OhioHealthy

Broker Guide

For Self-Funded Health Plan Designs and Stop-Loss Insurance

PROVIDING IMPORTANT INFORMATION REGARDING:

- **Eligibility**
- **Group submission**
- **Underwriting guidelines**
- **Installation**

Self-Funding Could Mean Healthy Savings for Your Clients

Why Self-Funded Plan Designs Are the Right Choice

More and more employers are considering a smart strategy to save money – with potential for immediate savings and cost containment into the future through self-funding. What was once traditionally viewed as viable for only larger companies, self-funded plan designs with stop-loss insurance offer key advantages that could benefit all employers.

OPPORTUNITIES FOR YOU

Quick turnaround on proposals with simplified underwriting.

OPPORTUNITIES FOR EMPLOYERS

Savings compared to fully insured plans and an **opportunity for a refund**.

Quality provider access.

Transparency with monthly reports showing how claim dollars are being spent.

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	Eligibility and Contribution Requirements
Groups	• Employers must have five or more enrolled employees for a self-funded plan design with stop-loss insurance from Trustmark Life Insurance Company. — Inforce groups with five or more eligible employees and five or more enrolled will be eligible to receive an offer for their new plan year. • An eligible group is one that files a completed and signed State Quarterly Wage and Tax Statement listing all employees and wages or an appropriate tax document. • Corporations, partnerships and sole proprietorships are eligible for coverage. • Carve-outs may be allowed, subject to non-discrimination rules. — Management carve-outs are not acceptable if the owners of the company are the only members. — Union employee carve-outs are permitted if the collective bargaining agreement addresses health coverage and the employer provides adequate proof of union membership, which includes: • Union membership rosters, or • Payroll records showing union dues If the above materials are provided, waivers from union employees are not required. • A Professional Employer Organization (PEO) is not eligible for stop-loss coverage from Trustmark Life Insurance Company. — Employers associated with a PEO may be considered. — Three months of payroll or a State Quarterly Wage and Tax Statement, separate from the other employers associated with the PEO, will be required.
Employees and Dependents	The self-funded plan must be offered to all eligible employees and their dependents. • An eligible employee to be considered for the employer's self-funded plan is one who: — Has a formal employer-employee relationship that can be confirmed by demonstrating the employer pays FICA wages and reports them on a Federal W-2. — Is an employee, including a proprietor or partner, who works for the participating employer for the minimum number of hours specified by the employer, but no less than 25 hours per week on a regular basis. — If applicable, under the Affordable Care Act: • Is an employee of the employer who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the employer's Measurement Period1 and is eligible during the employer's Stability Period2, as documented by the employer and consistent with the Affordable Care Act, applicable regulations and regulatory guidance; • Has satisfied the waiting period, if any, required by the employer; and • Is a member of a class eligible for coverage. A person may be considered an eligible employee if they are not actively at work due to hospital confinement or disability. An employee must reside in the U.S. and be: — A U.S. citizen and possess a Social Security number; or — A legal alien, and possess a green card and a Social Security number • An eligible dependent is an eligible employee's: — Legally married spouse — Child who has not yet attained age 26 (age may vary by state), or a child who is the subject of a court-issued, qualified medical support order. A child placed for adoption (including the time before the adoption is final) will be considered an eligible dependent. Note: Child includes adopted children, stepchildren and foster children. A foster child means a child who is placed with the eligible employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. — Domestic partner3, when legally required — Civil unions, when legally required

	Eligibility and Contribution Requirements (cont.)
Employees and Dependents (cont.)	• Groups with employees earning at least minimum wage and who are not considered full-time employees must submit the employees' hourly rate, number of hours worked per week and job description. • Groups employing both spouse/domestic partner on a full-time basis should write them as employee and dependent with the older written as the employee. If both appear on the State Quarterly Wage and Tax Statement as full-time employees, they can be written as separate employees. • Independent contractors, commissioned or 1099 employees may be considered on groups of five or more enrolled employees if they work for only one employer and comprise no more than 50 percent of the total employees enrolling in the self-funded health plan. A copy of the 1099 form for each employee will be required. • Part-time, temporary, seasonal, retired or leased employees are not eligible for the self-funded plan unless required by federal law. • Boards of Directors, shareholders and/or silent partners are not considered eligible for the self-funded plan unless they can show a full-time employment status. [1] The period of time, as determined by the Employer and consistent with Federal law, regulation and guidance, utilized by the Employer to determine whether a variable hour employee is an Eligible Employee. [2] The period of time as determined by the Employer and consistent with Federal law, regulation and guidance, after the initial or standard Measurement Period has been completed. [3] Domestic partner coverage is an optional benefit.
Contributions	No employer contribution is required.

	Participation, Licensing and Appointments
Participation Requirements	• The minimum participation requirement for each eligible group enrolling for coverage is 75 percent of eligible employees after valid waivers are removed. — Eligible employees and dependents may be excluded from medical coverage and not be counted toward meeting participation requirements if they have comparable medical insurance not sponsored by the employer. Valid waivers include, but are not limited to the following types of coverage*: • Individual • Individual Exchange (Note: SHOP Exchange is not a valid waiver.) • Medicaid • Medicare • Spouse's group plan • Veteran's — If an employee is covered by another medical plan sponsored by the employer, that employee will be considered for participation. • No more than 20 percent of the employees enrolling for coverage may be on COBRA at the time of application.

Participation, Licensing and Appointments (cont.)

Licensing Requirements and Appointments	Brokers are required to hold a current license in each state in which business is being solicited and be appointed by Trustmark Life Insurance Company when the first piece of business is submitted in order to earn compensation. To be appointed, brokers must first submit the following paperwork to us: 1. Copy of current state license 2. Completed Appointment Questionnaire using form T300-55_OHy Brokers in preappointment states must be appointed before sending in their first case to Trustmark Life Insurance Company. Brokers in non-preappointment states must also be appointed, but may submit the appropriate paperwork with the signed Application for Insurance Coverage (SL-0601 APP) for their first case. No additional cases may be submitted until broker appointment is completed. Although Errors and Omissions (E&O) coverage is not required for appointment, it is highly recommended that brokers secure this coverage. Please note that many E&O carriers require a separate rider be purchased when selling stop-loss business. For a list of appointment guidelines by state, please refer to our website. Note: If the broker pays compensation to an agency, the agency must also be appointed. Pursuant to state requirements and our policy, when broker compensation is payable to an agency, both the agency and the writing individual must be licensed and appointed in the state where business is located. Compensation is paid only via direct deposit. For more information about broker compensation, including policies and practices, refer to the New Broker Compensation Guide. **Background Investigations** The Federal Violent Crime Control Act prohibits any individual convicted of certain crimes to participate in the business of insurance. The law also prohibits insurance carriers from conducting business with any individual convicted of such a crime. Therefore, we may conduct a background criminal investigation on any broker applying for appointment. Some states also require that a credit and/or criminal report be obtained on the broker prior to appointment. **Renewals and Reappointments** • Brokers are required to maintain a current license by complying with all state renewal and continuing education requirements. Information can be obtained by calling the state department of insurance.

General Plan Provisions

Multiple Option Plan Designs	Multiple option plan designs offer flexibility for today's employers. Employers simply combine currently marketed plan designs using the established guidelines to create a plan to meet their business needs and budget. • Multiple option plan designs may be formed at a group's anniversary. • Groups with a multiple option plan design can make a plan change at anniversary. Once the plan change is implemented, employees can only change from one plan to another at the time of the plan change or at the group's anniversary.
Limited Occupational/ 24-Hour Coverage	Sickness or injury which occurs while working for wage or profit is not covered, except for a member who is a sole proprietor, partner or executive officer of the company sponsoring a plan administered by OhioHealthy Plans, LLC, who is: • Not required by law to have Workers' Compensation or similar coverage; and • Does not have such coverage
Deductible Credit for New Groups	• A member continuously covered under a prior individual or group health plan with a calendar-year deductible will be credited for any portion of the deductible satisfied under the prior plan during the same calendar year. Only plan designs with a deductible greater than $0 are eligible to receive deductible credit. Deductible credit will not be given if moving to or from a health plan with a plan-year deductible. Credit is not provided for out-of-pocket amounts (other than amounts applied to the deductible), prescription drug card deductibles or for employees added to a self-funded plan after the group's initial effective date.

General Plan Provisions (cont.)

Stop-Loss Insurance	Stop-loss insurance limits the employer's claims liability in two ways: 1. Specific stop-loss protects the employer if employee or dependent eligible claims exceed a specified amount, or specific deductible. The specific deductible, based on group size and risk, will be determined in the quote; however, the employer has flexibility. For most states, the specific deductibles are $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000, $50,000 or $75,000 per participant. The stop-loss insurance pays eligible claims exceeding this amount for the remainder of the contract year. 2. Aggregate stop-loss provides additional protection if total eligible claims for all employees and dependents exceed a defined amount, or aggregate attachment point. If eligible claims exceed this amount, the stop-loss insurance pays additional eligible claims for the remainder of the year.
Stop-Loss Advancements	If claims spike early in the year exceeding the current claim fund balance, funds will be advanced to cover those costs. That money is then recovered from the employer's future payments. If claims continue at a high level, the stop-loss insurance provides a safety net. Advanced funds can be used for both specific or aggregate claims any time during the year, providing monthly payments are up to date.
Runout	• Runout is the period of time immediately following the end of the stop-loss insurance contract period in which we continue to process claims incurred, but not received, during the contract period. • The Traditional Cash Surplus option runout period twelve months. Any money remaining in the employer's claim pre-fund account at the end of the runout period will be refunded to the employer.
Member Claim Payment	As the primary risk holder, the plan sponsor is responsible for all claim decisions. Because the plan sponsor uses a third-party administrator (TPA) to pay claims, the TPA is given the authority to make the majority of claim decisions on behalf of the plan sponsor. If the sponsor elects to pay a claim that falls outside the scope of the plan document, that claim will not be covered under the stop-loss insurance contract.

Submitting a Case

Submission Requirements	The following items must be submitted for all groups enrolling: 1. Application for Insurance Coverage (SL-0601 APP) 2. Employee Eligibility Statements 3. Broker Compensation Notice (UW8_OHy) 4. State Quarterly Wage and Tax Statement (may be required at the discretion of the underwriter) 5. Prior carrier bill 6. Groups that cannot provide a prior carrier bill and start-up businesses will be required to provide an Eligible Employee Census (T401-14_OHy) Please provide all completed forms to your sales contact who will submit each new business case to us. All forms must be properly completed and specific details provided for all questions answered. Completeness is mandatory.
Submission Requirements for Qualified Groups	Simplify the underwriting process for groups by completing the member/dependent-level census, which replaces individual medical questionnaires. To receive an initial underwritten rate after reviewing the initial proposal, send the following to your sales contact: • Completed member/dependent-level census (T401-49) To submit the group for an offer of coverage, the following must be included: • Employer application • Self-Funded Plan Design Employee Enrollment Census Template (T401-41_OHy) • Employee Enrollment Acknowledgment (T401-40_OHy) • Employee/Dependent Waiver Template (T401-38_OHy) • Waiving Employee/Dependent Acknowledgment (T401-39_OHy) • Prior carrier billing statement • Broker agreement and appointment paperwork Underwriting will review and may request additional information. Note: Alternatively, groups can be underwritten via individual medical questionnaires, if they choose.

	Case Submission Guidelines
Application for Insurance Coverage (SL-0601 APP)	When an employer is applying for stop-loss insurance or ancillary insurance coverage, they should use the current version of the Application for Insurance Coverage (SL-0601 APP) based on the location of their headquarters. Refer to the appropriate state page on our website for the current application. Brokers may not alter the application on behalf of the employer. Altered forms will not be accepted. If the application is altered, a new form will be requested before an offer of coverage is made. The form must be signed and dated by both the company officer and the broker. The broker signing the application must hold a valid license, with the appropriate designations, effective prior to the signature date. The Company will rely on the data included in the application for stop-loss insurance to assist in underwriting the Employer for insurance. The Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form, which captures information regarding medical conditions and treatment of eligible persons, is made part of the application for insurance coverage and shall be relied upon in determining rates and eligibility for coverage. The Company has the right to revise the rates (retroactively or prospectively) for the Stop-Loss Insurance Contract, or rescind or terminate the Stop-Loss Insurance Contract if a person completes the Employee Eligibility Statement, Employee Application, Employee Enrollment Form or other similar form, collectively ("Form") with false, incomplete or misleading information or fails to notify the Company of any changes to the answers to the medical information question in any Form resulting in a material misrepresentation affecting the assessment of the risk or the terms or conditions for coverage.
Employee Eligibility Statement	• Use the current version of the Employee Eligibility Statement that corresponds to the completed Application for Insurance Coverage. • A completed Employee Eligibility Statement or waiver must be submitted for all employees eligible for coverage and employees in a waiting period. The Employee Eligibility Statement must be signed and dated within 90 days of the effective date. • If forms are submitted after the offer has been accepted, we may re-underwrite the group and charge the appropriate cost as of the original effective date. • Before an offer is accepted by a company officer, we should be advised of any changes in employee or dependent(s) health status that occurred after the Employee Eligibility Statement was completed. • Employee Eligibility Statements must be completed, signed and dated in ink by employees only. Brokers may not complete or alter any Employee Eligibility Statement on behalf of an employee. Altered forms will not be accepted. If the statement is altered, a new form will be requested before an offer of coverage is made. • If an employee fails to answer or correct a medical question, or fails to mark the waiver on the Employee Eligibility Statement, we will obtain the missing information through a telephone interview. • Please ensure each employee statement clearly indicates the coverage applied for and network selection prior to submitting to us. • Waivers must be completed, if applicable. • Upon completion of the Employee Eligibility Statement, any Notices that are attached must be detached and given to the employee.
Broker Compensation Notice (UW8_OHy)	The Broker Compensation Notice (UW8_OHy) must be completed and signed by the broker to ensure compensation is paid appropriately. The UW8_OHy is included with the Application for Insurance Coverage (SL-0601 APP).
Proposals	Proposals are generated using our online quoting system. Please call or email your sales contact to obtain a proposal. All employee names must correctly appear on the proposal. The proposal should correctly quote the group's requested plan design before it is submitted. All groups will be composite rated.
Prior Carrier Bill	• If the group is a takeover group, please submit the most recent prior carrier bill to us. Indicate whether or not COBRA was elected for any employee that has terminated coverage. If COBRA was elected, a completed Employee Eligibility Statement must be submitted. • If the group has no prior medical coverage, the Eligible Employee Census (T401-14_OHy) is required.

	Stop-Loss Underwriting Guidelines and Group Installation
Stop-Loss Insurance Coverage	• The underwriting process may include personal phone interviews by the Underwriting Department. • Individuals who waive coverage and are covered under another company's COBRA plan will be underwritten. Anticipated claims on these individuals will be assessed and may contribute to the group's rate-up in cost. • The stop-loss carrier reserves the right to rerate a group if a terminated individual elects COBRA within 60 days after he/she has been notified of COBRA eligibility.
Effective Date of Coverage	• Groups may only have a first of the month effective date. • All enrollment forms must be completed and received by the stop-loss carrier's Underwriting Department by the 10th of the effect calendar month being requested.. • If underwriting is not completed by the 20th calendar day, the group will receive a later effective date. An employer must not cancel current coverage until written notification is received from us. Coverage is not in effect until written notification is received from us.
Initial Underwriting	• Underwriting may request additional information during the underwriting process to properly evaluate the risk associated with the group. • Changes in plan design or effective date can be made during the initial underwriting process. • Once an offer is accepted by a company officer and the broker, and it is returned to us, no changes can be made to the health plan before the group's first anniversary. All groups will be medically underwritten. If an offer of coverage is extended, final rates will be based on the total health risk associated with the group.
Group Installation	**Offer** Upon completion of underwriting, if an offer of stop-loss coverage is extended, an offer notice that includes final rates will be sent to the sales contact. **Acceptance** After acceptance is received by Underwriting, the following documents will be provided to the employer: 1. Plan document 2. Administrative Services Agreement These documents must be signed and dated by the employer and returned to Underwriting. **Issuance** The group will be issued and an approval notice will be sent to the employer, sales contact and broker. The following information is sent to the group: • Employee plan document provides a comprehensive explanation of self-funded benefits for covered employees • Stop-loss insurance contract • Initial billing statement Additionally, the group administrator can conveniently access enrollment and administration resources at myOhioHealthyUnity.com. **Medical ID cards for each covered employee** ID cards for each covered employee will be mailed to the member directly. **Prescription Drugs** Groups with a prescription drug benefit will be activated in the pharmacy benefit manager's system within 10 days of their employer's acceptance of the offer or on the group's effective date, whichever is later.

	Administration Guidelines
Monthly Payment Amounts	**Employer Costs** The monthly employer bill includes costs for stop-loss insurance, claim funding and administration expenses. • Premium for stop-loss insurance is the cost for this insurance protection, which pays covered expenses that exceed the aggregate attachment point and specific deductible. • Claim funding is used for the group's annual claim liability. This money belongs to the employer and any money remaining at the time of surplus determination or at the end of the runout period can be used for future claim expenses, refunded to the employer. • Administration expenses cover costs such as claim processing, customer service, network access and other administrative services. • The bill is due on the due date noted on the bill. There is a 31-day grace period for late payment. Payment must be received by the 31st day or administrative services and stop-loss insurance coverage will be terminated.
Rate Guarantee	• All groups will have a 12-month rate guarantee. • All groups will be composite rated. • Adjustments for age will occur only at the employer's new policy period. • The monthly payment amount may change on any due date after it has been in effect for the applicable rate guarantee period. The rate guarantee period does not apply to any adjustment due to the following: 1. A change of more than 10% in the composition of the covered employees. 2. An addition of a subsidiary, location, newly purchased company, or a new class of employees to its plan. 3. The business is no longer in the same business as when the plan was originally effective. 4. Any changes to the plan's benefits. 5. Any change in federal or state law which affects all covered employees. The stop-loss carrier has the right to change the rates on any due date following the effective date of any state premium tax law, or change to such law. The amount of such change will be determined by the amount of the tax imposed.
Filing Form 5500	Unless an exemption applies, certain groups with self-funded plans are required by ERISA to file Form 5500 through the Department of Labor (DOL). Form 5500 must be filed within seven months after the end of the plan year. Fines and penalties will be enforced if plan sponsors fail to file or file late. For groups with 100 or more enrolled employees, we will provide data to facilitate the completion of Form 5500. For groups with fewer than 100 enrolled employees, we will continue to make the data to file Form 5500 available upon request.
Plan Design Changes	• Any change to the employer's current plan design may result in a stop-loss premium change or an increase to the monthly claim liability. All requests are subject to written approval by the stop-loss carrier. • No health plan design changes are allowed on new business cases within the first 12 months. • Employers may change plan designs on their new plan year, subject to underwriting approval. — Changes to the health plan design cannot be made within the three-month period prior to renewal as plan changes. • If a group requests the addition of a subsidiary, location, newly purchased company, or a new class of employees to its plan, or if group composition changes by 10 percent or more, the entire group must be re-underwritten. The group may be assigned a new group number and begin a new rate guarantee period. All claim history and accumulated benefits will be transferred to the new group health plan administration when appropriate. The rates will be the group's last renewal rates plus any adjustments to reflect the group's new composition and other risk factors as a result of the additional employees. These groups must submit all of the following: 1. Newly completed Application for Insurance Coverage (SL-0601) 2. Newly completed Eligibility Statement for employees being added to the plan 3. Most recent State Quarterly Wage and Tax Statement (may be required at the discretion of the underwriter) 4. Eligible Employee Census (T401-14_OHy) (may be required)

	Administration Guidelines (cont.)
Adding Employees and Dependents	**Annual Open Enrollment Period** Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year. Eligible employees and dependents who request coverage after the initial enrollment period will not be permitted to enroll in the plan until the annual open enrollment period or a qualifying special enrollee event. **Waiting Period** The waiting period is the amount of time the employee must wait before he or she is eligible for coverage under the self-funded plan. The waiting period cannot exceed 90 days. If 60 or more days are chosen as the waiting period, coverage must begin immediately following the waiting period. **Timely Enrollees** Timely enrollees are eligible employees who complete and sign an Employee Eligibility Statement for themselves and/or their dependents during the employer's waiting period or prior to the end of the initial enrollment period. The initial enrollment period is the 31 days following the waiting period. The effective date will be the first of the month following completion of the enrollment requirements. Self-funded coverage cannot become effective before the date the employee signs the Employee Eligibility Statement. Any Employee Eligibility Statement signed or received prior to the first day of employment will not be accepted. **Special Enrollees** Special enrollees who request coverage after the 31 days following the special enrollment event (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage) will not be permitted to enroll in the plan until the annual open enrollment period.
Medicare	• Health benefits, under self-funded plan designs, for employees or spouse/domestic partners who are age 65 and over will be paid secondary to Medicare when an employer has fewer than 20 employees. Covered charges will be reduced by any benefits payable by Medicare Parts A and B. Employees and spouse/domestic partners are considered to be enrolled under both Parts A and B whether or not they are actually enrolled. • When an employer has 20 or more employees and is subject to the Social Security Act (Section 1862 (b)), health benefits will be paid primary to Medicare. This will result in an increase in the monthly payment amount. An employee may choose to voluntarily waive coverage under the plan and elect Medicare as sole payor. • To determine employer size, Medicare will look at whether the employer had at least 20 employees (full- and part-time) in at least 20 weeks of the preceding or current calendar year.

	Administration Guidelines (cont.)
COBRA	Employers with 20 or more full- and part-time employees may be subject to COBRA. Our self-funded plan designs provide for continuation of coverage to satisfy COBRA requirements.
Terminations	The stop-loss insurance contract can be terminated for the following reasons: • Monthly payment is not received within 31 days of the due date; coverage for the entire group will terminate as of the due date. • The group fails to meet participation requirements. • The group submits a voluntary written request for termination. Coverage will be terminated at the end of the billing period in which the request is received and payment has been made. • The business moves to a state where stop-loss insurance coverage is not available. • The business is no longer engaged in the same business that it was on the date the group's stop-loss insurance contract was effective. • There is evidence of fraud or misrepresentation. • There is noncompliance with plan or contract provisions. • The employee benefit plan terminates. • The group suspends active business operations, is placed in bankruptcy or receivership, or is dissolved. **Early terminations:** If the administrative services agreement and stop-loss insurance contract terminate before the end of the contract period: • There is no aggregate stop-loss insurance available for the months the contract was in force. As a result, the employer is responsible for reimbursing Trustmark Life Insurance Company for any advances, including all aggregate advances. • The employer is responsible for funding all covered claims, below the specific deductible, if applicable, that were incurred and not processed while the agreement was in effect. For more information on terminations, including mid-contract year terminations and runout period claims payment, refer to the stop-loss insurance contract.
Reinstatements	Reinstatement is subject to underwriting approval.

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