed on BlueChoice paper for ease with this type of enrollment. When Parallel enrollment is chosen, all employees enrolling, either take medical and dental or no coverage. And, all employees must enroll in both the medical and dental under the same coverage level. (i.e. Employee enrolled with Family Medical, must take Family Dental).**

A BlueChoice Group Application is also required. Because the group has elected **Parallel** group enrollment, the BlueChoice Group Application applies to both the medical and dental.

#### New BlueChoice Group(s)

##### Sold With

#### Regional Traditional, Preferred or any DHMO Dental Non-Parallel Group Enrollment Selected

New BlueChoice medical group(s) that choose **Non-Parallel** group enrollment, and elect to offer any of the following dental plans; **DHMO, Regional DHMO, Regional Traditional, and or Regional Preferred**, must complete the following:

A BlueChoice Group Application is required for the BlueChoice medical. This Group Application will also cover DHMO dental if offered by the group.

A BluePreferred PPO Group Application. is required for the Regional Traditional and or Preferred dental.

The BlueChoice member application is used by the employee to enroll in medical or DHMO Dental. To enroll in Traditional or Preferred dental, a BluePreferred member application must be completed.

Employee enrolling in dental only completes the BluePreferred member application

## REGIONAL DENTAL BENEFITS (cont'd)

### MSGR Paperwork Requirements/Guidelines By Product(s) Sold

#### New POE BlueChoice/BluePreferred Sold With

#### Regional Traditional, Preferred or any DHMO Dental Parallel Group Enrollment Selected

Group is purchasing BlueChoice and BluePreferred medical and is also offering two dental plans; Regional Traditional, Preferred or any DHMO product.

**Two group applications are required**, one for the BlueChoice medical

And ,  
one for the BluePreferred medical and GHMSI Traditional and /or Preferred dental.

**Because the employer has chosen “Parallel” enrollment**, employees enrolling in the BlueChoice medical plan can complete the BlueChoice employee application to enroll in both the medical and dental coverage. They can enroll in either the DHMO, Regional Traditional or Preferred dental on this application.

The employees selecting BluePreferred can enroll in both the medical and dental on the BluePreferred application.

#### **BluePreferred enrollees may not select DHMO dental if offered.**

Note: In a POE that includes both BlueChoice and Blue Preferred you may not offer DHMO as the only dental option, as BluePreferred members can not elect this type of coverage.

If you want to offer DHMO in a POE that has both BlueChoice and BluePreferred, you must also offer either Regional Traditional or Preferred dental.

#### New POE BlueChoice/BluePreferred Sold With

#### Regional Traditional, Preferred or any DHMO Dental Non-Parallel Group Enrollment Selected

Group is purchasing BlueChoice and BluePreferred medical and is also offering two dental plans; Regional Traditional, Preferred or any DHMO product.

#### **Two group applications are required:**

One for the BlueChoice medical /DHMO dental , if offered

And,  
one for the BluePreferred medical and GHMSI Traditional and or Preferred dental.

Employees enrolling in BlueChoice complete the BlueChoice employee application to enroll in the medical and any dental coverage.

The employees selecting BluePreferred can enroll in both the medical and either the Regional Traditional or Preferred dental on the same application.

Employee enrolling in dental only completes the BluePreferred member application.

#### **BluePreferred enrollees may not select DHMO dental if offered.**

Note: In a POE that includes both BlueChoice and Blue Preferred you may not offer DHMO as the only dental option as BluePreferred members can not elect this type of coverage.

If you want to offer DHMO in a POE that has both BlueChoice and BluePreferred, you must also offer either Regional Traditional or Preferred dental.

## **REGIONAL VISION BENEFITS**

### **OVERVIEW:**

- ⇒ Regional Vision is being offered by CareFirst BlueCross BlueShield through Davis Vision.
- ⇒ The new consolidated vision programs will be called BlueVision and BlueVision Plus.
- ⇒ BlueVision is included in all BlueChoice and BluePreferred plans, except the core MSGR plans and the Consumer Driven Health plans
- ⇒ BlueVision offers a comprehensive eye exam for a \$10 copay and discounts on eye ware including lenses, frames and contacts once per benefit period (12 month period).
- ⇒ BlueVision *Plus* offers a comprehensive eye exam and the opportunity to receive one free pair of eyeglasses or a supply of contact lenses each benefit period (12 or 24 month period).
- ⇒ Launched on all platforms on July 1, 2004, for October 1, 2004 effective dates.
- ⇒ Off cycle changes to add Regional Vision are available; except 90 days prior to the Account's renewal for MPOS and PPN.
- ⇒ The BlueVision *Plus* plan is installed on the same platform as the medical plan for the Account.

### **UNDERWRITING GUIDELINES:**

- ⇒ BlueVision (the core product) always has parallel enrollment.
- ⇒ BlueVision Plus is only offered to groups with the BlueVision core product. The exception to this rule is the case of the Consumer Driven Health plans that do not offer a core BlueVision product, but can be sold with the upgraded BlueVision Plus product.
- ⇒ BlueVision *Plus* may be either parallel or non-parallel.
- ⇒ New and renewing accounts must have 75% of eligible employees enrolling in the BlueVision *Plus* plan.
- ⇒ The only exception to the above rule is an existing non-parallel CFMI vision group that does not meet the 75% participation guidelines may be grandfathered for the first year (subsequent renewals will require account to be compliant).
- ⇒ The entire account will not be re-rated as a result of adding vision.
- ⇒ Freestanding vision and vision offered with dental is available for accounts with 2 eligible, one enrolled.
- ⇒ Groups whose renewal is released with medical and BlueVision *Plus*, but choose to terminate the medical may re-write the vision on a Freestanding basis

### **BUSINESS RULES:**

- ⇒ BlueVision *Plus* can be added to an existing medical CFMI (PPN or MPOS) account for an initial short plan year. It will run from the effective date the vision was added through the end of the current medical contract period.
  - BlueChoice and/or Blue Preferred products-short plan year BlueVision *Plus* can only be added if the (group **already has the BlueVision core product or is enrolled in a CDH product.**)
- ⇒ Vision cannot be added if a group is within 90 days of their medical contract renewal date.
- ⇒ Groups can change their parallel/non-parallel enrollment status upon renewal.
  - if the group is changing their medical benefits; OR
  - if the group is adding Regional Dental or BlueVision *Plus*.
- ⇒ BlueVision *Plus* is not an age-rated product, therefore, enrollees with vision only will not be included in the average age.
- ⇒ For all 1-50 groups (regardless of medical product), the BlueVision *Plus* tier rate structure must be consistent with the medical tier structure.

## **SELF-EMPLOYED INDIVIDUALS**

The passing of SB952 now allows **existing** self-employed groups to enroll in any of our MSGR products upon renewal.

- ⇒ This applies only to current self-employed enrollment; as no new self-employed can be written into the MSGR market.
- ⇒ Any migrations will be screened for self-employed eligibility and the complete migration information must be provided to the **General/Full Service Producer**, or CareFirst Broker Sales Representative (if a direct broker).
- ⇒ All requirements for any group moving from one CareFirst legal entity to another (PPN and MPOS (CFMI); BlueChoice (BlueChoice Inc); BluePreferred (GHMSI)) must be followed.
  - ⇒ Requirements include current tax documents, a new Group Application and new enrollment forms.
  - ⇒ If moving from a CFMI product to a GHMSI or BlueChoice Inc product, a first month's premium check is also required.

### **The following tax documents are required for any self-employed moving from one CareFirst legal entity to another:**

Form 1040 or 1040 EZ and any one of the following tax documents from previous taxable year:

- Schedule C or CEZ      Sole Proprietor Profit/Loss
- Schedule F              Farm Profit/Loss
- Schedule SE             Self-Employed Income
- Form 1120                Corporation
- Form 1120-S             Sub-Chapter S Corporation
- Form 1065 w/K-1        Partnership or Limited Liability Corporation (LLC)
- Form 7004                Request for Extensions; Application for Automated Extension of Time to File for Corporate Income Tax
- Form 4868                Individual Application for Extension

If the self-employed is a licensed professional, he/she is not required to provide tax documentation, but in lieu must provide the following:

- Copy of their Articles of Professional Incorporation and
- Letter of Good Standing from the licensing group

**Notarized letters are not acceptable documentation.**

### **Past Changes:**

Effective October 1, 2005 legislation was passed that changed the definition of "small employer group" as it related to the self-employed market.

- ⇒ Those who are self-employed will no longer be eligible to enroll as a new subscriber in a small employer group health plan product
- ⇒ There will no longer be an open enrollment period offered
- ⇒ Existing self-employed groups may continue to be enrolled with their current carrier

CareFirst suggests that those who are newly self-employed contact our Individual Sales Department **and apply for a medically underwritten health policy.**

## **SELF-EMPLOYED INDIVIDUALS (cont'd)**

### **BASIC ELIGIBILITY:**

- ⇒ An existing self-employed individual must reside and work in MD for at least 30 hours per week on a regular basis and the business must be an active entity.
- ⇒ Coverage through a spouse, Medicaid or any direct-pay policies would have classified the self-employed person as ineligible for Small Group Market Reform coverage.
- ⇒ Active Medicare-eligible self-employed were enrolled as long as they met the other eligibility requirements. CareFirst provides a Medicare rate for Medicare eligibles, for all products.
- ⇒ Licensed professionals were enrolled as long as they met the criteria as defined by House Bill 8, *“an individual engaged in a licensed profession through a professional corporation organized in accordance with Title 5, Subtitle I of the Corporations and Associations Article and who received health benefits through a professional association prior to July 1, 1994”*.  
*Note: A limited liability partnership does not meet this criteria.*
- ⇒ Self-employed individual’s primary method of deriving income must have been from the self-employment.

### **MSGR Product Portfolio:**

Brokers have found our MSGR Product Portfolio to be a useful tool in quickly referencing all of the options offered under CareFirst’s varied product lines with a high level description of each option. The on-line Benefit Summaries available on the Broker website can then be used to reference detailed benefits for each option. Please visit [www.carefirst.com](http://www.carefirst.com) under News and Updates for the most recent product portfolio.